In The Iowa Supreme Court
Supreme Court No. 20-0023

MARK H. ANDREW, M.D.,

Plaintiff-Appellee,

vs.

HAMILTON COUNTY PUBLIC HOSPITAL dba VAN DIEST MEDICAL CENTER,

Defendant-Appellant.

Appeal from the District Court for Hamilton County

The Honorable James A. McGlynn

Appellant's Final Brief

Oral Argument Requested

Frances M. Haas, AT0009838
David Bower, AT0009246
NYEMASTER GOODE, P.C.
700 Walnut Street, Suite 1600
Des Moines, IA 50309
Telephone: 515-283-3100
Facsimile: 515-283-8045

Email: fmhaas@nyemaster.com
Email: dbower@nyemaster.com

Attorneys for Defendant-Appellant
Hamilton County Public Hospital
dba Van Diest Medical Center

TABLE OF CONTENTS

Table of Authorities

Cases

Statutes and Regulations

Rules

Statement of Issues Presented for Review

I. Whether district court erred in denying summary judgment to the Hospital on Dr. Andrew's defamation claims.

II Whether the district court erred in holding that compensation Dr. Andrew may have earned, had the Hospital terminated the Agreement "without cause", constitutes wages under the Iowa Wage Payment Collection Act?

Routing Statement

This appeal presents both fundamental and urgent issues of broad public importance requiring ultimate determination by this Court, and a substantial question of enunciating legal principles. See Iowa R. App. P. 6.1101(2)(d) & (f).

To serve the public welfare, both Iowa and federal law encourage the confidential reporting of safety concerns relating to the provision of care by health care practitioners. In many instances, practitioners and health care entities are required to confidentially report certain conduct they believe "may" have occurred. To ensure the free flow of information, both Iowa and federal law provide broad immunity from any liability associated with such confidential reporting – reporting which, in many instances, may be based on incomplete information and the opinions of other health care practitioners. This broad statutory immunity exists precisely to permit and encourage such confidential reporting to allow the

relevant governmental bodies to fulfill their function of protecting the public welfare.

In analyzing Dr. Andrew's defamation claims, the district court erroneously applied common law, libel per se presumptions of falsity, malice, and damage to the Hospital's confidential reports of safety concerns relating to the care Dr. Andrew provided to his patients. In Bierman v. Weier, this Court declined to abandon these presumptions altogether, but expressly limited their application to cases "only when a private figure sues a nonmedia defendant for certain kinds of defamatory statements that do not concern a matter of public importance." 826 N.W.2d 436, 448 (Iowa 2013). Respectfully, the broad immunities provided under state and federal law for physicians and others who confidentially report patient safety concerns exist precisely for case like this, both to protect the public welfare and to avoid the inevitable chilling effect that will result from the rulings like the one that is the subject of this appeal.

The Hospital respectfully submits that guidance from the Iowa Supreme Court is needed for the district courts, health care providers, and counsel handling defamation claims like those asserted by Dr. Andrew.

Statement of the Case

Surgeon Mark Andrew ("Dr. Andrew") was a contractual employee for Hamilton County Public Hospital (the "Hospital"). (JA-I, 49). On December 15, 2016, Dr. Andrew's employment with the Hospital was terminated by then-CEO Lori Rathbun based on her determination that Dr. Andrew was not providing adequate patient care and had jeopardized the safety of his patients in violation of the parties' written Physician Employment Agreement (the "Agreement"). (JA- I, 49 [¶¶ 7, 9]; JA-I, 123 [§9(d)(i)]).

Following Dr. Andrew's termination, another physician filed two confidential written reports with the Iowa Board of Medicine (hereinafter "the Board") relating to Dr. Andrew's surgical practices and his prescribing of opioids. (JA-II, 18-26). The Hospital filed a

confidential written report with the National Practitioner's Data Base (hereinafter "the NPDB") reporting the termination of Dr. Andrew's privileges. (JA-II, 27-34).

On May 12, 2017, Dr. Andrew initiated this lawsuit, alleging breach of contract, breach of fiduciary duty, defamation, libel per se, and violation of the Iowa Wage Payment Collection Act ("IWPCA").[1] (JA- I, 7-11; JA-I, 48-53).

On December 21, 2019, the district court denied the Hospital's motion for summary judgment with respect to Dr. Andrew's claims for defamation, libel per se, and violation of the IWPCA.[2] (JA- I, 100-114).

---

[1] Dr. Andrew's Second Amended Petition is the operative pleading in this case. While pending in the United States District Court for the Northern District of Iowa, Judge Mark Bennett granted the Hospital's motion for summary judgment on Dr. Andrew's age discrimination claims. (JA-I, 12-43). Furthermore, Dr. Andrew voluntarily dismissed his claims against Lori Rathbun (deceased) on November 27, 2019. (JA-I, 100).

[2] The district court granted the Hospital's motion for summary judgment with respect to Dr. Andrew's breach of fiduciary duty

On January 7, 2020, the Hospital filed an application for interlocutory appeal, which was granted by this Court on February 7, 2020.

STATEMENT OF THE FACTS

A. Dr. Andrew's employment agreement with the Hospital.

Dr. Andrew, a general surgeon, was a contractual employee of the Hospital from 2008 through December 15, 2016. (JA-I, 49 [§§ 7, 12]). At all times relevant to this appeal, Dr. Andrew's employment with the Hospital was governed by a three-year written employment contract, which he and then-CEO Lori Rathbun executed on August 11, 2014. (JA-I, 116-132; JA-I 160 [54:9-55:1]).

The Agreement included several provisions relating to early termination, including termination "without cause" and "immediate termination." Relevant here, the Agreement provides:

> a. **Without Cause**. Either party may unilaterally terminate this Agreement without cause at any time by

---

claim and its motion for partial summary judgment with respect to Dr. Andrew's breach of contract claim. (JA-I, 100-114).

> notifying the other party in writing of its intention to terminate at least 90 days prior to termination. In the event Hospital terminates the Agreement pursuant to Section 9(a) Hospital may, at its option, relieve Physician of his duties under the Agreement during the notice period. If Hospital elects this option, Physician will continue to be eligible for employee benefit plans and will receive his compensation payments in accordance with Exhibit B during the notice period. Any bonuses owed to Physician pursuant to this Agreement will be determined and pro-rated based on the date Physician is relieved of his duties.
>
> [. . .]
>
> d. **Immediate Termination by Hospital.** This Agreement shall terminate immediately in the event Physician fails to meet any of the qualifications provided in Section 3 of this Agreement or if Hospital determines in good faith that:
>
> > (i) Physician is not providing adequate patient care or the safety of patients is jeopardized . . . .

(JA-I, 122-123). Further, the Agreement expressly provides that "[t]ermination of Physician's employment shall be governed solely by this Agreement and shall not be subject to corrective action, termination or grievance procedures applicable to other employees of

Hospital or to the hearing and appeal procedures set forth in the medical staff bylaws." (JA-I, 124 [§ 9(h)]).

B. A local pharmacy alerts the Hospital to concerns about Dr. Andrew's provision of care to one of his patients.

On or about November 15, 2016, a pharmacist at a local Hy-Vee notified the Hospital's Quality Manager, Peggy Roberts, that the pharmacy had concerns about prescriptions Dr. Andrew had written for his patient T.C. (JA-II 6 [§ 6]; JA-I, 196 [20:6-21]). Specifically, the pharmacist reported concerns with "large amounts and frequent refills" of hydrocodone prescriptions written by Dr. Andrew. (JA-II, 6 [§ 7]).

Roberts reported what she had learned to the Hospital's then-Chief Nursing Officer, Lisa Ridge. (JA-II, § 6). Ridge, in turn, brought this matter to Rathbun's attention. (JA-I, 196 [20:6-21]); JA-II, 6 [§ 8]). Rathbun promptly directed Ridge to conduct an investigation. (JA-I, 196 [20:6-21]; JA-I, 198 [33:24-34:3]); JA-II, 6 [§ 8]). In Rathbun's experience, it was "very unusual for an outside

pharmacist to call and highlight a concern to the quality manager at a hospital."[3] (JA-I, 198 [35:7-20]).

C. The Hospital investigates concerns about Dr. Andrew's provision of care.

At Rathbun's direction, Ridge reviewed T.C.'s lengthy medical chart and his report from Iowa's Prescription Monitoring Program ("PMP").[4] (JA-II, 6 [§ 8]). The medical chart showed that Dr. Andrew—a general surgeon—treated T.C. from July of 2012 until November of 2016 and assumed pain management care for T.C. even though he was not a pain specialist. (JA-I, 168-69 [149:25-150:10]). In

---

[3] In the course of her investigation, Ridge later learned that Hy-Vee was not the only local pharmacy that was concerned about Dr. Andrew. In fact, Ridge later learned that Dr. Andrew's prescriptions were "a long standing problem with several local pharmacies". (JA-II, 13).

[4] The PMP is a program run by the Iowa Board of Pharmacy and provides authorized providers and pharmacists with information regarding their patients' use of controlled substances. (JA-I, 165 [98:17-100:17]). Review of a patient's PMP can give a prescribing doctor information about whether a patient is misusing narcotics. (JA-I, 165 [98:17-100:17]). See also Prescription Monitoring Program, Iowa Board of Pharmacy, https: //pharmacy.iowa.gov/prescription-monitoring-program (last visited April 4, 2020).

addition, Ridge learned that other local pharmacies had similar concerns about Dr. Andrew's prescribing practices and had attempted to contact Dr. Andrew with no response. (JA-II, 9). One pharmacy reported that it had "refused to fill any further narcotics for [T.C.] and informed the patient as such." (JA-II, 9). Another pharmacy reported that it had "listed [T.C.'s] name on the Iowa Board of Pharmacy Website." (JA-II, 9). Ridge prepared a detailed report summarizing her review of the relevant documents and other information she learned, which she provided to Rathbun. (JA-II, 9-13).

After receipt of Ridge's report, Rathbun instructed the Hospital's Medical Director, Dr. Nicole Ehn, to review Dr. Andrew's care for T.C. (JA-I, 185 [28:12-29:4]). Following her review of Ridge's report, and T.C.'s patient chart and PMP, Dr. Ehn met with Dr. Andrew, Ridge, and Dr. Scott Altman[5] on December 8, 2016 to

[5] Dr. Altman was an outside consultant that worked with the Hospital on various issues relating to its operation. He was a

discuss Dr. Andrew's care of T.C. (JA-I, 170 [154:1-156:24]). Dr. Andrew informed the group that he typically limited his pain management care to postoperative opioid medications. (JA-I, 170 [157:4-7]). Andrew claimed that his prescription of pain medication for a longer period of time was atypical and rare. (JA-I, 170 [157:8-12]). He acknowledged that he never consulted the PMP for any of his patients, including T.C., and, in hindsight, use of the PMP would have flagged serious concerns in T.C.'s narcotic usage.[6] (JA-I, 171 [162:1-6]). Further, Dr. Andrew admitted he did not have T.C. sign a pain-management contract or use blood or urine testing to monitor his patients' use of narcotics. (JA-II, 16; JA-I, 165-166 [100:18-101:1, 116:11-117:14]). He testified that, aside from speaking to T.C., he did

---

practicing Emergency Physician licensed to practice medicine in the State of Illinois. (JA-I, 142 [12:12-16]).

[6] When he reviewed T.C.'s PMP at his deposition, Dr. Andrew observed T.C. appeared to be "double-double or triple-dipping" on single prescriptions that Dr. Andrew had written. (JA-I, 167-168 [145:3-147:2]). Had he learned about this issue earlier, Dr. Andrew testified that he would have "[p]robably discharged [T.C.] from my practice." (JA-I, 168 [147:11-13]).

nothing to determine if T.C. was abusing or misusing his prescription narcotics. (JA-I, 166 [117:11-14]).

At Rathbun's request, on December 9, 2016, Dr. Ehn summarized her assessment of Dr. Andrew's care of T.C. in a written report, which provides in relevant part:

> After reviewing [T.C.'s] chart, associated documentation and interviewing Dr. Andrew, I have remaining concerns regarding this case. First, it is unusual for a general surgeon to provide chronic pain management. Dr. Andrew states that he felt that [T.C.'s] pain was related to surgical issues, however it is noted several times in the chart that [T.C.'s] pain is likely related to his chronic orthopedic pain, arthritis in his hips and lumbar spine. Second, [T.C.] was prescribed a large amount of pain medication over the last [four] years. This was not adequately monitored by Dr. Andrew. He did not utilize the physician [sic] monitoring program and he did not confirm use with urine drug screens. He did not have the patient sign any contract regarding prescription of controlled substances. I continue to have questions regarding the medical treatment of this patient's testicular pain and subsequent orchiectomies. There does not appear to be any significant discussion about the after effects of a bilateral orchiectomy, the need for testosterone replacement and the risks and benefits of that. I wonder if a referral for a second opinion about his chronic testicular pain would have been appropriate prior to removing the second testicle. Lastly, the patient appears to have filled duplicate or multiple prescriptions, written

> on the same day, by Dr. Andrew, for large quantities of opioid medication. This raises questions about whether the patient was fraudulently manipulating prescriptions or if the physician was providing multiple, large quantity prescriptions.

(JA-II, 16-17). Dr. Ehn was concerned that a general surgeon was providing chronic pain management, especially in light of Dr. Andrew's failure to use tools such as the PMP, consultation with a pain specialist, a pain contract, or drug screenings. Dr. Ehn testified that she had "never seen" multiple prescriptions written for narcotics on the same day, which was reflected in the material she reviewed. (JA-I, 187 [41:1-22]). She also testified she was concerned that T.C.'s patient chart contained no documentation of consultation or counseling prior to T.C.'s right orchiectomy. (JA-I, 187 [41:1-22]).

Based on the information provided by Ridge and Dr. Ehn, Rathbun and Dr. Altman became concerned that Dr. Andrew may have treated other past and current patients in a similar, dangerous manner. (JA-I, 150 [71:1-8]; JA-II, 6 [§ 12]). As a result, Rathbun directed Ridge to consult the surgery department and determine

whether other patients who had treated with Dr. Andrew for pain management for an extended period of time. (JA-II, 7 [§ 12]). Ridge identified another patient, L.H., whom Dr. Andrew had treated for a cyst over for two years. (JA-I, 7 [§ 13]). As with T.C., Dr. Andrew had assumed long-term pain management care of L.H. and had not taken the appropriate steps to monitor L.H.'s narcotic usage. (JA-I, 168-69 [149:25-150:25]).

D. The Hospital's decision to terminate Dr. Andrew's employment.

After learning of this second patient and further consultation with Dr. Altman, Rathbun determined that, based on her "obligation to ensure patient safety and quality, [she] did not feel comfortable with Dr. Andrew staying on board as a physician at that point in time." (JA-I, 198A [45:16-47:2; JA-I, 149 [67:6-17]). As she testified:

> But the more immediate concern that caused me to terminate him immediately was surrounding a patient where we were advised from local pharmacies that there were concerns with prescribing practices, and within that my primary concern was after reviewing the documentation with my chief nursing officer and Dr. Scott Altman and Dr. Nicki Ehn, I became extremely

> alarmed about the level of opiate prescriptions that were – painkillers that were being prescribed to this patient, the fact that pharmacies had called without response from Dr. Andrew about their concerns related to those prescriptions, notes in the chart that the pharmacies were concerned about the prescribing practices, his response after being interviewed with firing the patient immediately when he didn't see any concerns with his practice, yet there was no documentation in the chart that he had fired the patient after being educated multiple times on pain management and that we had a pain management specialist, Dr. Christian Ledet, on staff, never consulted with Dr. Ledet or referred the patient over to Dr. Ledet. He maintained a practice with this patient for multiple years that did not seem appropriate for a general surgeon in practice.

(JA-I 195-196 [16:13-17:13]). Rathbun also shared Dr. Ehn's and Dr. Altman's concerns that Dr. Andrew had not sufficiently discussed with T.C. the aftereffects of a bilateral orchiectomy, the need for testosterone replacement, and the procedure's risks and benefits. (JA-I, 197-198 [31:3-32:4]). Based on his consultation with Rathbun, Dr. Altman confirmed that Rathbun's "principal concern really was [human resources], that [Rathbun] could have an employee who might be doing dangerous things or things that were not – that were concerning to her as an employer." (JA-I, 149 [67:6-13]).

On December 15, 2016, Rathbun met with Dr. Andrew and informed him that she was terminating his employment, effective immediately, pursuant to Section 9(d)(i) of the Agreement. (JA-I, 49 [¶¶ 12-13]; JA-I, 196 [18:7-19:16]). She provided Dr. Andrew with a written termination letter, which stated that the Hospital was terminating his employment "due to significant concerns about prescribing practices and patient care issues." (JA-I, 139; JA-I, 171 [165:25-166:25]). In relevant part, the letter of termination read:

> This letter is to inform you that your employment contract with the Hospital is being terminated pursuant to paragraph 9(d). This termination is effective immediately. You will no longer treat hospital and clinic patients. Pursuant to your contract, paragraph 9(h), your medical staff membership at the Hospital also terminates at this time.
>
> [. . .]
>
> This action is being taken due to significant concerns about prescribing practices and patient care issues. Please be advised that these issues have also been reported to the Iowa Board of Medicine and Medical Staff for the purposes of evaluation and Peer Review.

(JA-I, 139).

Despite the plain language of Section 9(h) of the Agreement ("Termination of Physician's employment shall be governed solely by this Agreement and shall not be subject to corrective action, termination or grievance procedures applicable to other employees of Hospital or to the hearing and appeal procedures set forth in the medical staff bylaws"), Dr. Andrew believed he should have been permitted to go through the peer review process before the termination of employment. (JA-I, 124; JA-I, 173 [176:3-16]). However, he agrees that Rathbun—not the Hospital's medical staff—had authority as CEO of the hospital to terminate his employment.[7] (JA-I, 174 [179:8-15]).

[7] As Dr. Altman testified, peer review is a quality improvement process for hospitals to "learn and improve and do better". (JA-I, 153 [91:3-13]). However, peer review is separate from – and serves an entirely different purpose than – a hospital's employment decisions. (JA-I, 153).

E. The Hospital's reports to the Iowa Board of Medicine and the National Practitioner Data Bank.

1. Dr. Altman's reports to the Iowa Board of Medicine.

Dr. Altman submitted two reports to the Iowa Board of Medicine about his concerns with Dr. Andrew's care of T.C. and L.H., on December 14, 2016 and December 15, 2016 respectively. (JA-II, 18-26). Dr. Altman believed he had an obligation to submit these reports because of the Hospital's concern about Dr. Andrew's quality of care and the potential risk to other patients. (JA-I, 151A [80:10-19]). Dr. Altman testified that the patient safety issues presented were "as serious" as he had ever seen. (JA-I, 152-153 [88:23–89:2]).

The two reports submitted by Dr. Altman each contain a lengthy "Narrative Information" section outlining the facts surrounding Dr. Andrew's care for each respective patient.[8] (JA-II, 19-20; JA-II, 23-25]). In these sections, Dr. Altman summarized the volume and length of time of Dr. Andrew's narcotic prescriptions,

[8] Dr. Altman also submitted the written reports provided by Ridge and Dr. Ehn. (JA-II, 20).

which included between "12 and 15,000 Hydrocodone tablets" for T.C. alone. (JA-II, 19). He also highlighted various circumstances surrounding Dr. Andrew's care for these two patients, including:

- The fact that local pharmacies contacted the Hospital with concerns about Dr. Andrew's prescriptions, and reported to the Hospital that voice messages had been left for Dr. Andrew without response;

- The fact that one of the patient's PMP report revealed the use of multiple pharmacies, multiple insurance policies (plus cash payments, different birth dates, and different home addresses to fill the prescriptions;

- The fact that significant surgeries (back surgery and bilateral hip replacement surgeries) were performed on the patient at other hospitals, yet Dr. Andrew continued to prescribe narcotics for the patient;

- The failure to utilize the PMP or a pain contract; and

- The performance of a second orchiectomy without documented discussion of the consequences or adequate consultation with a urological specialist.

(JA-II, 19-20).

Dr. Andrew ***does not*** dispute the recitation of the facts in either of Dr. Altman's reports. Instead, he takes issue with Dr. Altman's concerns about Dr. Andrew's care for these two patients. (JA-II,

179A-179B [224:21–228:16; 229:20–230:6]). Those concerns were expressed in the "Your Expectations" section of Dr. Altman's reports:

Your Expectations

1) **What would you like the Iowa Board of Medicine to do about your complaint?**

- The Physician
  Volume of narcotic prescribing appears to be well beyond acceptable under any circumstances. It raises questions of marked naïveté, gross incompetence, and/or collusion with the patient for self-use, dealing, and/or distribution. Under any of those circumstances, should this physician's prescribing authority be reconsidered?

  Could this be an impaired physician who needs intervention and help?

  Non-emergent bilateral orchiectomy is generally not an endeavor to be taken without significant counsel and forethought. This case appears to vary significantly from standard of care and raises questions of clinical competency. Once again, is this a one-off, or fit a pattern. His surgical competency should be reviewed. Should this physician's surgical privileges be limited by the State?

- This Patient
  Redacted 's care has been turned over to Dr. R. Daher, an Internist for ongoing pain management and endocrine care.

  Narcotic purchasing appears to be well beyond acceptable under any circumstances. It raises questions of his participation in potentially illegal activities; including dealing and/or distribution. This is supported by his reported use of differing birthdates, addresses, and payment sources. Should this situation be referred to appropriate legal authorities for further investigation?

- Other Potential Patients
  Is it possible for the Board of Medicine to query the Iowa (and potentially other State's) PMP by provider to see if this situation is a one-off – or a pattern of narcotic overprescribing? If other potentially at risk patients are identified; the hospital would like to know so medical and pain management services can be provided to those patients.

(JA-II, 21).

Your Expectations

1) **What would you like the Iowa Board of Medicine to do about your complaint?**

Request assessment of both the surgical and the prescribing practices. This appears to be another case of an unusual surgical process and outcome, especially given that the patient initially presented after prior unsuccessful Orthopedic interventions; combined with narcotic prescribing that appears to be excessive.

Since this is the second case of excessive narcotic prescribing, further raising concern for the potential of more. Can the Board of Medicine to query the Iowa (and potentially other State's) PMP by provider to identify other potentially at risk patients (if any)? The hospital would like to offer medical/surgical and pain management services to those patients.

(JA-II, 26).

2. The Hospital's report to the National Practitioner Data Bank.

Following the termination of Dr. Andrew's employment, Rathbun directed Ridge and Terri Klemesrud, a Credentialing Specialist for the Hospital, to report the termination of Dr. Andrew's employment and clinical privileges to the National Practitioner Data Bank ("NPDB"). (JA-II, 7 [¶ 16]). Ridge assisted in drafting this report, which was reviewed by Dr. Ehn to ensure that all of the factual statements contained therein were accurate. (JA-II, 7 [¶¶ 18-19]; JA-I. 190 [56:18 – 57:11]). The Hospital believed it had a legal duty to report the fact of the termination of Dr. Andrew's employment and clinical privileges to the NPDB. (JA-II, 7 [¶ 17]).

F. Dr. Andrew's belated claim for a violation of the Iowa Wage Payment Collection Act ("IWPCA").

While this case was pending in the United States District Court for the Northern District of Iowa, Judge Mark Bennett granted the Hospital's motion for summary judgment on Dr. Andrew's age

discrimination claims. (JA-I, 12-43). Following Judge Bennett's *sua sponte* remand, Dr. Andrew moved to amend his Petition to add a claim under the IWPCA. (JA-I, 44-45). The district court granted Dr. Andrew's motion the same day without giving the Hospital the opportunity to file a resistance. (JA-I, 46).

ARGUMENT

I. The district court erred in denying summary judgment to the Hospital on Dr. Andrew's defamation claims.

Error preservation: An order denying summary judgment is interlocutory and not a final order. Cote v. Derby Ins. Agency, Inc., No. 16-0558, 2017 WL 3283862, at *9 (Iowa Ct. App. Aug. 2, 2017); Carroll v. Martir, 610 N.W.2d 850, 857 (Iowa 2000) (district court has "the power to correct any of the rulings, orders or partial summary judgments it has entered"). The issues of law before the Court were raised and ruled on by the district court, and raised in the Hospital's Application for Interlocutory Appeal, which was granted by this Court on February 7, 2020.

Standard of review: The standard of review for summary judgment is for correction of errors at law. Hollingshead v. DC Misfits, LLC, 937 N.W.2d 616, 618 (Iowa 2020) (citation omitted). The party requesting summary judgment "has the burden of showing the absence of a genuine issue of material fact", and the facts in the record are reviewed "in the light most favorable to the nonmoving party" and "draw every legitimate inference in favor of the nonmoving party." Id.

A. The district court erred in presuming the falsity of the alleged defamatory statements at issue.

Confidential reports filed with the Board and the NPDB are protected by the statutory immunities found in the Iowa Code and Administrative Code, and the HCQIA, respectively. Under Iowa law, a person filing a confidential report to the Board is immune from civil liability unless "such act is done with malice." Iowa Code § 272C.8(1)(b). *See also* Iowa Admin. Code r. 653-24.1(3) (same). The immunity provided by the HCQIA is arguably even broader. *See* 42 U.S.C. § 11137(c) (providing immunity for reports to the NPDB made

"without knowledge of the falsity of the information contained in the report.").[9] The district court's ruling, however, failed to even identify the alleged defamatory statements at issue, let alone any genuine issues of material fact that remain on the issue of falsity for a jury to decide. Instead, the district court appeared to apply the traditional presumption of malice and falsity that accompanies a claim for libel per se. See, e.g., Bierman v. Weier, 826 N.W.2d 436, 444 (Iowa 2013) (discussing evolution and contours of libel per se doctrine and its presumptions). Such presumptions, however, do not – and respectfully, cannot – apply to any statements included in the Hospital's Reports.

[9] "Thus, immunity for reporting exists as a matter of law unless there is sufficient evidence for a jury to conclude the report was false and the reporting party knew it was false." Brown v. Presbyterian Healthcare Servs., 101 F.3d 1324, 1334 (10th Cir. 1996). "This protection from liability, by the breadth of its terms, extends to civil actions brought under state tort law, where the damages claimed are solely the result of a report to the NPDB." Lee v. Hosp. Auth. of Colquitt Cty., 353 F. Supp. 2d 1255, 1265 (M.D. Ga. 2004), aff'd sub nom Lee v. Hosp. Auth., 397 F.3d 1327 (11th Cir. 2005).

It is well-established that a plaintiff bears the burden of proving "actual malice" (rather than a defendant proving the absence of malice) in the face of a qualified privilege. See Reeder v. Carroll, 759 F.Supp.2d 1064, 1087 (N.D. Iowa 2010); Barreca v. Nickolas, 683 N.W.2d 111, 121 (Iowa 2004); Kelly v. Iowa State Educ. Ass'n, 372 N.W.2d 288, 296 (Iowa Ct. App. 1985). To apply common law presumptions of malice and falsity to the Hospital's Reports would turn these statutory immunities on their head, as ***every report*** filed with the Board of the NPDB suggests or implies some degree of professional incompetence, which under this Court's precedent, is actionable as libel per se.[10] See, e.g., Suntken v. Den Ouden, 548 N.W.2d 164, 167 (Iowa 1996) ("Among statements which are libelous

[10] The public policy rationale for this burden-shifting framework is to ensure the free-flow of (confidential) information deemed necessary, by the Iowa legislature and Congress, to protect the public welfare. Reports may ultimately prove unfounded, or, at least in the case of the majority of such reports, not to rise to a level warranting disciplinary action. *See* https://medicalboard.iowa.gov/physicians/enforcement. The public policy rationale for encouraging (and requiring) the reporting of problems that ***may*** exist is to ensure the reporting of problems that ***do*** exist.

per se are those which charge business incompetence of lack of skill in the trade, occupation, profession, or office by which one earns his living.").

In the context of these statutory immunities, "malice" means "a knowing or reckless disregard for the truth of a statement." Reeder, 759 F.Supp.2d at 1087. See also Barreca, 683 N.W.2d at 121 (to establish "actual malice" plaintiff must prove that that the statement(s) at issue was published with a "knowing or reckless disregard for the truth."). Inherent within the definition of "actual malice" is a requirement that the statement(s) at issue are actually untrue – *i.e.* ***false***. See, e.g., Masson v. New Yorker Magazine, Inc., 501 U.S. 496, 513 (1991) (the Court "cannot discuss the standards for knowledge or reckless disregard" without first determining that the statements themselves were, indeed, false). Accordingly, Dr. Andrew was required to show that there was a genuine issue of material fact on the issue of falsity for a jury to decide. The district

court's apparent application of the traditional libel per se presumptions was erroneous.

Further, in Bierman v. Weier, this Court clarified that libel per se presumptions apply "only when a private figure sues a nonmedia defendant for certain kinds of defamatory statements ***that do not concern a matter of public importance***." 826 N.W.2d 436, 448 (Iowa 2013) (emphasis added). Here, the confidential reporting framework put in place by the legislature is necessary for the Board to fulfill its functions of protecting the public welfare. See Iowa Admin. Code r 653–1.2 (purpose of the Board of Medicine includes "the investigation of violations or alleged violations of statutes and rules relating to the practice of medicine and surgery, osteopathic medicine and surgery"). Indeed, Iowa law expressly protects the confidentiality of Board proceedings (and provides immunity to reporting parties) precisely "to assure the free flow of information" necessary for the Board to accomplish its purpose. Iowa Code § 272C.6(2).

The Hospital respectfully submits that the statements included in the Reports – and statements included in any report filed with the Board relating to patient safety – "concern a matter of public importance". Bierman, 826 N.W.2d at 448. For this additional reason, the district court's apparent application of the traditional libel per se presumptions was erroneous.

B. The district court erred in applying a "good faith" standard to Dr. Andrew's defamation claims based on the Hospital's Reports to the Board.

The district court also erroneously held that the immunity provided Iowa Code and Administrative Code for reports to the Board applies only to "statements made in good faith". (Ruling at 9). To the contrary, "[t]he statutory text does not require a showing that the [report] be filed in good faith." Gibson v. Buckley, DDS, No. 14-1108, 2015 WL 2394116, at *3 (Iowa Ct. App. May 20, 2015) (McDonald, J.). Rather, the immunity provided under Iowa law applies to all confidential reports to the Board except those that are

made with "malice". Iowa Code § 272C.8(1)(b). *See also* Iowa Admin. Code r. 653-24.1(3) (same).

"Good faith" relates to a speaker's motivations, independent of concepts of truth and falsity – *i.e.* things like honesty of intent, the absence of the design to defraud, etc. See, e.g., Jackson v. State Bank of Wapello, 488 N.W.2d 151, 156 (Iowa 1992). In order to prove malice, a plaintiff must prove both falsity and publication with a "knowing or reckless disregard for the truth." Barreca, 683 N.W.2d at 122. Motives are irrelevant.[11] Thus, the district court erred in holding that a jury should decide whether the Hospital's "motivation was only the health, safety, and welfare of the patients in the hospital". (Ruling at 10).

[11] Dr. Andrew's reliance on Kelly v. Iowa State Educ. Ass'n, 372 N.W.2d 288 (Iowa Ct. App. 1985) is misplaced. There, the court considered whether evidence of a defendant's "good faith" was sufficient to rebut the presumption of malice that accompanies the publication of a false defamatory statement. Id. at 297-97. That issue is unrelated to a plaintiff's burden to prove malice.

C. The district court erred by refusing to consider the Hospital's opinion defense, and by failing to hold, as a matter of law, that the alleged defamatory statements at issue were protected statements of opinion.

As noted in the Hospital's summary judgment briefing, Dr. Andrew does not contest the underlying ***facts*** set forth in the Reports. (JA-I, 89-93). Rather, his concerns relate solely to Dr. Altman's ***opinions*** drawn from those facts.[12] (JA-I, 92-94). The Hospital pled and argued that the alleged defamatory statements Dr. Andrew complains of are protected opinions. (JA-I, 59 [¶ 12]). The district court, however, failed to consider (or even discuss) that opinion defense. The issue of "whether a statement is one of fact or opinion is a question of law to be decided by the court." Bruning v. Carroll Cnty. Cmty. Sch. Dist., No. C04-3091-MWB, 2006 WL 1234822, at *16 (N.D. Iowa May 3, 2006). Proper application of Iowa law establishes, as a matter of law, that the statements at issue are constitutionally-protected opinions.

---

[12] The NPDB Report includes only a recitation of facts and a report that Dr. Andrew's privileges were terminated. (JA-II, 27-34). It does not include opinions. See supra Section I.D.

1. Iowa's three-factor test for determining whether a statement is actionable defamation or a constitutionally-protected opinion.

Statements "regarding matters of public concern that are not sufficiently factual to be capable of being proven true or false and statements that cannot reasonably be interpreted as stating actual facts are absolutely protected under the Constitution." Yates v. Iowa West Racing Ass'n, 721 N.W.2d 762, 771 (Iowa 2006). See also Gertz v. Robert Welch, Inc., 418 U.S. 323, 339-340 (1974) ("Under the First Amendment there is no such thing as a false idea. . . . But there is no constitutional value in false statements of fact."). This Court has adopted the Eighth Circuit Court of Appeals' three-factor test used to determine whether where a statement is actionable defamation or a constitutionally-protected opinion:

(1) The precision and specificity of the disputed statement, and whether the statement has a precise core meaning;

(2) The verifiability of the statement – the degree to which the statement is objectively capable of proof or disproof; and

(3) The "literary context" in which the disputed statement was made.

Jones v. Palmer Communications, Inc., 440 N.W.2d 884, 891-92 (citing and quoting Janklow v. Newsweek, Inc., 788 F.2d 1300, 1302 (8th Cir. 1986). See also Kiesau v. Bantz, 686 N.W.2d 164, 177 (Iowa 2004) (same). Through the lens of these factors, the relevant inquiry is whether the alleged defamatory statement can reasonably be interpreted as stating actual facts and whether those facts are capable of being proven true or false. Id. Stated another way, "statements of opinion can be actionable if they imply a provable false fact, or rely upon stated facts that are provably false." Id. (quotation omitted).

As applied to this case, these considerations – individually and collectively – compel the conclusion that the statements at issue are constitutionally-protected opinions.

2. The district court failed to identify the allegedly defamatory statements at issue.

In order to determine whether a statement constitutes actionable defamation or a constitutionally-protected opinion,

logically, the court must first identify the actual statement(s) at issue. Although the district court failed to do so, Dr. Andrew identified six alleged defamatory statements in the Hospital's reports to the Board in his summary judgment briefing:

1) Dr. Andrew's failure "to use the PMP" was a breach of a standard of care;
2) Dr. Andrew's failure to "refer [the patient] to a pain management specialist" was a breach of a standard of care;
3) Dr. Andrew's failure to "utilize a pain management contract" was a breach of a standard of care;
4) Dr. Andrew's failure to "use urine testing" was a breach of a standard of care;
5) Dr. Andrew's failure to "refer [the patient] for a second opinion prior to performing surgery" was a breach of a standard of care; and
6) The "amounts" of opioids prescribed by Dr. Andrew were excessive.

(JA-I, 92-94). A review of the Board Reports themselves, however, demonstrates that most of these alleged statements – at least as characterized by Dr. Andrew – ***were not even made***. Regardless, those statements that were actually made were Dr. Altman's ***opinions***.

With respect to the first four alleged statements, the Board Reports do not allege a breach of any standard of care with respect to Dr. Andrew's failure "to use the PMP", to "refer [the patient] to a pain management specialist", to "utilize a pain management contract", or to use "urine testing". The "Narrative Information" set forth by Dr. Altman therein does state, factually, that Dr. Andrew did not use the PMP, utilize a pain contract, and did not refer the patient to a pain medicine specialist.[13] (JA-II, 19-20). None of these facts, however, are disputed by Dr. Andrew.

With respect to the fifth alleged statement, Dr. Altman did report his concerns about the bilateral orchiectomy[14] performed by Dr. Andrew (an opinion also shared by Dr. Ehn):

> Non-emergent bilateral orchiectomy is generally not an endeavor to be taken without significant counsel and

---

[13] There is no mention of the use of urine testing in the Board Reports.

[14] An orchiectomy is a surgical procedure to remove a patient's testicle(s). Dr. Andrew had performed an orchiectomy on one of the patient's testicles several years prior to performing the second orchiectomy.

> forethought. This case appears to vary significantly from the standard of care and raises questions of clinical competency. Once again, is this a one-off, or fit a pattern. His surgical competency should be reviewed. Should this physician's privileges be limited by the State?

(JA-II, 21). However, as discussed below, Dr. Altman's statement that a surgical procedure "appears" to vary from the standard of care constitutes his ***opinion*** based on his consideration of the reported facts.

Finally, with respect to the sixth alleged statement, Dr. Altman expressed his concern that Dr. Andrew's narcotic prescribing "appears" to unacceptable and excessive (again, a concern shared by Dr. Ehn):

> Volume of narcotic prescribing appears to be well beyond acceptable under any circumstances. It raises questions of marked naiveté, gross incompetence, and/or collusion with the patient for self-use, dealing, and/or distribution. Under any of these circumstances, should this physician's prescribing authority be reconsidered?
>
> . . . . . .
>
> This appears to be another case of an unusual surgical process and outcome . . . combined with narcotic prescribing that appears to be excessive.

(JA-II, 21).

However, Dr. Altman's concern about volume (*i.e.* the length of time) and manner in which the narcotic prescriptions were provided was based on the ***facts*** he reported, none of were disputed by Dr. Andrew:

- The fact that local pharmacies contacted the Hospital with concerns about Dr. Andrew's prescriptions, and reported to the Hospital that voice messages had been left for Dr. Andrew without response;

- The fact that one of the patient's PMP report revealed the use of multiple pharmacies, multiple insurance policies (plus cash payments, different birth dates, and different home addresses to fill the prescriptions; and

- The fact that significant surgeries (back surgery and bilateral hip replacement surgeries) were performed on the patient at other hospitals, yet Dr. Andrew continued to prescribe narcotics for the patient.

(JA-II, 19-21).[15] Here again, as discussed below, statements that narcotics prescription "appear" to be unacceptable and/or excessive

[15] Dr. Altman's concerns regarding each of the items reference in the Board Reports was shared (and reported) by another physician

constitute Dr. Altman's ***opinion*** based on his consideration of the reported facts.

3. The statements at issue expressed Dr. Altman's opinions and, as such, cannot form the basis for a defamation claim.

Application of the Janklow factors compels the conclusion that the alleged defamatory statements at issue in this case are constitutionally-protected opinions. Here, review of these factors in reverse order is appropriate, as the "literary context" of the statements at issue is dispositive.

a. The clear "literary context" of the Board Reports demonstrates that the statements at issue are opinions.

The "literary context" of a statement "focuses on the category of publication, its style of writing and intended audience." Jones, 440 N.W.2d at 891-92 (quoting Janklow, 788 F.2d at 1303). This factor – also referred to as the "social context" – recognizes that "[s]ome type of writing or speech by custom or convention signal to readers or

---

employed by the Hospital, as well as the Hospital's retained expert. (JA-II, 14-17).

listeners that what is being read or heard is likely to be an opinion, not fact." Ollman v. Evans, 750 F.2d 970, 983 (D.C. Cir. 1984). See also Janklow, 788 F.2d at 1303 (citing same). Important to this analysis are consideration of the following:

- The "type of forum in which the statement is made". Janklow, 788 F.2d at 1302-1303.
- The intended audience's "understanding of a particular type of writing". Ollman, 750 F.2d at 983.
- The "genre" of the statement. Id. at 984.
- The "tone and the use of cautionary language". Jones, 440 N.W.2d at 892 (quoting Janklow, 788 F.2d at 1302).
- The "public context" of the statement and its importance to the core values of the First Amendment. Janklow, 788 F.2d at 1303.

As applied to this case, these considerations compel the conclusion that the disputed statements are constitutionally-protected opinions.

First, the forum and intended audience of any confidential reports filed with the Iowa Board of Medicine is ***solely*** the Iowa Board of Medicine. The same is true for reports filed with the

National Practitioner Data Bank. Such reports are confidential and not available (or disclosed) to the public.

Second, under Iowa law, a physician has a legal obligation to file a report with the Board where such physician has "knowledge as defined in this rule that another person licensed by the board ***may have*** engaged in reportable conduct." Iowa Admin. Code r 653-22.2(2) (emphasis added). "Knowledge" is defined to mean "any information or evidence of reportable conduct acquired by personal observation, from a reliable or authoritative source, or under circumstances causing the licensee to believe that wrongful acts or omissions ***may have occurred***."[16] Iowa Admin. Code r 653-22.2(1) (emphasis added).

[16] "Reportable conduct" means "wrongful acts or omissions that are grounds for license revocation or suspension under these rules or that otherwise constitute negligence, careless acts or omissions that demonstrate a licensee's inability to practice medicine competently, safely, or within the bounds of medical ethics, pursuant to Iowa Code sections 272C.3(2) and 272C.4(6) and 653—Chapter 23." Iowa Admin. Code r 653-22.2(1).

Such a report is a "particular type of writing" for a specific "audience" (*i.e.* the Board of Medicine), and it can be presumed that the audience understands that the report is based on the reporting physician's ***opinion*** that the reported conduct at issue "may" constitute wrongful acts of omissions. Ollman, 750 F.2d at 983. Plainly, the "custom or convention" (here, a custom or convention required by law) signals to the Board that Dr. Altman's concerns about the reported conduct "is likely to be an opinion, not fact."[17] Id.

Third, "tone and use of cautionary language" used by Dr. Altman demonstrates to the Board that the statements at issue are opinions. Jones, 440 N.W.2d at 892 (quotation omitted). For example, the Board Reports state:

- "Volume of narcotic prescribing ***appears*** to be well beyond acceptable". (JA-II, 21 (emphasis added)).
- The double orchiectomy "***appears*** to vary significantly from standard of care and raises questions of clinical competency." (JA-II, 21 (emphasis added)).

[17] Indeed, the Board's website states that formal charges are filed in only about ten percent of the over 700 complaints filed each year. See https://medicalboard.iowa.gov/physicians/enforcement.

- "This ***appears*** to be another case of an unusual surgical process and outcome . . . combined with narcotic prescribing that ***appears*** to be excessive." (JA-II, 26 (emphasis added)).

It cannot plausibly be argued that the Board would interpret such language as anything other than the reporting physician's opinions.

Moreover, each opinion was communicated to the Board in the context of larger questions of the sort that the Board exists to address:

- "Under any of these circumstances, should this physician's prescribing authority be reconsidered?" (JA-I, 21).

- "Should this physician's surgical privileges be limited by the State?" (JA-I, 21).

- "Is it possible for the Board of Medicine to query the Iowa (and potentially other State's) PMP by provider to see if this situation is a one-off – or a pattern of narcotic overprescribing?" (JA-I, 21).

The mandatory, confidential reporting framework put in place by the legislature is necessary for the Board to fulfill its functions of protecting the public welfare. See Iowa Admin. Code r 653–1.2. Iowa law expressly protects the confidentiality of Board proceedings (and provides immunity to reporting parties) precisely "to assure the free

flow of information" necessary for the Board to accomplish its purpose. Iowa Code § 272C.6(2). Thus, the "public context" and importance of confidential reports filed with the Board cannot be overemphasized, and the substance of such reports is, by any definition, "regarding matters of public concern".[18] Yates, 721 N.W.2d at 771.

Taken as a whole, the literary context of the Board Reports compels the conclusion that the statements at issue contained therein are constitutionally-protected opinions.

b. The statements at issue are not "precise", "specific", and "easy to verify".

The first two Janklow factors ("precision and specificity", objectively "verifiable"), are closely related to each other: "[I]f a statement is precise and easy to verify, it is likely the statement is a fact." Jones, 440 N.W.2d at 891. Here, the statements is issue – *i.e.* Dr.

[18] When considering an opinion defense, it is "crucial" for courts to understand the public arena in which allegedly defamatory statements are made so as not to run afoul of the "core values of the First Amendment." Janklow, 788 F.2d at 1303 (citing Ollman, 750 F.2d at 1002-1005).

Altman's concern regarding the appropriateness of the treatment provided – are not objectively capable of proof or disproof such that they can be verified. Jones, 440 N.W.2d at 891-92.

The Board's standards of practice for "appropriate" pain management are inherently vague and subject to the interpretation of physicians. See Iowa Admin. Code r 653-13.2 ("Standards of practice – appropriate pain management"). That is because "[t]he board recognizes the complexity of treating patients with chronic pain or a substance abuse history." Id. at 653–13.2(4).

The purpose of these standards of practice is "to encourage appropriate pain management, including the use of controlled substances for the treatment of pain, while stressing the need to establish safeguards to minimize the potential for substance abuse and drug diversion." Id. at 653–13.2.1. While the rules do state that "[i]nappropriate pain management is a departure from the acceptable standard of practice in Iowa and may be grounds for disciplinary action," the only definition for what may constitute "inappropriate

pain management" is that it "may include nontreatment, undertreatment, overtreatment, and the continued use of ineffective treatments." Id. at 653–13.2.6.

The standards of practice do require that any physician prescribing opioids for chronic pain must "exercise sound clinical judgment and establish an effective pain management plan" in accordance with a number of requirements and recommendations. Id. at 653–13.2(5). Some of these requirements and recommendations are as follows:

- The rules "strongly encourage" the "consultation/referral to a physician with expertise in pain medicine, addiction medicine or substance abuse counseling or a physician who specializes in the treatment of the area, system, or organ perceived to be the source of the pain may be warranted depending upon the expertise of the physician and the complexity of the presenting patient." Id. at 653–13.2(5)(a).

- "The patient should receive prescriptions for controlled substances from a single physician and a single pharmacy whenever possible." Id. at 653–13.2(5)(b).

- "The physician shall document discussion of the risks and benefits of controlled substances with the patient or person representing the patient." Id. at 653–13.2(5)(c).

- "Modification or continuation of drug therapy by the physician shall be dependent upon evaluation of the patient's progress toward the objectives established in the treatment plan. The physician shall consider the appropriateness of continuing drug therapy and the use of other treatment modalities if periodic reviews indicate that the objectives of the treatment plan are not being met or that there is evidence of diversion or a pattern of substance abuse." Id. at 653–13.2(5)(d).

- "Pain, physical medicine, rehabilitation, general surgery, orthopedics, anesthesiology, psychiatry, neurology, rheumatology, oncology, addiction medicine, or other consultation may be appropriate. The physician should also consider consultation with, or referral to, a physician with expertise in addiction medicine or substance abuse counseling, if there is evidence of diversion or a pattern of substance abuse." Id. at 653–13.2(5)(e).

- "A physician who treats patients for chronic pain with controlled substances shall consider using a pain management agreement with each patient being treated that specifies the rules for medication use and the consequences for misuse. In determining whether to use a pain management agreement, a physician shall evaluate each patient, taking into account the risks to the patient and the potential benefits of long-term treatment with controlled substances. A physician who prescribes controlled substances to a patient for more than 90 days for treatment of chronic pain shall utilize a pain management agreement if the physician has reason to believe a patient is at risk of drug abuse or diversion. If a physician prescribes controlled substances to a patient for more than 90 days for treatment of chronic pain and chooses not to use a pain management agreement, then the physician shall document in

the patient's medical records the reason(s) why a pain management agreement was not used." Id. at 653–13.2(5)(g).

- "A physician who prescribes controlled substances to a patient for more than 90 days for the treatment of chronic pain shall consider utilizing drug testing to ensure that the patient is receiving appropriate therapeutic levels of prescribed medications or if the physician has reason to believe that the patient is at risk of drug abuse or diversion." Id. at 653–13.2(5)(i).

- "The board recommends that physicians utilize the prescription monitoring program when prescribing controlled substances to patients if the physician has reason to believe that a patient is at risk of drug abuse or diversion." Id. at 13.2(7).

The rules, however, provide no guidance on precisely when a physician should undertake the various recommendations set forth therein.

The point of this lengthy discussion is only that determination about what constitutes inappropriate or excessive pain management practices is inherently subjective, and requires the consideration of the Board's various requirements and recommendations in the exercise of clinical judgment. While Dr. Andrew and his retained expert may disagree with Dr. Altman (and Dr. Ehn) on some or all of

the conclusions to be drawn from the undisputed facts is immaterial – their ***opinions*** are not, in the constitutional sense, objectively capable of proof or disproof such that they can be verified. See, e.g., Jones, 440 N.W.2d 884, 891-92 (Iowa 1989).

Combined with the literary context of the Board Reports, the lack of objective verifiability of the statements at issue compels the conclusion that they are constitutionally-protected opinions.

D. The district court abused its discretion by *sua sponte* raising issues relating to the Health Care Quality Improvement Act that were never plead, argued, or claimed by the Parties.

The district court correctly held that any procedural rights Dr. Andrew might otherwise have under the Hospital's medical staff bylaws, rules, regulations, and internal peer review processes were "contracted away" in the Agreement. (JA-I, 103 (citing Agreement, at ¶ 9(h)). On its own initiative, however, the district court also identified certain "notice and hearing requirements" under the Health Care Quality Improvement Act, 42 U.S.C. § 11101 et seq., which it concluded "must be satisfied" prior to Dr. Andrew's

termination,[19] and which "may be an issue" with respect to the Hospital's statutory immunity. (JA-I, 110).

Dr. Andrew ***never*** plead, argued, claimed, or even suggested that he was denied any procedural rights under the HCQIA or that statutory immunity was not available to the Hospital. The Court need only review Dr. Andrew's resistance to the Hospital's motion for summary judgment. There is no mention of notice and procedural rights under the HCQIA. To the contrary, Dr. Andrew ***expressly argued*** that his defamation claims – whether based on the NPDB Report or the Iowa Board of Medicine Reports – were

---

[19] To be clear, the HCQIA says nothing about a hospital's right to terminate the ***employment*** of a physician. *See* 42 U.S.C. § 11101. Rather, the HCQIA sets forth certain procedures when a statutorily-defined "professional review activity . . . affects (or may affect) adversely, the clinical review privileges, or membership in a professional society, of the physician." 42 U.S.C. § 1151(9). The procedural requirements of the HCQIA have "no applicability" in instances "where termination of the employment contract precedes (and thereby automatically triggers) to the loss of clinical privileges and medical staff membership." Langerberg v. Warren General Hospital, No. 1:12-cv-175, 2013 WL 6147576, at *5-*8 (W.D. Penn. Nov. 22, 2013). Dr. Andrew's employment was terminated which, as noted by the Landerberg court, automatically triggered (and thus, "affected") the loss of clinical privileges and medical staff privileges.

governed by the same "actual malice" standard. (JA-I, 92-94). Further, the only "process" to which Dr. Andrew ever claimed entitlement was pursuant to the Hospital's internal medical staff bylaws, rules, regulations, and internal peer review processes. (JA-I, 88-89). The Court should not consider these issues – never raised below – on appeal.[20]

Indeed, had this Court not entered a stay of the proceedings, the Hospital would have been prevented from offering expert testimony relevant to this new issue interjected by the district court, including testimony relating to industry practice and the confidentiality of reports to the NPDB. Further, the Hospital was never put on notice that it should consider a limited waiver of the

[20] "It is elementary that an issue should not be considered by the court unless it is fairly raised in the pleadings." Henry Walker Park Ass'n v. Mathews, 91 N.W.2d 703, 710 (Iowa 1958). This rule of basic fairness ensures that parties to the litigation have the opportunity to discover and present evidence to support their claims and defenses. See, e.g., Duque v. McDonnell, No. 13-0287, 2013 WL 4504928, at *3 (Iowa Ct. App. Aug. 21, 2013) (reversing district court's sua sponte ruling that appellee had failed to comply with statutory service requirements).

attorney-client privilege with respect to any advice of counsel that may have been given relating to whether a report to the NPDB was required under the circumstances. Evidence such as this would plainly be relevant to the ultimate issue in any defamation claim – namely, whether actionable false statements were knowingly or recklessly made.

This Court should not consider any new arguments Dr. Andrew might raise relating to the HCQIA because they were not raised below, and his failure to disclose this new theory (namely, because he never raised it) is not substantially justified nor would it be harmless. See Iowa R. Civ. P. 1.517(3)(a). The district court abused its discretion in raising these issues *sua sponte*.

However, even if the Court were to consider Dr. Andrew's untimely argument, it is largely circular and would return to the Court back to 'go'. That is because if Dr. Andrew had raised these issues below, the Hospital would have argued, alternatively, that Dr. Andrew's defamation claim based on the NPDB Report fails as a

matter of law under Iowa's common law qualified privilege.[21] If that qualified privilege[22] applies – which is an issue of law – the jury is tasked only with determining whether such privilege was "abused". Id. That ultimate issue requires a plaintiff to prove "actual malice" – the same requirement when the immunity found in the HCQIA applies. Id. Thus, whether the HCQIA immunity applies or not is effectively irrelevant: the analysis is the same regardless, and the circle is complete.

---

[21] Because Dr. Andrew never plead, argued, claimed, or even suggested that the HCQIA's immunity is not available to the Hospital, that issue was never addressed by the Hospital at the district court. Rather, the Hospital responded to the only argument Dr. Andrew actually raised – namely, the issue of whether there was any issue of material fact on the issue of "actual malice".

[22] This qualified privilege has been characterized as existing "with respect to statements that are otherwise defamatory if the following elements exist: (1) the statement was made in good faith; (2) the defendant had an interest to uphold; (3) the scope of the statement was limited to the identified interest; and (4) the statement was published on a proper occasion, in a proper manner, and to proper parties only." Barreca, 683 N.W.2d at 118 (quotation omitted). The Barreca court rejected this formulation, and held that the district court's role is only to determine whether the occasion of the statement was qualifiedly privileged. Id.

Finally, and for a very simple reason, this entire exercise is largely academic and irrelevant to the issues on appeal. That is because the NPDB Report ***does not include*** the allegedly defamatory statements that Dr. Andrew identified in his pleadings and argument to the district court. To the contrary, the NPDB Report includes only a recitation of the factual background surrounding Dr. Andrew's care for one of his patients – facts which Dr. Andrew does not dispute. Indeed, the allegedly defamatory statements Dr. Andrew identified for the district court – "an allegation that Dr. Andrew's volume of narcotic prescribing was excessive or that he was colluding with his patient to use or sell prescription drugs" – appear nowhere in the NPDB Report. (JA-II, 27-34).

Accordingly, even if the arguments relating to the HCQIA introduced by the district court had been properly raised by Dr. Andrew, they are immaterial to the issues raised in this appeal.

II. THE DISTRICT COURT ERRED IN DENYING SUMMARY JUDGMENT TO THE HOSPITAL ON THE HOSPITAL'S CLAIM UNDER THE IOWA WAGE PAYMENT COLLECTION ACT ("IWPCA").

Error preservation: An order denying summary judgment is interlocutory and not a final order. Cote v. Derby Ins. Agency, Inc., No. 16-0558, 2017 WL 3283862, at *9 (Iowa Ct. App. Aug. 2, 2017); Carroll v. Martir, 610 N.W.2d 850, 857 (Iowa 2000) (district court has "the power to correct any of the rulings, orders or partial summary judgments it has entered"). The issues of law before the Court were raised and ruled on by the district court, and raised in the Hospital's Application for Interlocutory Appeal, which was granted by this Court on February 7, 2020.

Standard of review: The standard of review for summary judgment is for correction of errors at law. Hollingshead v. DC Misfits, LLC, 937 N.W.2d 616, 618 (Iowa 2020) (citation omitted). The party requesting summary judgment "has the burden of showing the absence of a genuine issue of material fact", and the facts in the record are reviewed "in the light most favorable to the nonmoving

party" and "draw every legitimate inference in favor of the nonmoving party." Id.

A. Compensation Dr. Andrew may have earned, had the Hospital terminated the Agreement "without cause", is not "wages" under the IWPCA.

The Agreement provided for several methods of termination, including the following:

> a. **Without Cause.** Either party may unilaterally terminate this Agreement without cause at any time by notifying the other party in writing of its intention to terminate at least 90 days prior to termination. In the event Hospital terminates this Agreement pursuant to this Section 9(a) Hospital may, at its option, relieve Physician of his duties under the Agreement during the notice period. If Hospital elects this option, Physician will continue to be eligible for employee benefit plans and will receive his compensation in accordance with Exhibit B during the notice period. Any bonuses owed to Physician pursuant to this Agreement will be determined and pro-rated based on the date Physician is relieved of his duties.
>
> [. . .]
>
> d. **Immediate Termination by the Hospital.** The Agreement shall terminate immediately in the event Physician fails to meet any of the qualifications provided in Section 3 of this Agreement or if Hospital determines in

> good faith that: (i) Physician is not providing adequate patient care or the safety of patients is jeopardized.

(JA-I, 122-123). Dr. Andrew's employment was terminated pursuant to Section 9(d)(i), effective immediately.

Dr. Andrew's breach of contract claim (not a subject of this appeal) is based on his contention that the Hospital did not act in "good faith" when it determined that he was "not providing adequate patient care or the safety of patients is jeopardized." The district court correctly held that Dr. Andrew's breach of contract damages are limited to the 90 days of salary he might have earned had the Hospital terminated the Agreement "without cause" pursuant to Section 9(a) (JA-I, 107 (recovery limited to "the amounts allowed by Paragraph 9a of the contract.")).

However, the district court denied the Hospital's motion for summary judgment on Dr. Andrew's claim under the IWPCA. It apparently accepted Dr. Andrew's argument that salary he might have earned during a 90-day notice period (had such notice been provided) constitutes a "severance payment" – and thus "wages" –

under the IWPCA. (JA-I, 111 ("Iowa Code Section 91A.2(7)(b) indicates severance pay is included in the definition of wages.")). That is plainly not the law.

The IWPCA defines "wages" to include "compensation owed" by an employer for "[l]abor or services rendered by an employee, whether determined on a time, task, piece, commission, or other basis of calculation" and "[v]acation, holiday, sick leave, and severance payments which are due an employee under an agreement with the employer or under a policy of the employer." Iowa Code Chapter 91A.2(7). Although not defined in the statute, a "severance payment" is generally understood to be an amount which is granted at the contract termination and which is not conditioned on the provision by the employee of any additional labor or services. See, e.g., McClure v. International Livestock Imp. Services Corp., 369 N.W.2d 801, 804-05 (Iowa 1985); Prof. Staff Ass'n v. Public Emp. Rel. Bd., 373 N.W.2d 516, 518 (Iowa App. 1985).

Here, had the Hospital terminated the Agreement "without cause" pursuant to Paragraph 9(a), Dr. Andrew would have remained an employee of the Hospital for the duration of the 90-day notice period. During that time, Dr. Andrew would have continued to ***earn*** his salary – paid on the same schedule – ***as those amounts became due***. (JA-I, 122 [¶ 9(a)]). Such amounts would be paid ***prior*** to the termination of the contract, and are not amounts granted at the contract termination. A hypothetical opportunity to perform additional labor or services, and as a result, earn more money is not – under any definition – a "severance payment".

Dr. Andrew previously placed significance on the fact that the Agreement permitted the Hospital, at its election, to "relieve" Dr. Andrew of his duties during the 90-day notice period. This contractual option, however, is immaterial. Had the Hospital terminated Dr. Andrew's employment "without cause" and elected to relieve him of his duties, his employment with the Hospital would

nonetheless have continued for the duration of the 90-day period.[23] Notwithstanding Dr. Andrew's argument to the contrary, the law does not prohibit an employee from having the "job" of getting paid to sit at home and do nothing. That is precisely what the Agreement contemplates.

McClure v. Int'l Livestock Imp. Services Corp. is directly on point and is the controlling legal authority.[24] 369 N.W.2d 801 (Iowa 1985). There, the Court expressly held that an employer's alleged failure to comply with a contractual "notice of termination provision" does not give rise to a claim under the IWPCA. Id. at 805.

The employment contract at issue in McClure provided that it "shall continue until either party shall give not less than 30 days advance written notice of termination thereof." Id. at 802. The relationship between the parties soured, and the employer severed

---

[23] This was acknowledged by Dr. Andrew in his resistance to the Hospital's application for interlocutory appeal.

[24] Although cited and discussed extensively in the Hospital's motion for summary judgment, the district court did not cite or discuss McClure in its Ruling.

the plaintiff's employment with providing the contractually-required notice. Id. Just like the present case, the employee sued alleging both breach of contract and a claim for wages under the IWPCA. Id. The district court held that the employer had no reason to terminate the plaintiff "for cause", and found in his favor on both claims, awarding him the $2,500 he would have earned during the 30-day contractual notice period, as well as liquidated damages and attorney fees pursuant to the IWPCA. Id.

The Iowa Supreme Court reversed the district court's holding that the plaintiff had a cause of action under the IWPCA. Id. at 804. While affirming the district court's holding that the employer breached the employment agreement by failing to provide the 30-day contractual notice, the Court held that $2,500 at issue was not for "services rendered" under the IWPCA (as the plaintiff obviously provided no services after the termination of the agreement), but rather was the measure of damages for a common law breach of contract action. Id.

The situation described in McClure is substantively indistinguishable from the present case and requires the same result. The damages Dr. Andrew claims are not "wages" under the IWPCA. To hold otherwise would convert ***every*** case in which an employee alleges breach of a "notice of termination" into a coterminous claim under the IWPCA. That is not the law. Dr. Andrew's remedy lies in contract.

B. The Hospital is entitled to judgment as a matter of law on Dr. Andrew's claim under the IWPCA.

Because the damages Dr. Andrew claims are not "wages" under the IWPCA, the district court erred in denying summary judgment to the Hospital on Dr. Andrew's claim under the Iowa Wage Claim Protection Act.

CONCLUSION

For these reasons, Defendant Hamilton County Public Hospital d/b/a Van Diest Medical Center respectfully requests that the Court reverse the district court and hold that Dr. Andrew's defamation claims (Counts III and IV) and claim for violation of the Iowa Wage

Payment Collection Act (Count V) fail as matter of law, and remand to the district court for further proceedings.

REQUEST FOR ORAL SUBMISSION

Defendant-Appellant Hamilton County Public Hospital dba Van Diest Medical Center respectfully request oral argument regarding the issues presented in this appeal.

/s/ Frances Haas, AT0009838
NYEMASTER GOODE, P.C.
625 First Street SE, Suite 400
Cedar Rapids, Iowa 52401700
Telephone: 319-286-7007
Facsimile: 319-286-7050
Email: fmhaas@nyemaster.com

/s/ David T. Bower, AT0009246
NYEMASTER GOODE, P.C.
700 Walnut Street, Suite 1600
Des Moines, Iowa 50309
Telephone: 515-283-3100
Facsimile: 515-283-8045
Email: dbower@nyemaster.com
ATTORNEYS FOR DEFENDANT
HAMILTON COUNTY PUBLIC
HOSPITAL

CERTIFICATE OF COMPLIANCE WITH TYPE-VOLUME LIMITATION, TYPEFACE REQUIREMENTS, AND TYPE-STYLE REQUIREMENTS

1. This brief complies with the type-volume limitation of Iowa R. App. P. 6.903(1)(g)(1) or (2) because:

[X] this brief contains 10,820 words, excluding the parts of the brief exempted by Iowa R. App. P. 6.903(1)(g)(1).

2. This brief complies with the typeface requirements of Iowa. R. App. P. 6.903(1)(e) and the type-style requirements of Iowa R. App. P. 6.903(1)(f) because:

[X] this brief has been prepared in a proportionally spaced typeface using Microsoft Word 2013 in Palatino Linotype 14 point font.

/s/ David T. Bower

CERTIFICATE OF FILING AND SERVICE

I hereby certify that on June 19, 2020, I electronically filed the foregoing with the Clerk of the Supreme Court of Iowa using the Iowa Electronic Document Management System, which will send notification of such filing to the counsel below:

Mark Thomas
Laura Martino
Michael Currie
GREFE & SIDNEY, P.L.C.
500 East Court Avenue, Suite 200
Des Moines, Iowa 50309
Email: mthomas@grefesidney.com
lmartino@grefesigney.com
mcurrie@grefesigney.com
ATTORNEYS FOR PLAINTIFF

/s/ David T. Bower