

THE STATE OF SOUTH CAROLINA  
In The Supreme Court

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MAR 15 2013

APPEAL FROM RICHLAND COUNTY  
Court of Common Pleas

**S.C. Supreme Court**

Doyet A. Early, III, Circuit Court Judge

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Appellate Case No. 2013-000225

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Paresh Shah, M.D. and Paresh Shah, M.D., P.A.....Petitioners,

v.

Palmetto Health Alliance, f/k/a Richland Memorial Hospital.....Respondent.

---

**APPENDIX**  
**VOLUME VI OF VI (Pages 2451-2749)**

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00034

1 BY MR. GOINGS:

2 Q. What is the policy at Palmetto Health Richland  
3 involving patient complaints and how patient complaints are  
4 handled through the QA process?

5 A. Patient complaints with a physician named in the  
6 complaint did come to me, because I have -- handled the  
7 medical staff patient complaint process.

8 Q. Okay. And in what forms would this patient  
9 complaint come in?

10 A. It could come in any form. It could come from a  
11 phone call to me; it could come written up on a memo; it  
12 could come on one of those occurrence reports.

13 Q. Okay. And would you address this patient  
14 complaint with the physician?

15 A. No.

16 Q. What would you do?

17 A. I would get the chart and I would look for  
18 documentation regarding the event, and then I would -- it  
19 would be worked up just like all other cases. I then would  
20 identify which screen had failed and it would be written up  
21 on the QA worksheets. And then it would be put into the  
22 routine process, and it would go to another physician in  
23 that department for review.

24 Q. In a policy regarding staff complaints, such as  
25 nurses or technicians, how is that handled in the QA

00035

1 process?

2 A. The complaint is about a staff person or a nurse?

3 Q. Or a staff person or a nurse or a technician

4 makes the complaint --

5 A. Makes the --

6 Q. -- about a certain doctor, how is that handled?

7 A. Well, most of the time, if that happened, they  
8 could come in one of two ways. It could come in exactly  
9 the same way that I just mentioned; that person could fill  
10 out an occurrence report.

11 Occurrence reports go -- at that time went to the  
12 risk manager. If there was a physician issue noted on the  
13 occurrence reports, the risk manager would forward those to  
14 me.

15 Q. Okay.

16 A. But that staff person, if they didn't want to  
17 write an occurrence report, they would report their concern  
18 to their supervisor and their supervisor would then give  
19 them direction as to what to do.

20 Q. When you receive complaints on physicians, do you  
21 have a process where you screen this complaint to determine  
22 the accuracy or the veracity of the complaint?

23 A. I will pull the chart and look for documentation  
24 related to that.

25 Q. Okay. So when a complaint comes in, you do your



00046

1 Selby; is that your testimony?

2 A. No.

3 Q. What was your understanding about how Dr. Shah's

4 QA should have been handled after the consent order of

5 settlement was entered?

6 A. My understanding was, that the only change in the

7 process for QA for Dr. Shah is who reviewed the cases.

8 Q. Okay. Who explained to you that, that was the

9 way Dr. Shah's QA should be handled?

10 A. My first message related to that was, Howard West

11 told me that all of his cases would no longer go to any

12 physician on the radiology staff at the hospital and that

13 they would -- once an outside reviewer --

14 MR. CRAWFORD: I'm going to object to the

15 question to the extent that you intend to ask her a

16 question that would be subject to attorney-client

17 privilege. I don't think the witness should be asked that

18 type of question, or should she be allowed to answer that

19 type of question.

20 MR. GOINGS: Are you instructing your witness

21 not to answer this question?

22 MR. CRAWFORD: I am.

23 MR. GOINGS: Okay.

24 MR. CRAWFORD: To the extent it involves

25 attorney-client privilege.

00049

1 discussed that with anyone else.

2 Q. Did you ever have a meeting, where you were in a  
3 room with other people to discuss the substance of the  
4 court orders?

5 A. No.

6 Q. You were just told maybe on the telephone, "This  
7 is how you need to do Dr. Shah's QA"?

8 A. Right. And I believe that I testified before  
9 that I was not privilege to that court order; that my only  
10 knowledge was what I was told and instructed to do; that it  
11 was sealed, that was my understanding of that information.

12 Q. What were your responsibilities in conducting his  
13 -- his -- Dr. Shah's QA?

14 A. There -- in -- which -- I'm sorry, I don't  
15 understand. I've already testified that my handling of Dr.  
16 Shah's QA was no different than anyone elses. My only  
17 instructions that were different, now, for the rest of the  
18 entire medical staff was, that his cases were no longer  
19 reviewed by anyone in the radiology department.

20 Q. Okay. And you selected the cases, correct?

21 A. The selection process did not change. Whenever  
22 cases came to me through chart review, through an  
23 occurrence report, through any -- anytime that we found  
24 anybody, any patient, that had an adverse event, however we  
25 came upon that information, was routed through the QA

00050

1 process. The selection of what we did, did not change.

2 Q. What knowledge do you have that Dr. Selby had  
3 oversight authority in the case selection?

4 A. I did not have knowledge of that at that time.

5 Q. Other than you, who else at the hospital was  
6 involved in facilitating Dr. Shah's QA?

7 MS. JONES: Object to the form.

8 A. (The witness pauses.)

9 Q. Who did you work with at the hospital to  
10 facilitate Dr. Shah's QA?

11 A. The chief of the department of radiology.

12 Q. So you worked with Dr. Bayard to facilitate his  
13 QA?

14 A. When he was chief.

15 Q. Administratively, who else did you work with to  
16 facilitate Dr. Shah's QA?

17 A. The department -- the director of radiology.

18 Q. And who's the director of radiology?

19 A. Well, I think there were two people during my  
20 tenure there. There was Greg Webb and Ken Parks. I also  
21 worked with Richard Meeks.

22 Q. Did you work with Howard West?

23 A. Not directly.

24 Q. When you say "not directly," what does that mean?

25 A. Well, he wasn't involved in the day-to-day QA

00052

1 A. No.

2 Q. Who is Drew Hamilton?

3 A. He was the corporate compliance officer.

4 Q. Okay. The cases that were given to Dr. Selby,  
5 explain to me how they were selected for review.

6 A. They were not selected intentionally for review.

7 They were cases that had complications from invasive  
8 procedures done by Dr. Shah.

9 There were also cases that involved patients,  
10 where there were concerns by other staff members who  
11 witnessed certain events.

12 There were cases of patients who complained about  
13 Dr. Shah and the care that they received. Those were the  
14 cases that were prepared for Dr. Selby, as they came.

15 Q. Were those cases looked at by you, through your  
16 review process, to determine what is administrative in  
17 nature and what is not administrative in nature?

18 A. If I got an -- if I got a report that was  
19 something that I felt was truly administrative in nature,  
20 that -- then I would route that back up to the director of  
21 the department or radiology.

22 Q. If an issue is unclear, whether it's  
23 administrative in nature or not, did you go to Dr. Bayard  
24 to ask his opinion whether or not a certain case would be  
25 administrative in nature?

00061

1 radiologist, who would look at that, and he would determine.  
2 whether he thought that it was unfounded, ridiculous, or  
3 whatever. He would just -- if he felt that there was  
4 concern or there was some validity, then the department --  
5 it would be discussed at the departmental QA meeting.

6 The person that the complaint was made about --  
7 whether it was Dr. Shah or another physician -- was  
8 encourage to be at this meeting, and they were openly  
9 discussed. That's part of how they determined what they  
10 were going to do with this information.

11 Then the department would make a decision on what  
12 type of action was -- needed to be done, or was appropriate  
13 for that particular issue.

14 Q. After the court orders were entered into, what  
15 did you do with staff complaints about Dr. Shah?

16 A. I did the same exact thing, only prepared the  
17 case to go to Dr. Selby.

18 Q. So staff complaints would go to Dr. Selby.

19 A. If I got a staff complaint about Dr. Shah, that  
20 would be worked up into a case review and would go -- would  
21 go into the pile of records, issues that needed to be  
22 forwarded to Dr. Selby.

23 MS. JONES: Robert, do you mind if we take a  
24 minute?

25 MR. GOINGS: Yes, let's please do that.

00001

1 STATE OF SOUTH CAROLINA ) IN THE COURT OF COMMON PLEAS

2 ) FIFTH JUDICIAL CIRCUIT

3 COUNTY OF RICHLAND ) CASE NO.: 2006-CP-40-04035

4

5 Paresh Shah, M.D. and Paresh )

6 Shah, M.D., P.A., ) DEPOSITION OF

7 Plaintiff, ) KAREN HART

8 vs. ) SEPTEMBER 25, 2008

9 Palmetto Health Alliance d/b/a )

10 Palmetto Richland Memorial )

11 Hospital f/k/a Richland )

12 Memorial Hospital, )

13 Kester S. Freeman, Jr.; )

14 Charles D. Beaman, Jr.; )

15 Greta Harper, M.D.; )

16 David Keisler, M.D.; )

17 N. John Stewart, Jr., M.D.; )

18 Karen Hart; )

19 Ellis "Mac" Knight, M.D.; )

20 J. Kevin Baugh, M.D.; )

21 C. Osborne Shuler, M.D.; )

22 Eva Jane Rawl, M.D.; )

23 Stephen C. Stanfield, M.D.; )

24 Clay Nichols, M.D.; )

25 Jim Lloyd, M.D.; )

00013

1 management, competency, orientation of new staff, day-to-  
2 day compliance to the standards of care, and the Medicare  
3 conditions of participation.

4 Q. Is this job very similar in nature to the -- to  
5 your job when you were working at Palmetto Health Richland?  
6 Or is it different?

7 A. It is different. The similarities, though, are  
8 that I am still in the quality arena. Performance  
9 improvement and quality was what I did at Richland before  
10 moving over to HomeCare.

11 Q. Okay. Let me back up a little bit. You were --  
12 how many years did you -- did you work as a -- as a  
13 registered nurse as a -- you know, the typical duties of a  
14 registered nurse?

15 A. Ten -- about ten years at Palmetto Health  
16 Richland, or Richland then.

17 Q. And what departments did you work in?

18 A. I worked in neuroscience.

19 Q. Okay. Who's your current supervisor?

20 A. Holly Knight.

21 Q. All right. When you worked at Palmetto Health  
22 Richland, what was your job title?

23 A. At which time?

24 Q. Well, in early 2000. In early 2000.

25 A. The director of quality at Richland.

00096

- 1 Q. At the hearing panel --
- 2 A. Yes. At the probation hearing.
- 3 Q. Correct me if I'm wrong, but I read your
- 4 testimony, or portions of your testimony, to mean that Dr.
- 5 Shah was not cooperative in the QA process. Correct?
- 6 A. That's correct.
- 7 Q. What time periods was Dr. Shah not cooperative
- 8 with the QA process?
- 9 A. The whole time that I was employed there in that
- 10 position.
- 11 Q. And during this time was when that initial
- 12 lawsuit was going on in the '90s. Correct?
- 13 A. Right. I mean, I started in that position in
- 14 '91.
- 15 Q. Okay. So he was not cooperative with the QA
- 16 process, is what -- that's your opinion. Correct?
- 17 A. Correct.
- 18 Q. And are you aware that there was also legal
- 19 action taken, that the hospital was undertaking a malicious
- 20 peer review against him?
- 21 A. Is that the second one that I'm referring to?
- 22 Q. It may be. So you testified that Dr. Shah was
- 23 not cooperative in the QA process.
- 24 A. Right.
- 25 Q. Correct? And would you agree with me, that there



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November 4, 2003

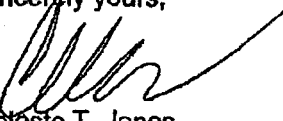
Dr. Paresh Shah  
Palmetto Richland Memorial Hospital  
Radiology Department, 2<sup>nd</sup> floor  
Columbia, SC 29203

Re: Quality Assurance Reviews/Palmetto Richland Memorial Hospital

Dear Dr. Shah:

This is to confirm your phone conversation with Dr. Selby in which you stated that you no longer desire to schedule a face-to-face meeting with him concerning the QA Reviews.

Sincerely yours,



Celeste T. Jones

CTJ/pkj

cc: J. Bayne Selby, Jr., M.D.  
Frederick A. Crawford, Esquire  
Howard West, Esquire

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PHA/Shah  
005227

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October 15, 2003

**VIA FACSIMILE ONLY**

John Bayne Selby, Jr., M.D.  
Chairman, Department of Radiology  
MUSC  
169 Ashley Avenue  
Charleston, SC 29425

Re: QA Review: Paresh Shah, M.D.

Dear Dr. Selby:

This is regarding the eight medical records sent to you on September 17, 2003 concerning the above-referenced matter. Dr. Shah has contacted us today and requested an opportunity to meet with you to discuss these records before you issue your final clinical review report and recommendations.

To that end, please telephone Dr. Shah at (803) 434-2600 to schedule a mutually agreeable time to discuss the cases. If you are unable to settle on a mutually agreeable time, please contact me to follow the provisions of the Order to schedule the matter. Please advise me when you have scheduled the meeting.

Pursuant to the Order, the hospital will pay your fees and expenses associated with the review, meeting, travel, etc. related to your work on this matter. Your fees can reasonably include any administrative costs incurred in transcribing and managing these records.

Thank you again for your service in this matter.

Very truly yours,



Celeste T. Jones

CTJ/pkj

cc: Paresh Shah  
N. John Stewart, M.D., Chief of Staff  
Frederick A. Crawford, Esquire

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COLUMBIA 767847v1

PHA/Shah  
005228

**Buonforte, Mary Ann**

---

**From:** Jones, Celeste  
**Sent:** Friday, February 20, 2004 1:05 PM  
**To:** Buonforte, Mary Ann  
**Subject:** RE: Meeting Wednesday February 25, 2004

-----Original Message-----

**From:** Jones, Celeste  
**Sent:** Friday, February 20, 2004 10:24 AM  
**To:** 'selbyjr@muscc.edu'  
**Cc:** Buonforte, Mary Ann; 'Tracie Prestigiacomo'  
**Subject:** Meeting Wednesday February 25, 2004

Dear Dr. Selby,

You are scheduled to meet with Dr. Shah at 2:00 p.m. on Wednesday, February 25, 2004 at Richland Memorial Hospital here in Columbia. The hospital has reserved the Nuclear Medicine Conference Room located on the first floor of the hospital for the meeting.

I will deliver all of the materials from your first three reviews so they will be available if needed. Please bring with you the chart materials and films from the last set of charts you reviewed so they will be available. Carol Gosney and/or Karen Hart, who are the staff persons who normally attend QA meetings, will also be present. I will meet you at the hospital to introduce you to them. The MEC Meeting will be at 5:00 p.m. in the Hospital Board room.

Please call me if you have any questions--office 803-276-2255 or cell 803-315-6723. Thank you.

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PHA/Shah  
007047

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◊ REGISTERED PATENT ATTORNEY

May 30, 2003

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REPLY TO:

Columbia

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JUN 3 2003

McNair Law Firm. P.A.

Re: Shah v. Close, et al., Civil Action No. 96-CP-40-0271  
Our File No. 182-092

Dear Dr. Shah:

This is to confirm our conversation on Wednesday, May 28, 2003, wherein I advised you that we were holding a introductory meeting for Dr. Selby, the radiologist from the Medical University of South Carolina who will be conducting your Quality Assurance review ("QA") at 10:00 a.m. on the morning of June 16, 2003, in the Palmetto Richland Radiology Department.

The purpose of this meeting is to give Dr. Selby an opportunity to meet with those persons who are generally involved in the QA process "to assist him in gaining an understanding of the manner in which QA reviews are traditionally conducted within the [Radiology] Department".

As we discussed, we would like for you to attend and to be generally available to meet with and talk to Dr. Selby on the afternoon of June 16, 2003, and the morning of June 17, 2003, as may be requested by Dr. Selby.

We would also ask that you make yourself available to Dr. Selby during the thirty (30) days following our meeting on June 16, 2003. As you know, the Supplement Order states that "within thirty (30) days of receiving the cases or complaints for review, the decision [of Dr. Selby] shall be sent to the MEC...". Accordingly, we need to keep this deadline in mind so that we can facilitate and expedite Dr. Selby's QA review.

FA

PHA/Shah  
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Paresh P. Shah, M.D.  
May 30, 2003  
Page 2

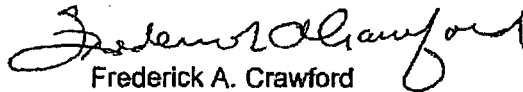
We have tentatively scheduled a meeting between you and Dr. Selby at 8:30 a.m. on June 17, 2003 to give you an individual opportunity to express your opinions on the customary procedures followed by the Department with regard to Quality Assurance reviews.

It should also be noted that the PR Conference Room on the first floor of Three Medical Park has been reserved on June 16 and June 17, 2003, for Dr. Selby's use.

Should you have any questions with regard to the scheduled meeting and/or the QA review, please do not hesitate to call me at 771-4400, Howard West, Esq. at 296-2124 or Celeste Jones, Esq. at 799-9800.

With kindest regards, I am

Sincerely,



Frederick A. Crawford

FAC/tmp

cc: Joel Collins, Esquire  
Howard P. West, Esquire  
Celeste T. Jones, Esquire

PHA/Shah  
005231

July 15, 2003

N. John Stewart, MD  
Chief of Staff  
Palmetto Richland Memorial Hospital  
3 Medical Park, Suite 200  
Columbia, SC 29203

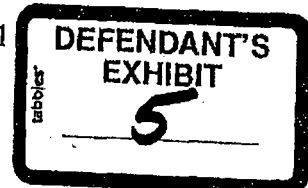
Dear Dr. Stewart,

This represents my initial Quality Assurance Review on Dr. Paresh P. Shah. This report is compiled following extensive review of the two-volume set of medical records and radiology films provided to me. I also spent one day at Palmetto Richland Memorial Hospital where I met and spoke with Dr. Shah, Dr. John Bayard (Chief of Radiology) and Dr. John Stewart (Chief of Staff). I further reviewed the Department of Radiology Rules and Regulations, PRH Medical Executive Committee Executive Session June 2, 2003, and the spring 2003 Executive Session minutes for the following departments:

Family Practice  
OB/GYN  
Emergency Medicine  
Neurology  
Children's Hospital Department  
CHD Surgical Care Evaluation Committee  
Surgery  
Psychiatry  
Nephrology  
Ad Hoc ICU  
Anesthesia  
Neurosurgery  
Cardiac Services  
Anatomic Pathology  
Oncology  
Internal Medicine

I observed Dr. Shah in the performance of two procedures. Finally, I reviewed Dr. Shah's curriculum vitae.

Attached you will find my specific review for each of the 18 charts presented to me. Before summarizing my review, I would like to make some additional general comments. There have been a number of legal proceedings involving Dr. Shah and the medical community over the past years. I did not find that these had any bearing on this medical review. All of the interested parties were very open and cooperative. I had complete access to all materials I requested.



PHA/SHAH/019a  
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cc:  
cm  
file

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July 22, 2003

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REPLY TO:

Columbia

Paresh P. Shah, M.D.  
Palmetto Richland Memorial Hospital  
Radiology Department  
Five Richland Medical Park  
Columbia, South Carolina 29203

Re: Shah v. Close, et al., Civil Action No. 96-CP-40-0271  
Our File No. 182-092

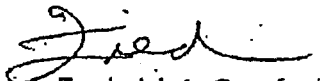
Dear Dr. Shah:

This is to confirm our conversation on Monday, July 21, 2003, wherein we discussed Dr. J. Bayne Selby's report and I inquired whether or not you would like to "meet with" or "talk to" Dr. Selby with regard to any of his findings on any particular case. You advised that you did not need to meet personally with Dr. Selby but that you would review the report during your vacation beginning July 23, 2003, and would contact Dr. Selby upon your return.

To that end, I telephoned Dr. Selby and he advised that he will be available to speak with you, upon reasonable notice, on any day during the month of August, 2003.

With kindest regards, I am

Sincerely,

  
Frederick A. Crawford

RECEIVED  
JUL 23 2003

FAC/tmp

cc: Joel Collins, Esquire  
Howard P. West, Esquire  
Celeste T. Jones, Esquire

McNair Law Firm, P.A.

PHA/Shah  
005229

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6 BY THE SUPREME COURT OF NC  
7 CERTIFIED SPECIALIST IN TAXATION LAW  
8 BY THE SUPREME COURT OF NC  
9 P.E.  
10 REGISTERED PATENT ATTORNEY

October 15, 2003

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## VIA U.S. MAIL

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Radiology Department  
Five Richland Medical Park  
Columbia, South Carolina 29203

Re: Shah v. Close, et al., Civil Action No. 96-CP-40-0271  
Our File No. 182-092

Dear Dr. Shah:

This is to confirm our conversation this morning at approximately 11:45 a.m. wherein you requested a meeting with Dr. J. Bayne Selby to discuss the Quality Assurance cases forwarded to him by letter of attorney Celeste Jones dated September 17, 2003. Pursuant to your request, I contacted attorney Celeste Jones and requested that she contact Dr. Selby immediately so that he may arrange a mutually convenient time in which to meet with you, in Columbia, to review each of the Quality Assurance cases referenced above.

Obviously, your request for a hearing at this "late" date will necessitate an extension of the thirty (30) day time period set forth in the Order of Judge Keesley.

Notwithstanding, we are receptive to your request and will work with you, and Dr. Selby, in good faith, to arrange a mutually convenient time for the two of you to meet to discuss the above-referenced Quality Assurance cases, in accordance with Judge Keesley's Order.

*PC*  
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PHA/Shah  
006122



Paresh P. Shah, M.D.  
October 15, 2003  
Page 2

With kindest regards, I am

Sincerely,

  
Frederick A. Crawford

FAC/tmp

cc: Howard P. West, Esquire (via facsimile)  
Celeste T. Jones, Esquire (via facsimile)

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PHA/Shah  
006123

MEC-7

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2 ALSO MEMBER TEXAS BAR  
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4 CERTIFIED SPECIALIST IN BANKRUPTCY LAW  
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7 IN THE SUPREME COURT OF SC  
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February 23, 2004

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REPLY TO:

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**VIA HAND DELIVERY**

Paresh P. Shah, M.D.  
Palmetto Richland Memorial Hospital  
Radiology Department  
Five Richland Medical Park  
Columbia, South Carolina 29203

Re: Shah v. Close, et al., Civil Action No. 96-CP-40-0271  
Quality Assurance Meeting with Dr. Bayne Selby  
Our File No. 182-092

Dear Dr. Shah:

Pursuant to our meeting with Howard West on Thursday, February 12, 2004, I have requested that Dr. Bayne Selby come to Columbia to meet with you to discuss a number of cases which were recently sent to him for Quality Assurance review pursuant to the Order of the Honorable William Keesley dated January 7, 2003 (the "Order"). Dr. Selby has recommended and you have agreed to a meeting at 2:00 p.m. on Wednesday, February 25, 2004, in the second floor conference room located in the Palmetto Richland Radiology Department.

Pursuant to your request, I will have a representative of the Hospital present to take minutes of the discussion.

I have also conveyed to Dr. Selby, your request that he attend an upcoming Quality Assurance meeting in the Department of Radiology. As you know, the Order provides, in relevant part:

"The outside reviewer shall also be given the opportunity, at his option, to witness a Quality Assurance meeting in the Department..."

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Paresh P. Shah, M.D.  
February 23, 2004  
Page 2

As soon as that meeting is scheduled, I would appreciate your notifying me, at the earliest possible date, so that I can give Dr. Selby as much notice as possible so that he can determine whether or not he can accommodate your request.

With kindest regards, I am

Sincerely,



Frederick A. Crawford

FAC/sdm

cc: J. Bayne Selby, Jr. M.D. (via U.S. Mail)  
Howard P. West, Esquire (via facsimile)  
Celeste T. Jones, Esquire (via facsimile)

PHA/Shah  
005226

ATTORNEYS AND COUNSELORS AT LAW

- ① ALTO HENRIETTA WINTERS, N.Y.
- ② ALTO HENRIETTA GEORGE DOR
- ③ ALTO HENRIETTA TERRY DOR
- ④ ALTO HENRIETTA NORTH CAROLINA DOR
- ⑤ CONFIRMED SPECIALLY IN  
DEPARTMENTAL LAW
- ⑥ BY THE SUPREME COURT OF THE  
CONFIRMED SPECIALLY IN DEPARTMENTAL  
LAW BY THE SUPREME COURT OF THE  
N.Y.
- ⑦ CONFIRMED SPECIALLY IN DEPARTMENTAL  
LAW BY THE SUPREME COURT OF THE  
N.Y.
- ⑧ CONFIRMED SPECIALLY IN DEPARTMENTAL  
LAW BY THE SUPREME COURT OF THE  
N.Y.

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February 25, 2004

Minutes of meeting between Dr. Bayne Selby and Dr. Paresh Shah:

Dr. Shah wants to get his QA process incorporated back into the Radiology Department's routine QI meetings. He would like to have Dr. Selby attend these meetings to present his QA findings. Dr. Selby is agreeable to this, if acceptable to all parties, and is in accordance with the court order. Dr. Shah wants to by-pass the lawyers in the handling of the cases that go to Dr. Selby for review. Dr. Selby did inquire as to how long his services would be needed, ie, is this forever, or is there a targeted end-date for requiring this outside review process on Dr. Shah?

Dr. Selby and Dr. Shah talked directly to each other about Dr. Shah's routine practice patterns related to Dr. Shah's volume and performance. Due to a shortage of radiologists currently on staff, Dr. Shah says he is busier than ever. He feels there is a lot of pressure and certain ED doctors are "out to get him." He states they question every variance and shout at him. He says that in the case of ED patient x-ray interpretations, especially trauma cases, he tends to only interpret findings relevant to the patient's injuries and does not always interpret incidental findings.

Dr. Selby asked Dr. Shah about the case where he interpreted and reported another patient's CT abdomen films for the patient. This resulted in patient and referring physician complaints. Dr. Shah stated that he amended the report and offered to re-scan the patient at no cost, but she refused. Dr. Selby discussed patient identification procedures to prevent these types of errors.

There was no case by case discussion of the cases that Dr. Selby had reviewed; only generalized comments about practice patterns.

Dr. Selby categorized his findings as being related to H&Ps/pre-procedural assessments, interventional procedures and missed diagnoses. Dr. Selby made the following recommendations to Dr. Shah for performance improvement:

- Improve documentation in H&Ps/pre-procedural assessment
- Obtain CME courses in CT scanning for appendicitis
- Be more conscientious about looking at CT scans along with the plain films before making interpretations
- Report all incidental findings on reading studies/films
- Mend fences (relationships) with other radiologists and physicians and end the legal issues
- Seek consultation from other radiologists on difficult cases to learn and prevent mistakes
- Utilize patient safety procedures related to identification verification process to prevent mix up among studies and films

Dr. Selby will present his findings to the Medical Executive Committee today.

Recorded by Karen Hart, RN  
Quality/PI Manager

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**PALMETTO HEALTH RICHLAND  
MEDICAL EXECUTIVE COMMITTEE  
EXECUTIVE EXECUTIVE SESSION  
April 5, 2004**

Minutes of the MEC's executive executive session held Monday, April 5, 2004. The following members were present: Drs. Keisler, Smith, Harper, Stewart, Langston, Jones, Moloo, Waheed, Dubuisson, Newman, Korrapati, Christmann, Felmy, Thompson, Catalano, Malone, Nottingham, Shipley and Raymond.

Minutes of the February 25, 2004 Special Called Meeting and the March 1, 2004 Executive, Executive Session were reviewed and approved by the appropriate motion.

**PURPOSE OF THE MEETING:** Dr. Keisler stated that the purpose of the meeting is to comply with Addendum 1, Article I, Section 1.4 of the Palmetto Health Richland (PHR) Medical/Dental Staff Bylaws, Rules and Regulations, which provides "if the corrective action could involve a reduction or suspension of clinical privileges ... the affected Practitioner shall, at his request be permitted to make an appearance before the MEC prior to its taking action on such report." This is a preliminary appearance and not a hearing. The MEC will receive any information Dr. Shah would like to submit in regard to the QA reports of Dr. Selby.

These reports have been previously provided to Dr. Shah and the MEC. Dr. Shah has been given the opportunity to meet with Dr. Selby, and did meet with him on February 25, 2004.

The duties of the MEC as set forth in Article 10.2.2(b) of the PHR Medical/Dental Staff Bylaws are to serve as the Medical Staff Quality Committee and to receive and act on the findings and results of Medical Staff quality assurance activities, as confirmed by the Court's Order.

The scope of this meeting is not to discuss the procedure followed by the outside reviewer or the contents of the Order. The patient medical records and films addressed in the four QA reports from Dr. Selby were made available to and reviewed by MEC members in considering this matter.

Dr. Keisler reported that Dr. Shah has indicated that he would like to meet with the MEC to present further information and be available for further questions from the MEC.

Dr. Shah appeared before the MEC and Dr. Keisler thanked him for his attendance.

Dr. Shah began by discussing the patient who had a prolonged lymphangiogram procedure and justified his management of this patient by stating that often times in the department patients have to void without a catheter or bed pan and are asked to void on towels. He stated this option was made available to the patient and she declined. Additionally, he expressed concern about losing access to the lymphatics if there was any movement of the patient at all.

Additionally, Dr. Shah reviewed with the MEC four of the cases that had been reviewed by Dr. Selby and explained his viewpoint about those concerns. One case involved a report that was done on a wrong patient; another was a ureteral stent placed in the wrong position subsequently requiring surgery. Further, he commented on two cases of CT of appendicitis and express sorrow for the misread on these cases. During and after his presentation, members of the MEC had

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questions to Dr. Shah about their concerns regarding the QA reports and also asked him about things he has done to change his patient management and interaction with the staff.

Dr. Keisler thanked Dr. Shah for attending the meeting and he was excused.

Dr. Keisler commented that as Chief of Staff he receives written comments from nurses and techs and indicated that it is an acceptable practice for issues or concerns to be documented. He then restated the role of the MEC as outlined by the Court and that Dr. Shah approved Dr. Selby as the outside reviewer. Further, that the QA review has been done appropriately as outlined by the Court Order.

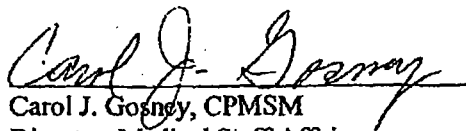
Dr. Keisler also noted that the letter written by Dr. Shah to the Chairman of the Palmetto Health Richland Board of Trustees has been referred to the Chairman of the Palmetto Health Board of Directors who is responsible for credentialing for the hospital.

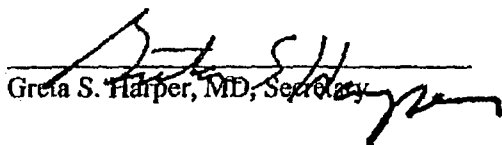
Discussion was held regarding Dr. Shah's contention that the QA is not being handled appropriately within the guidelines outlined by the Court. It was also noted that since there is no formal departmental QA, it would be difficult for Dr. Selby to attend Departmental QA Meetings to discuss his QA as Dr. Shah's contends he should.

There was discussion of Dr. Shah's documentation problems, the difficulty of trying to separate competency issues from personality issues; the apparent lack of Dr. Shah's insight into his problems; the need to address Dr. Selby's specific comments and/or recommendations in his reports; staff issues in the department; and Dr. Shah's integrity and compassion as a physician.

Dr. Keisler distributed for review the actions that are available to be taken by the MEC. Following a series of motions that failed, and a lengthy discussion of various options available, motion was made, seconded and carried unanimously that Dr. Shah be placed on a ninety (90) day probation. Further, that Dr. Keisler appoint an ad hoc committee to develop the conditions of the probation to bring back to the MEC for approval. The period of the probation will begin with the issue of the Letter of Probation.

There being no further business, the meeting was adjourned.

  
Carol J. Gosney, CPMSM  
Director, Medical Staff Affairs

  
Greta S. Harper, MD, Secretary

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In response, the Hospital convened a Fair Hearing Committee (the "Committee") to conduct a hearing on Dr. Shah's request pursuant to Article VII of the Fair Hearing Plan of the Hospital's Medical/Dental Staff Bylaws, Rules and Regulations ("Bylaws"). The hearing was conducted in four separate evening sessions on December 6, 2004, December 9, 2004, January 12, 2005, and February 1, 2005. During the hearings, which created 712 pages of transcript testimony, the Committee reviewed the voluminous record that had been presented to the MEC, exhibits consisting of two bankers' boxes of medical records and x-rays from 36 chart reviews, as well as other patient and staff complaints. The Committee found ample evidence to support the MEC's decision to place Dr. Shah on probation, and recommended that the MEC impose additional terms of probation which required Dr. Shah to complete training on abdominal CT scans and further required Dr. Shah to undergo evaluation and treatment, if any was recommended, by Dr. Bill Burke, a counselor selected by the Committee to help Dr. Shah with his patient and co-worker relationships.



The outside reviewer shall use his best efforts to complete the review process, complete the written clinical review forms, and deliver a written report with recommendations (where appropriate) (collectively, the "Decision") within the customary time frames. Within 30 days of receiving the cases or complaints for review, the Decision shall be sent to the MEC, pursuant to section 10.2.2(b) of the Bylaws, with copies to Dr. Shah and the COS. Additionally, should the outside reviewer feel that a case or complaint involves a matter that is outside his expertise, he shall notify both Dr. Shah and the COS, in writing, but shall select a Radiologist to review the matter who shall submit his Decision, as soon as possible (but not later than 30 days after receipt of the file), to the MEC, with copies to Dr. Shah and to the COS.

*WAC #8*  
Upon receipt of the Decision, the MEC shall determine what action, if any, should be taken, pursuant to section 10.2.2(b) of the Bylaws, including, but not limited to, whether or not the matter should be referred for corrective action in accordance with Addendum 1 to the Bylaws.

If a corrective action, pursuant to Addendum 1 of the Bylaws, is initiated by the MEC or otherwise initiated from matters previously evaluated by the outside reviewer, the actions required by the Chief or the Department in sections 1.2, 1.3 and 1.4 of Addendum 1 to the Bylaws shall be deemed to have been satisfied by the Decision.

Similarly, if a corrective action is initiated against Dr. Shah pursuant to Addendum 1 to the Bylaws that involves a QA matter not previously evaluated by the outside reviewer, the MEC shall send the matter to the outside reviewer, pursuant to the QA Process outlined above, and his Decision will be deemed to satisfy the obligations of the Chief and/or the Department under sections 1.2, 1.3 and 1.4 of the

00063

1 A. If the --

2 MR. CRAWFORD: Object to the form.

3 WITNESS ANSWERS:

4 A. Yes.

5 Q. Okay. So why do you like to have the physician  
6 in the room, or available to discuss this certain  
7 complaint?

8 MS. JONES: Object to the form.

9 BY MR. GOINGS:

10 Q. Why would the radiology department table an  
11 issue, pending attendance of the physician at issue?

12 A. Because they want to get all -- collect all the  
13 facts before they render a decision on the case.

14 Q. And that's important to do. Correct?

15 A. Yes.

16 Q. It's important to find out what the physician had  
17 to say about the certain procedure. Correct?

18 A. Yes.

19 Q. And why is that important?

20 A. Oftentimes, documentation does not say the whole  
21 event.

22 Q. Okay.

23 A. Does not give the whole picture.

24 Q. From Years 2002 to present -- no, excuse me --

25 2000 -- from Years 2000 to 2004, tell me how QA -- or the

00064

1 frequency of the QA meetings in the radiology department

2 were?

3 A. From 2002?

4 Q. From 2000 to 2004. I apologize.

5 A. 2000?

6 Q. To 2004.

7 A. We were meeting quarterly for the -- probably the

8 first part of that time frame, and then the meeting times

9 started being far and far and -- farther and fewer between,

10 because they would reschedule, or we would have a meeting

11 and we would not have a quorum.

12 Q. Okay. So there was a -- would you agree there

13 was a lack of QA in the radiology department during this

14 time period?

15 MR. TOAL: Object to the form of the question.

16 MR. GOINGS: (To the witness) You can answer.

17 WITNESS ANSWERS:

18 A. The QA -- there was a lack of Q -- resolution of

19 QA cases during this time frame. The QA process, by myself

20 and my department, did not change.

21 Q. Explain how the -- your QA -- the -- your

22 department QA did not change.

23 A. We continued to review cases, receive complaints.

24 We continued to set up and summarize the cases, putting

25 them in the computer and establishing the cases. We

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1 continued to ask the physicians to review the cases. But  
2 resolution of all the cases could not occur because there  
3 was no meeting to render an opinion on the cases.

4 Q. So do you agree with me, that during this time  
5 period, more attention was given to Dr. Shah's QA than the  
6 other --

7 MR. CRAWFORD: Object to the form of the  
8 question.

9 Q. -- physicians?

10 A. I do not agree with that. I didn't say that.

11 Q. That's okay. So is it your testimony, that the  
12 same amount of quality assurance was given on all the other  
13 radiologists just as much as it was given to Dr. Shah?

14 A. Yes.

15 Q. Okay. Explain that answer. Give me examples.

16 A. We continued to receive and review patient  
17 records for complications as they came through. The QA  
18 process did not change.

19 Q. So it's your testimony that there was no focused  
20 scrutiny on Dr. Shah; is that correct?

21 A. That's correct.

22 Q. But at the same time there were no -- or there  
23 was a lack of QA meetings for the other physicians.

24 Correct?

25 A. Correct.

Approved  
5/17/01

**DEPARTMENT OF RADIOLOGY**  
**Performance Improvement Meeting**  
**January 18, 2001**  
**Executive Session Minutes**

**Present:** Doctors Bayard, Doelle, Hudson, Maves, Waldron, Sheridan, Williams, Aitchison and Moradian. Also present were Richard Meeks and Greg Webb.

**Absent:** Doctors Close (excused,) Cupples, Dommers, Glassman, Kantsiper, Shah, Marchand, Richmond (excused,) and Wang (excused.)

Dr. Sheridan called the meeting to order at 1210 and presided.

**Minutes:** The minutes from the November 16, 2000 meeting were approved as written.

**Reports:**

**Turnaround Time:** The average TAT in reporting is about 30 hours from the time of patient check-in to the report being released by the radiologist. (Electronic signature.) The average TAT in hours was presented by individual radiologist for comparison for January-December 2000. It is to be noted that radiologists who perform and read special procedures and who interpret mammograms have longer TATs, which is expected. In October-December 2000 the Department's percentage of reports released within 24 hours from check-in time was 83%. Other variables that affect the TAT are front end delays (after check-in) related to patient preparation and often a 30-60 minute delay in getting the actual film to the Radiologist to be read and required comparison readings. Mr. Webb and Mr. Meeks will see if they can track the TAT beginning with the completion of the study to report release. Mr. Webb and Dr. Sheridan addressed ED concerns regarding Radiology service, specifically related to preliminary reports that change on the final reading. Another issue with TAT is that the time measured really does not reflect when the ordering physician actually receives the written report. Currently, all inpatient studies automatically print to the nursing unit, to be placed in the patient's chart by that floor's staff personnel. Outpatient studies' written results are mailed to the physicians. This is very labor intensive. The Department discussed auto-faxing instead of mailing, citing pros and cons to both processes. Does a written report still need to be sent? Dr. Sheridan will ask for preferences and feedback from the medical staff leadership at the next MEC meeting. Dr. Sheridan also reminded everyone to check their back log often and alert others who also have a back log of reports to release. Mr. Webb indicated he could have someone check this daily and notify the Radiologists as needed. There was also discussion concerning interpreting studies from PAX. In spite of the problems, Dr. Sheridan asked everyone to give it a try by at least reading ED studies from PAX. Dr. Sheridan will also send out a memo regarding this. The Department agreed that the TAT process will continue to be given high priority for improvement for this year.

**Fluoro Time:** November and December 2000

There were 777 diagnostic procedures performed during this time period with one case using >15 minutes of fluoro. However, this procedure (Mobile intensifier during reduction surgery) done by an orthopaedic. In November 2000 there were 664 special procedures done with 8 cases of fluoro > 20 minutes (1.2%) and in December 2000 there were 690 special procedures with 12 cases of fluoro > 20 minutes (1.7%). These rates fall below the target standard of a < 2 % excessive fluoro time rate. There were no Imaging Center fluoro procedures exceeding 15 minutes.

Colon Review: November and December 2000

There were seven colon radiographic studies results correlated with the pathology results by Dr. Kantsiper, finding no variances in interpretation.

Tumor Board Review: November and December 2000

There were six patient cases with radiological studies that were reviewed by the Tumor Board finding no variances.

Other Statistics: Mr. Meeks distributed graphs showing various radiology-activity year-to year comparisons. These were accepted as information.

**Past Action:** Case #s 648 and 605 remain pending awaiting further direction from legal counsel and the MEC.

**Invasive Procedure Review Report:** Compliance rates to various indicators for 526 radiology invasive procedures were reviewed. Compliance was high except regarding Informed Consents. Dr. Sheridan reminded everyone that when consents are obtained in different areas of the department, the form needs to be placed in the patient's chart.

**Data Report:** Trends in the types of occurrences for the department was reviewed. No action needed.

**Case Presentation:**

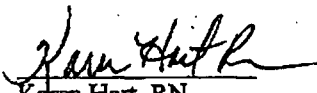
**# 1150** Interventional Procedure Complication

F/C: Do not believe images suggested pseudoaneurysm prior to intervention. Drainage of fluid collection occurred properly. Reviewing radiologist viewed images on PAX.

Action: Department members want to see the images.

Status: *Pending* final disposition of case until next meeting when films can be reviewed by all.

There being no further business, the meeting adjourned at 1320.

  
Karen Hart, RN  
Director of Quality

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DEPARTMENT OF RADIOLOGY  
QA MEETING  
Executive Session Minutes  
May 17, 2001

Present: Doctors Aitchison, Bayard, Cupples, Richmond, Shah, Sheridan, and Mr. Meeks  
Excused: Doctors Waldron, Kantsiper, Williams and Maves  
Absent: Doctors Close, Doelle, Dommers, Glassman, Hudson and Marchand

Dr. Sheridan called the meeting to order at 1220 and presided.

Minutes: The minutes from 1/18/01 were approved. (There was no meeting in March due to lack of a quorum.)

Reports: Mr. Meeks presented

Turnaround Time: January-April average TAT (reports released within 24 hours of patient check in time) was 85% (28 hours on average for the Department.) The goal is 92%. The Department continues to improve the work flow process. The average hours the transcribed report is in the Radiologists' "review cue" (awaiting release) is 14.5 hours. The Radiologists stated there needs to be a standard set for what is an *acceptable cue time*. The Radiologists were given their individual numbers in comparison to the others.

Fluoro Time: January-March had no diagnostic procedures with FT > 15 minutes. Two percent of special procedures done during this time period had FT > 20 minutes. (56/2866) Each Radiologist was given their individual numbers in comparison to the others. At the next meeting Mr. Meeks will provide a report showing the trends in causes of excessive FT.

Colon Review: Of the 19 cases reviewed, two required additional review due to positive pathology results. These were determined have no variance in radiological interpretation and there was no impact on patient care.

Tumor Board: Of the 30 cases reviewed there were no variances between the radiological study and the pathology reports.

Mammography QA: Dr. Cupples reported a problem concerning lost studies resulting in long delays in interpretation. Two case examples were cited. It was determined that there is currently no P&P concerning the process, including a time period to have mammograms interpreted. Dr. Cupples does not know if the dictation was lost or if the dictation was never done. Old studies just appear for him to read without explanation. This has been reported to Radiology Administration.

Past Action Cases:

#s 648 and 605—Both of these cases have been sent to the MEC Quality Improvement Oversight Committee with no response back yet. The cases remain open.

#1150 Interventional Procedure Complication

F/C: The films were reviewed by the radiologists present at this meeting and after lengthy discussion it was determined that results of needle aspirates should be obtained and drains not placed in light of potential pseudoaneurysms. QA category 5 assigned.

Action: Letter to the Radiologists noting this recommendation.

Status: Closed

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**Case Presentation:**

#1306 Interventional Procedure Complication

F/C: A recommendation was made that when the presence of a foreign device is present, that fluoroscopic monitoring during additional procedures be done. QA Category 5 assigned.

Action: Discussion with the Radiologist concerning the above.

Status: Closed

#2556 Death s/p Procedure

F/C: There is no direct evidence that insertion of a PICC line contributed to this patient's death.

Action: None. QA category 2 assigned.

Status: Closed

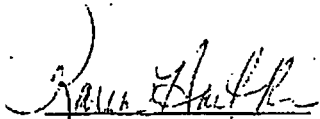
#1346 Respiratory Arrest in Radiology

F/C: Complication handled appropriately. QA category 2 assigned.

Action: None

Status: Closed

There being no further business, the meeting adjourned at 1335.



Karen Hart, RN  
Director of Quality

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**PALMETTO HEALTH**  
**DEPARTMENT OF RADIOLOGY**  
**QUALITY REVIEW MEETING**  
September 20, 2001

**Present:** Doctor Sheridan and Williams and Richard Meeks.

**Excused:** Dr. Waldron

**Minutes:** The minutes from the 5/17/01 meeting were reviewed.

**Reports:**

**Turnaround Time:** TAT average in August was 22 hours and in radiologist's cue was 9 hours.

**Fluoro Time Review:** (May-August) There were 1763 diagnostic procedures and 461 Imaging Center procedures performed with no excessive fluoro time. There were 2956 special procedures with 32 of these going beyond 20 minutes of fluoro. The radiologists and the RSO reviewed these cases. The data is also presented showing individual radiologist excessive fluoro time rates. They range from 0.4% to 1.5%. There were no outliers.

**Colon Review:** (May-August) 8 case with no variances

**Tumor Board Review:** (May-August) 22 cases with one class I variance, resolved with no impact on patient care.

**Case Presentation:**

**#3236** Variance in Interpretation

F/C: Extra-axial hemorrhage present but not described on CT head scan. Missed diagnosis had no effect on outcome. QA category 2 assigned

Action: Discussed with interpreting radiologist.

Status: Closed

**#3350** Interventional Procedure Complication

F/C: Pulmonary hemorrhage intra and post lung biopsy, requiring intubation and mechanical ventilation x 2 days. Known complication. QA category 2 assigned.

Action: None

Status: Closed

**#3358** Interventional Procedure Complication/IV Sedation Event?

F/C: Respiratory arrest during declotting of dialysis catheter was not related to IV sedation.

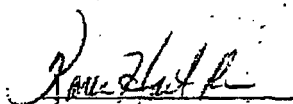
Related to patient disease. Managed appropriately. QA category 2 assigned.

Action: None

Status: Closed

Dr. Sheridan provided a list of pediatric patients and ED patients with physician concerns about the initial interpretation of radiological studies effecting treatment plans. These cases will be prepared and presented at the next meeting.

**Performance Improvement Projects for 2002:** Discussion took place concerning current performance improvement initiatives going on in the department and potential areas to focus in the future. Looking at CT scanning in C-Spine trauma for detection of fractures vs. plain films was suggested.

  
Karen Hart, RN  
Director of Quality

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**DEPARTMENT OF RADIOLOGY  
QUALITY REVIEW MEETING  
September 20, 2001**

**Present:** Doctor Sheridan and Williams and Richard Meeks.  
**Excused:** Dr. Waldron

**Minutes:** The minutes from the 5/17/01 meeting were reviewed.

**Reports:**

**Turnaround Time:** TAT average in August was 22 hours and in radiologist's cue was 9 hours.

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**Case Presentation:**

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F/C: Extra-axial hemorrhage present but not described on CT head scan. Missed diagnosis had no effect on outcome. QA category 2 assigned

Action: Discussed with interpreting radiologist.

Status: Closed

**#3350** Interventional Procedure Complication

F/C: Pulmonary hemorrhage intra and post lung biopsy, requiring intubation and mechanical ventilation x 2 days. Known complication. QA category 2 assigned.

Action: None

Status: Closed

**#3358** Interventional Procedure Complication/IV Sedation Event?

F/C: Respiratory arrest during declotting of dialysis catheter was not related to IV sedation.

Related to patient disease. Managed appropriately. QA category 2 assigned.

Action: None

Status: Closed

Dr. Sheridan provided a list of pediatric patients and ED patients with physician concerns about the initial interpretation of radiological studies effecting treatment plans. These cases will be prepared and presented at the next meeting.

**Performance Improvement Projects for 2002:** Discussion took place concerning current performance improvement initiatives going on in the department and potential areas to focus in the future. Looking at CT scanning in C-Spine trauma for detection of fractures vs. plain films was suggested.

Karen Hart, RN  
Director of Quality

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*Enrolled  
C.G.  
10/3/01*



**DEPARTMENT OF RADIOLOGY**  
General Session Minutes  
November 20, 2001

Minutes of the Department of Radiology monthly business meeting held on Tuesday, November 20, 2001 at 12:00 noon in the Nuclear Medicine Conference Room. The following members were in attendance: Drs. Bayard, Close, Doelle, Glassman, Hudson, Kantsiper, Shah, Sheridan, and Waldron. Mr. Webb was also present. The meeting was called to order by Dr. Sheridan, Chief, who presided.

**MINUTES OF THE OCTOBER MEETING:** Minutes of the October meeting were approved as written by common consent.

**PAST ACTION REPORT:** Dr. Sheridan reported that he would be meeting with Mr. Singerling, John Stewart, MD John Bayard, MD and Ms. Zimmer prior to the next departmental meeting to discuss and review EMTALA Rules and Regulations. He then stated that he would report results at the next scheduled department meeting.

**MEC:** Dr. Sheridan reported that physicians voted that meeting attendance requirements for Active Staff members be removed from the Medical Staff By-laws at the November 5<sup>th</sup> Quarterly Staff meeting. Additionally, he informed department members that anticipated security modifications for the hospital should be implemented on December 17<sup>th</sup> and suggested that physicians have their hospital ID badges made at the designated locations prior to the effective date. Lastly, he announced that Lilly Filler, MD will serve as Chief, John Stewart, MD will serve as Vice Chief and David Keisler, MD will serve as Secretary during the year 2002.

**ADMINISTRATION:** No report.

**DEPARTMENT:** Mr. Webb informed department members that the Certificate of Need (CON) has been approved by the Board for the Radiology Department. Details for purchasing CR and CT equipment is currently being considered for next year. He also mentioned to date, reading station locations have not been specified. One physician questioned the possibility of relocating PACS. Mr. Webb responded that due to expense issues, alternative avenues were being considered for transporting PACS. A discussion ensued regarding the utilization capital funds to move PACS. Lastly, Mr. Webb reported on staffing concerns.

Dr. Sheridan announced that he would be resigning as Chief of the Department of Radiology effective December 31, 2001. **Following this motion was made, seconded and carried with two abstaining that John Bayard, MD serve as Chief and Steven Glassman, MD serve as Vice Chief of the Department of Dentistry for the two year term/2002 - 2003.**

There being no further business Executive Session was not held and the meeting adjourned.

Veronica D. Vinson  
Credentialing Coordinator  
Medical Staff Affairs

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**Department of Radiology  
Quality Review Meeting  
Executive Session Minutes  
February 7, 2002**

**Present:** Drs. Bayard, Doelle, Donmers, Glassman, Richmond, Shah, Sheridan and Williams.  
Also Richard Meeks

**Excused:** Drs. Marchand, Waldron and Hudson

**Absent:** Drs. Close, Cupples and Kantsiper

Dr. Bayard called the meeting to order at 1205 and presided.

**Minutes:** The 9/20/01 minutes were approved as written.

**Reports:** Mr. Meeks provided reports on the following Departmental activities for 2001:

- Overall report turnaround time has improved by 17 percent; individual TAT results have been given to each radiologist demonstrating improvement.
- Radiologist report review cue time has improved by 33%; however there are still some radiologist outliers
- Total number of readings the same as 2000
- Tumor Board: 82 cases reviewed with one variance I
- Fluoro Time-Specials: 8594 cases reviewed; 131 with FT >20 minutes or 1.5 percent
- Fluoro Time-Diagnostics: 5367 cases reviewed; 1 with FT >20 minutes or .018 percent
- Fluoro Time-Imaging Center: 1114 cases reviewed; 0 with FT >20 minutes

**Mammography QA:** Audit overview for 1/1/-12/31/01 Accepted as information. Dr. Cupples not present at the meeting to discuss any details.

- |                             |        |                                |
|-----------------------------|--------|--------------------------------|
| ➤ False negatives           | 0.11%  |                                |
| ➤ False positives           | 18.50% |                                |
| ➤ True negatives            | 78.04% |                                |
| ➤ True positives            | 2.35%  |                                |
| ➤ Sensitivity               | 95.50% |                                |
| ➤ Specificity               | 81.03% |                                |
| ➤ Positive predictive value | 11.26% |                                |
| ➤ Negative predictive value | 99.86% |                                |
| ➤ Accuracy                  | 81.39% | National ACR average is 80-85% |

**Case Presentation:** None of the assigned cases were reviewed. Asked to reschedule another meeting for 2/21.

**Other Business:** IV sedation documentation and post-procedure documentation requirements were discussed.

The meeting adjourned at 1300.

Karen Hart, RN

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DEPARTMENT OF RADIOLOGY  
General Session Minutes  
April 16, 2002

Minutes of the Department of Radiology monthly business meeting held on Tuesday, April 16, 2002 at 12:00 noon in the Nuclear Medicine Conference Room. The following members were in attendance: Drs. Bayard, Close, Cupples, Dommers Hudson, Marchand, Waldron and Mr. Webb was also present. The meeting was called to order by Dr. Bayard, Chief who presided.

**MINUTES OF THE MARCH MEETING:** Minutes of the March meeting were approved as written by common consent.

**PAST ACTION ITEM:** Dr. Close gave a status update regarding PIC-Line Team.

**PAST ACTION REPORT:** EMTALA Rules and Regulations – Mr. Webb informed department members of the conclusions following a meeting with Drs. Knight, Stewart and a compliance representative. A lengthy discussion ensued regarding accepting ED patient's etc.

**MEC:** Dr. Bayard informed department members that a lengthy discussion ensued regarding Columbia Heart Center Cardiologists and their association with other hospitals. He then mentioned that no specific issues relating to Radiology were discussed.

**OTHER BUSINESS:** Dr. Bayard informed department members that centralized scheduling will be relocating from the Department of Radiology on campus to the IT facility on Parklane Road by mid May. A lengthy discussion ensued following his report regarding the transition i.e., consultation services, specials scheduling, etc. Mr. Webb suggested that a Beta run take place to avoid over scheduling.

Dr. Bayard opened a discussion regarding the possibility of changing the Department of Radiology Meeting schedule. Following a discussion **a motion was made, seconded and carried unanimously that the Department of Radiology meet bi-monthly at 7:00 am in the Nuclear Medicine Conference Room beginning June 18<sup>th</sup>.**

**ADMINISTRATION:** Mr. Webb reported the concerns that were mentioned at the March 19<sup>th</sup> Department of Radiology pertaining to the departmental renovations are being resolved. He then informed department of the anticipated logistics regarding the renovations for ROCKU, etc. Additionally he mentioned that the design plans are expected to be completed by December, 2002. Also, he reminded physicians that non use of film badges is a JACHO issue. Mr. Webb then informed that centralized scheduling and department managers should be notified of schedule changes i.e. vacation, etc. Lastly, he informed physicians of the current parking arrangements at Palmetto Health Richland in preparation for demolition of 8 Medical Park.

There being no further business Executive Session was not held and the meeting was adjourned.

Veronica D. Vinson  
Credentialing Coordinator  
Medical Staff Affairs

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**DEPARTMENT OF RADIOLOGY**

**General Session Minutes**

**August 22, 2002**

Minutes of the Department of Radiology monthly business meeting held on Thursday, August 22, 2002 at 7:00 am in the Nuclear. The following members were in attendance: Drs. Bayard, Caldwell, Close, Cupples, Hudson, Kantisper, Marchand, Richmond Waldon and Williams. Dr. Filler, Ms. Koen, Mr. Singerling and Mr. Webb were also present. The meeting was called to order by Dr. Bayard, Chief who presided.

**MINUTES OF THE JUNE MEETING:** Minutes of the June meeting were approved as written by common consent.

**PAST ACTION ITEM:** No items requiring action.

**PAST ACTION REPORT:** No report.

**NEW BUSINESS:** Dr. Filler was present to address concerns relative to preparation for the upcoming JCAHO Survey in November as it relates to the Radiology Department. She discussed the importance of the appropriate documentation of patient charts as it relates to patient safety issues. Further, she noted that each chart must include the following six components: 1) pre-op and post-op diagnoses, 2) what procedures were performed, 4) blood loss 5) patient disposition, 6) Anesthesiology/complications.

Following this, it was noted that a pre-printed form has been developed and is currently in use in the Department that identifies the required six components (copy in the file). A detailed discussion was held regarding the appropriate method of documentation and it was noted that cryptic documentation of procedures/treatment does not meet JCAHO Standards.

Discussion was also held relative to the appropriate documentation for invasive/moderate sedation procedures. It was requested that Mr. Pat Hickey be contacted for direction regarding the appropriate documentation of invasive procedures. This will be reported at the next meeting by Ms. Koen.

The appropriate use of radiation badges was discussed and it was noted that improvement has been made in this area.

Lastly, discussion was held regarding the importance of having a departmental policy that addresses timeliness in beginning patient procedures. Once a policy is developed, it is important that each physician be required to adhere to the policy. Additionally, Dr. Filler stated that policies addressing patient "work ins" and disruptive employees must be established and implemented.

**ADMINISTRATION:** Mr. Singerling provided a status update regarding the main lobby renovations and mentioned it is anticipated that the reconstruction will be completed in approximately five weeks. He then reported on the projected restoration of patient rooms, Children's Hospital, etc. Additionally he outlined the overall logistics planned for PHR in preparation for the upcoming JCAHO Survey. Lastly he presented a financial report including capital needs for 2003. A discussion ensued regarding expenses incurred due to the utilization of temporary employees. Following this, Mr. Singerling commented on the importance of employee retention and informed department members of the resources that are in place to address this concern. One physician opened a discussion regarding the current parking situation. Subsequent to some discussion, it was recommended that this

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issue be revisited at the next department meeting. Lastly, Mr. Singerling provided a synopsis regarding the CERNER project.

**DEPARTMENT:** Mr. Webb informed department members that the current Centralized Scheduling number is 296-8888. He then reported on the filmless images process and requested that physicians contact him with any issues/problems. He then furnished a detailed overview regarding Press Gainey statistics, Radiology Department renovations and PICC Lines. Mr. Webb advised department members that Dr. Bayard presented the Infiltration Form (copy in file) to the MEC and that it has been implemented for utilization. Lastly, Dr. Bayard mentioned that vacations for Image Care had been scheduled for the remainder of the year.

There being no further business Executive Session was not held and the meeting was adjourned.

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Veronica D. Vinson,  
Credentialing Coordinator  
Medical Staff Affairs

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**Department of Radiology  
Quality Review Meeting  
Executive Session Minutes  
August 29, 2002**

**Present:** Drs. Glassman, Kantsiper and DeJesus. Also present was Richard Meeks

**Excused:** Drs. Bayard, Close, Waldron and Caldwell

**Absent:** Drs. Cupples, Dommers, Marchand, Richmond, Shah, Williams and Hudson

Dr. Glassman chaired the meeting.

**Department Reports:** Mr. Meeks                      January – July 2002 data

- Report turnaround time: 27.14 hours There are five radiologists with consistently <24 hour average TAT; four with 24-36 hours TAT and three with > 36 hours TAT.
- Radiologist report review cue time: 10.86 hours There are five radiologists with consistently less than 8 hours average cue time; four at 9-15 hours and three at 16-24 hours. It was suggested that these results be posted to influence physician behavior.
- Tumor Board: 49 cases reviewed with one variance II-Failure to identify mass on CT of C/A/P. Resolved by Dept Chief; no adverse affect on patient care.
- Fluoro Time-Specials: 5024 cases reviewed; 51 with FT >20 minutes or 1.0 percent
- Fluoro Time-Diagnostics: 3279 cases reviewed; 2 with FT >15 minutes or 0.06 percent
- Fluoro Time-Imaging Center: 772 cases reviewed; 0 with FT >15 minutes

**Mammography QA:** Audit overview for 1/1/-8/29/02 Accepted as information. Dr. Cupples not present at the meeting to discuss any details.

- |                             |        |                                |
|-----------------------------|--------|--------------------------------|
| ➤ False negatives           | 0.03%  |                                |
| ➤ False positives           | 5.72%  |                                |
| ➤ True negatives            | 93.95% |                                |
| ➤ True positives            | 0.31%  |                                |
| ➤ Sensitivity               | 92.00% |                                |
| ➤ Specificity               | 94.26% |                                |
| ➤ Positive predictive value | 5.07%  |                                |
| ➤ Negative predictive value | 99.97% |                                |
| ➤ Accuracy                  | 94.25% | National ACR average is 80-85% |

**Moderate Sedation and Invasive Procedures:** The P&P was discussed. The ASA score needs to be determined pre-procedure. There must be a post-procedure note and all physicians must be credentialed to give moderate sedation.

**Interpretation Variances for June/July 2002:** Eight Emergency Room patient cases were identified to have variances in the initial radiological interpretation. In two of the cases the patients were called back for further treatment. The other six cases were over-read by the ED physicians and treated appropriately. All variances were discussed with the involved radiologist.

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**Case Presentation:** A backlog of cases have been reviewed and summarized below:

#s 4126, 4113, 4107, 6567

Missed Diagnoses

#s 4105, 4115

Results Not Communicated in Timely Manner

#s 4123, 4116, 4124, 4036, 4106

Variance in Interpretations

#s 6868, 6892, 3881, 4823, 4875

Interventional Procedure Complications

F/C: Opportunities for improvement were identified and discussed with the involved radiologists.

There were no adverse affects on the patients.

Status: Closed

**Other Business:** The hospital's JCAHO accreditation survey is scheduled for later this year. A list of radiology department associated standards of care was distributed as helpful information for the physicians.

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Karen Hart, RN

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**PALMETTO HEALTH**  
**RICHLAND**  
**DEPARTMENT OF RADIOLOGY**  
General Session Minutes  
October 15, 2002

Minutes of the Department of Radiology monthly business meeting held on Tuesday, October 15, 2002 at 7:00 am in the Nuclear Medicine Conference Room. The following members were in attendance: Drs. Bayard, Dommers, Hudson, Kantisper, Marchand, Shah, and Waldron. Mr. Webb was also present. The meeting was called to order by Dr. Bayard, Chief who presided.

**MINUTES OF THE AUGUST MEETING:** Minutes of the August meeting were approved as written by common consent.

**PAST ACTION ITEM:** No items requiring action.

**PAST ACTION REPORT:** Mr. Webb presented a status update regarding the parking situation and stated that an "administrator" has been contracted to evaluate the parking situation at Palmetto Health Richland.

**MEC:** Dr. Bayard reported that the JCAHO survey is scheduled for November 11<sup>th</sup> - 15<sup>th</sup>. He then reminded department members that in order to be credentialed for Moderate Sedation privileges, physicians *must* reapply and pass the Moderate Sedation Quiz. Additionally he stated that October 31, 2002 is the deadline for submitting the Moderate Sedation Quiz. After this date, only physicians who have reapplied and passed the Moderate Sedation Quiz may exercise Moderate Sedation procedures. Lastly Dr. Bayard urged department members to contact Medical Staff Affairs if they have not taken the Quiz.

**ADMINISTRATIVE REPORT:** Mr. Webb presented a status update regarding the "grand rounds" team relating to JCAHO preparedness. He stated that the objective of the team is to review cleanliness, equipment etc. and that the Radiology Department will be visited on October 21<sup>st</sup>. He then addressed the concerns relative to the preparation for the upcoming JCAHO Survey in November as it relates to the Radiology Department. He discussed the importance of the appropriate documentation of patient charts as it relates to patient safety issues. He then distributed and explained the criteria outlining documentation of information required to meet JCAHO standards for inpatient/outpatient exams (copy in file). Dr. Bayard furnished a scenario and reviewed "prep call" logistics. Following much deliberation with regard to documentation of H&P's Dr. Bayard stated that each physician *must* comply with what is necessary to meet JCAHO standards and that H&P's are considered a part of the procedure.

Mr. Webb presented a detailed overview regarding financials, staff retention, Press Gainey statistics, PACS, and the anticipated Radiology department renovations. Mr. Webb also distributed and reviewed the EPICENTER (CERNER) RADNET PROOF OF CONCEPT Schedule (copy in file). He stated that the HBO system will be converting to the Cerner System May of 2003. Following a lengthy discussion including the capabilities/advantages of the system and how it may be utilized from home, Mr. Webb recommended that department members attend the October 30<sup>th</sup> training session. Lastly, Ms. Norman encouraged physicians to contact her with any comments or questions.

**DEPARTMENT:** Following a discussion regarding the nursing staff deciding which procedures are considered emergent, it was recommended that this issue is addressed prior to when patient care is being rendered and the possibility of implementing a policy regarding this matter.

There being no further business Executive Session was not held and the meeting was adjourned.

  
Veronica D. Vinson,  
Credentialing Coordinator  
Medical Staff Affairs

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000029

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**DEPARTMENT OF RADIOLOGY**

## General Session Minutes

December 17, 2002

Minutes of the Department of Radiology monthly business meeting held on Tuesday, December 17, 2002 at 7:00 am in the Nuclear Medicine Conference Room. The following members were in attendance: Drs. Bayard, Cupples, DeJesus, Doelle, Dommers, Glassman, Hudson, Kantisper, Marchand, Waldron, and Williams. Mr. Webb and Mr. Singerling were also present. The meeting was called to order by Dr. Bayard, Chief who presided.

**MINUTES OF THE OCTOBER MEETING:** Minutes of the October meeting were approved as written by common consent.

**PAST ACTION ITEM:** No items requiring action.

**PAST ACTION REPORT:**

**MEC:** Dr. Bayard reported on the results of the JCAHO Survey and stated that the Alliance has received a three year accreditation.

**ADMINISTRATIVE REPORT:** Mr. Singerling furnished a status update regarding employee retirement benefits and echoed Dr. Bayard's report regarding the JCAHO Survey and thanked department members for their support. He then stated that the DHEC Survey was scheduled the following week. He then reported on probable solutions to address departmental space issues. Lastly, he reviewed time issues with regard to services that needed to be addressed to increase efficiency.

Mr. Webb presented a detailed overview regarding PACS, staffing, capital equipment, and the anticipated Radiology department renovations. Lastly, he mentioned that procedures for converting from the HBO system to the Cerner System is progressing as scheduled.

**ELECTION OF OFFICERS:** A motion was made, seconded and carried unanimously that W. John Bayard, MD serve as Chief of the Department of Radiology and that Alan B. Kantisper, MD serve as Vice Chief for the one year term 2003.

There being no further business Executive Session was not held and the meeting was adjourned.

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Veronica D. Vinson,  
Credentialing Coordinator  
Medical Staff Affairs



**DEPARTMENT OF RADIOLOGY**  
General Session Minutes  
February 18, 2003

Minutes of the Department of Radiology business meeting held on Tuesday, February 18, 2002 at 7:00 am in the Nuclear Medicine Conference Room. The following members were in attendance: Drs. Bayard, Caldwell, Close, Glassman and Shah. Mr. Webb and Mr. Singerling were also present. The meeting was called to order by Dr. Bayard, Chief who presided.

**MINUTES OF THE DECEMBER MEETING:** Minutes of the December meeting were approved as written by common consent.

**PAST ACTION REPORT:** No items requiring action.

**MEC:** Dr. Bayard furnished an update with regard to obtaining patients' appropriate history. He then reviewed the Telephone Order Read Back (TORB) procedure and order forms and stated that the form will be implemented within the next 2-3 months. Additionally, he mentioned that this form will serve as a prompt for the ordering physician to indicate the reason for the in-patient procedure. Lastly, Dr. Bayard stated that this is a patient care issue and a JCAHO requirement. Much discussion followed his report.

**ADMINISTRATION REPORT:** Mr. Singerling presented a status update regarding the master facility-planning meeting. He then opened a discussion regarding capital equipment. A lengthy discussion followed his report regarding reimbursement for CT's. Mr. Webb then provided a detailed overview regarding renovations in the Radiology Department i.e. ROCU, PACS, Diagnostic Room, EPI Center, CT Area, etc. He then reviewed the "time out" procedure for surgical site identification. Additionally, Mr. Webb assessed a chart outlining Radiologists turnaround time/timeline of procedures. Lastly, a discussion ensued regarding log in and signing capability from home. Following this, Mr. Webb stated that he would meet with Pat Stevenson and report findings at a future departmental meeting.

**DEPARTMENT:** Dr. Bayard voiced his concerns regarding vacation scheduling and night call. Subsequent to much discussion department members agreed that a policy be established for distribution to the members of the department regarding call availability for Radiologists.

There being no further business Executive Session was not held and the meeting was adjourned.

  
Veronica D. Vinson,  
Credentialing Coordinator  
Medical Staff Affairs

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**DEPARTMENT OF RADIOLOGY**  
General Session Minutes  
June 17, 2003

Minutes of the Department of Radiology business meeting held on Tuesday, June 17, 2002 at 7:00 am in the Nuclear Medicine Conference Room. The following members were in attendance: Drs. Bayard, Caldwell, Close, DeJesus, Kantsiper and Shah. Mr. Webb and Mr. Singerling were also present. The meeting was called to order by Dr. Bayard, Chief who presided.

**MINUTES OF THE FEBRUARY MEETING:** Minutes of the February meeting were approved as written by common consent.

**PAST ACTION REPORT:** No items requiring action.

**MEC:** Dr. Bayard furnished an update regarding Physician Outcomes as reported by Dr. Raymond. A discussion ensued following his report.

**ADMINISTRATION REPORT:** Mr. Singerling presented a status update regarding the recruitment of RN's. He then stated that the inpatient satisfaction score indicated the latest quarterly raw score of 85 which equates to PHR scoring higher than 94% of all 600+ bed peer hospitals. Additionally, Mr. Singerling mentioned that it's the highest quarterly score since the creation of Palmetto Health. A discussion ensued regarding the Highway 60 facility as it relates to the Radiology Department and PACS. Following much discussion regarding the current and future utilization of PACS, department members strongly agreed to endorse the efforts to enhance PACS imaging between the Highway 60 facility and the Department of Radiology at Richland. Also, physicians expressed an interest in attending future meetings regarding PACS. Mr. Singerling then stated that the strategic planning regarding the management structure of the facility is currently being discussed and it is anticipated the facility will be operational beginning late this fall. Department members accepted his report as information. Mr. Webb then provided a detailed overview regarding capital (including FY '04 requests), PACS, Press Ganey scores, the Cerner System, and CON approval for CT's. One physician voiced his concerns regarding "blanks" appearing on dictation reports. Following much deliberation, Mr. Webb stated that he would investigate the transcription concerns and report findings at a future department meeting. Mr. Webb then voiced his concerns regarding staffing issues including that there is evidence of a growing pattern with regard to calling in nurses on weekends for non-emergent PICC'S procedures. He also mentioned that the nursing staff has been requested to report future weekend non-emergent "call backs" and that a study will be developed pertaining this issue. Lastly, Mr. Webb stated that the Radiology Department picnic is scheduled for June 28<sup>th</sup>.

**DEPARTMENT:** Dr. Bayard reported that the processing for the Nighthawk physicians is progressing.

There being no further business Executive Session was not held and the meeting was adjourned.

Veronica D. Vinson  
Credentialing Coordinator  
Medical Staff Affairs

PHA/SHAH/008a  
000009

**CONFIDENTIAL**

**DEPARTMENT OF RADIOLOGY**  
General Session Minutes  
December 16, 2003

Minutes of the Department of Radiology business meeting held on Tuesday, December 16, 2003 at 7:00 am in the Nuclear Medicine Conference Room. The following members were in attendance: Drs. Bayard, Cupples, DeJesus, Dommers, Jr., Kantsiper and Shah. Mr. Singerling was also present. Drs. Caldwell and Waldron were excused. The meeting was called to order by Dr. Bayard, Chief who presided.

**MINUTES OF THE OCTOBER MEETING:** Minutes of the October meeting were approved as written by common consent.

**PAST ACTION REPORT:** No items requiring action.

**MEC:** Mr. Singerling reported that the Heart Center construction is progressing and it is anticipated that it will open October, 2005 as scheduled. He then stated that Drs. David Keisler, C. Dorn Smith and Greta Harper will serve as Chief, Vice Chief and Secretary of the Medical Staff.

**ADMINISTRATION REPORT:** Mr. Singerling provided a report regarding the disproportionate share program as it relates to Palmetto Health Richland (PHR). He also stated that PHR has tightened the process on capital purchases until the government has resolved this issue. Dr. Cupples then mentioned he will continue discussions with Mr. Webb regarding purchasing a mammography system including when and which vendor to utilize for purchasing the system. Mr. Singerling announced that Mr. Tim Thompson would be leaving in January, 2004 and that Mr. Lathren is preparing to secure a replacement as soon as possible. A discussion ensued regarding the impact to the CERNER Project and PACS subsequent to Mr. Thompson's leaving. Following this, Dr. Bayard opened a discussion regarding the hospital's responsibility for providing PACS connections to locations outside of the hospital where Radiologists are practicing. Mr. Singerling responded he believes that it is not the hospital's responsibility to provide connections to non PHR sites. Lastly, Mr. Singerling stated that he would follow-up with IT regarding the request.

**DEPARTMENT:** Dr. Bayard opened a discussion reiterating the necessity for timely assessment of patients. He then reviewed the protocol as it relates to patient assessments as discussed during prior meetings. Additionally, Dr. Bayard mentioned it is anticipated that Ms. Tamenia Keels, PA will also be providing morning assessments dependent upon her schedule. Dr. Kantsiper stated he will address this matter with Ms. Keels.

Dr. Bayard distributed and discussed a proposed resolution outlining the staff radiologists' responsibility for night and weekend call coverage. Following a discussion **a motion was made seconded and carried unanimously that the resolution for Radiology Department Resolution for call coverage be accepted as written with the following amendments to read ..... 10% above or below the average total... also .... more frequent or less frequent "on call".....** copy in the file.

There being no further business Executive Session was not held and the meeting was adjourned.

**CONFIDENTIAL**

Veronica D. Vinson  
Credentialing Coordinator  
Medical Staff Affairs

PHA/SHAH/007  
001155

**Radiology Quality Review Meeting  
(Executive Session of Radiology Departmental Meeting)  
May 25, 2004**

**Present:** Drs. Bayard, Waldron, Shah, Richmond, Kantsiper, Dommers and DeJesus (per phone)  
Also present were Richard Meeks and Dave Bowman and Melissa Brantley from Image Care.

The meeting was called to order by Dr. Bayard at 1200. Dr. Bayard emphasized that the purpose of the meeting was to discuss physician-related operational issues and performance improvement and efficiency for patient care. Three PI indicators have been chosen: Cue Time, Scheduling and Incomplete Work Reports. Individual case review identified via occurrence reporting can also be reviewed as needed. Quarterly reporting desired.

Cue Time: The goal beginning in June will be to have a Cue Time  $\leq$  10 hours. High cue times may be related to radiologist not having a proxy sent back for re-transcribing and then the report gets sent back to wrong cue. Average cue times compared by radiologists shown for multiple time periods back to July 2003 and June 2003 to April 2004 monthly departmental averages were shown and reviewed. Cue Time average in 2003 was 22 hrs. (Switch-over to Cerner occurred in June 03.) Cue time average for Jan-April 04 is already down to 14 hours on average.

Scheduling: Currently problematic because of understaffing. Melissa at Image Care is working on resource-based scheduling.

Incomplete Work Reports: There were 294 incomplete cases January 1 -May 8. 105 not on PACS and have referred to Carrie and Bernard. 81 not dictated; 69 reported. You cannot track dictation to transcription in Cerner; can only track exam to dictation time. (Peachtree can track it.) The goal is to have  $\leq$  4 hour turnaround time. Recently, Paula has begun listening to stray dictations and matches to reports. She then puts the studies still needing dictation back in the cue. It was recommended that the dictation include exam date and made available to read date.

Case Presentation:

#9496 Variance in Interpretation

F/C: Radiological impression "suggestive of..." and "recommend follow up" were adequate and appropriate for this interpretation. QA Category 2. Status: Closed

#10120 Interventional Procedure Complication-Retroperitoneal Hemorrhage

F/C: High-risk patient on multiple blood thinners after thrombolysis with urokinase increased risk of hematoma formation. Care was appropriate and complication was unavoidable. QA Category 2. Status: Closed

#11337 Bleeding Complication with Mammotome Biopsy

F/C: Skin nicks and post biopsy hematoma are not deviations from standard of care. However, these complications do require documentation of such. QA Category 1. Status: Closed

#11347 Missed Diagnosis

F/C: Cannot tell by images of air enema if enough air was placed in colon. Radiologist may have placed enough air to see cecum but did not save image. Better image documentation vs. inflation of more air recommended. QA Category 1. Status: Closed

#s10922 and 11336 pended due to reviewing radiologist not present to discuss.

Karen Hart, RN  
Quality Manager

PHA/SHAH/016  
000060

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**Department of Radiology  
Executive Session Minutes  
October 19, 2004**

**Cue Time:** September 30, 2003 – October 1, 2004 Cue Times by Radiologist were reviewed. The Department average cue time was 19 hours with the last three months of the time period (July-Sept04) as 18 hours. The goal remains at 4 or less hours. Analysis of the data shows that six radiologists had cue times of < 10 hour and that all radiologists, except for three had improved overall. The action that has been taken is that they now have a proxy list to help get reports out.

**Scheduling:** Continue to use locums Monday-Friday; Pediatric interventionalists help out when they can. (Dr. Williams has left Image Care and PHR.)

**Incomplete Work Reports:** Actions being taken-Carrie checks twice a week, department managers check daily. Untranscribed reports are research in PACS and if not done, taken to the Radiologist to complete. This process is working well. Reports are reviewed by the Dept QA Team. Issues: Dropped dictations, missed accession numbers, altered exams and bar code user errors. Noted that reports cannot be released without review and electronic signature to each exam even when there are multiple exams linked together. This seems to be more of a problem with special procedures.

**Case Review:**

**Questionable Interpretations:** 35 cases were referred in by Quality Dept, Risk Management or physician request. All were reviewed by Dr. Bayard and the appropriate radiology manager. Only minor variances identified. Not all cases have been resolved to date.

**Tumor Board Summary-Sept 30, 2003-Oct 1, 2004:** 91 cases reviewed. There were two cases with minor variances and no adverse affect on patient care or outcome.

**#11336 Missed Diagnosis-Breast Cancer Case**

F/C: Standard of care not met. Abnormality most likely missed on two separate exams. Determined to be a Class IV variance in which the findings or diagnosis should have been identified. QA Category 3 assigned. Case has been discussed with the radiologist and the outcome of this final review will be communicated to him as well. Status: Closed

**#11815 Missed Diagnosis-Mandible Fracture**

F/C: Re-review of the CT head/face found that it would have been difficult to identify the mandible fracture. (Class II variance) A non-displaced hair line fracture was ultimately identified. QA Category 2 assigned.

**#10922** remains pending for final review results

Karen Hart, RN  
Quality Manager

PHA/SHAH/017b  
000002

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Notes from Department of Radiology Meeting

Oct 19, 2004

Called to Order at 0710

Adjourned at 0820

Present: Drs. Dommers, Close, Waldron, Bayard, Cupples, Caldwell

Richard Meeks, Greg Webb, John Singerling, Kevin Lee, Karen Hart and Carrie Clark-Sorensen

General Session: Dr. Bayard presided

Minutes from last meeting-reviewed prior to meeting and approved

MEC: no report

Admin report: by Greg Webb Hosp is 7.5 million over projected 2005 budget goal. Will know over the next 2 wks if the dollars for rad capitol requests approved for MRI upgrade and add'l 5<sup>th</sup> special procedures room.

Department Report: by Greg Webb Dept cont's to use locums M-F and interventional and peds help as can find. The new PACS, version 4.5 is scheduled to come in January, however, this is an optimistic date. The vender is in the final stages of systems configuration. There are many issues to be considered: integration, slow memory retrieval, station needs for quads vs. duals. Quads are needed to look at more than one prior study at a time as you cannot use dual monitor to view 3 prior studies plus the current film showing during special procedures. It was felt that currently, there are insufficient quality stations. PET scanner needs need to be evaluated. Web-based PACS will be available in the next 6.0 upgrade. Greg explained the new "Blue Sheet" process for improving the TAT for preliminary reporting. (Copy of form-check off version provided.) Dr. Waldron has agreed to pilot the following process for ED patients: After the xray is taken, the tech will take the film to the reading area, the RAD will fill out the new form, the tech will then enter preliminary results from the form into Cerner which will "blow into" PACS. The ordering physician will then be able to view the report in Cerner. Final readings will consist of the RAD reviewing and QAing the preliminary report before making the final interpretation. There will be different form templates for CTs and diagnostics. In Cerner, the preliminary report entered does not automatically become the final report. The final report will require an electronic signature. Voice recognition is at least a year away.

Radiation Safety: Mr. Lee reported that no one is registering high level radiation exposure on their monitors, but that there needs to be increase used usage (wearing of) the radiation monitors. DHEC regs require that during special procedures, overhead or roll over shields be used. RADPADs are now available to use around injection sites to minimize exposure to surrounding tissue. DHEC has granted two more Radiologist to be Iodine certified users. The department currently only has two (Kantsiper and Glassman) Doctors Caldwell and Bayard will be getting their CEUs and preceptor requirements soon. Radiologists were encouraged to review their exposure reports. Information concerning monitoring and inspection was handed out to the radiologists.

Other Business: Mr. Singerling was concerned that there was no one present from the Medical Staff office to take minutes of this meeting. Also, Dr. Waldron stated he never got a meeting notice for today's meeting. Dr. Bayard will follow up

Went into Executive Session: Meeks, Lee and Clark-Sorensen left

Review of Minutes: None to review

PAR: none

Cred: none

Performance Improvement needs to be added here as a standing agenda item. The quality reviews and PI discussion will no longer take place at separate meetings. See attached minutes for today's meeting.

No other business, adjourned at 0820

PHA/Shah  
005090

Redacted  
PAs

**PALMETTO HEALTH RICHLAND  
MEDICAL EXECUTIVE COMMITTEE  
SPECIAL CALLED MEETING  
February 25, 2004**

Minutes of the MEC's Special Called Meeting held Wednesday, February 25, 2004. The following members were present: Drs. Keisler, D. Smith, Stewart, Langston, Jones, Stinson, Buerkert, Dubuisson, Eden, Korrapati, Christmann, Felmly, Thompson, Catalano, Malone, Nottingham and Brugh. Mr. Jim Lathren and Mr. John Singerling (for radiology coverage discussion only).

Dr. Keisler, Chief, called the meeting to order and presided. He also stressed the confidentiality of the information that would be discussed.

**PURPOSE OF MEETING:** To continue the previous called meeting in order to review the most recent QA findings by Dr. Bayne Selby, outside reviewer for Dr. Paresh Shah. Additionally, to receive additional information from Dr. Selby who was invited to attend this meeting.

**REVIEW OF DR. SELBY'S LAST QA FINDINGS:** Members were given opportunity to review Dr. Selby's findings from the most recent QA review.

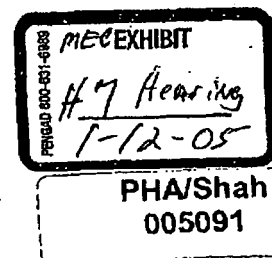
Dr. Keisler introduced Dr. Bayne Selby, an interventional radiologist from MUSC who is currently serving as Chair of the Radiology Department at MUSC. Dr. Selby has assumed responsibility as the outside reviewer of QA for Dr. Shah.

Dr. Selby indicated that he has tried to be balanced in his review and hopefully be helpful to the MEC. To date, he has reviewed three sets of records. He indicated that he has noticed a slight evolution from the first group of records where they appeared to be more administrative where Dr. Shah did not want to play by the rules. The second group of cases had to do more with interventional procedures and the last group appeared to be more diagnostic radiology. He then agreed to answer questions from members.

Dr. Selby was questioned regarding how to measure his findings. Specifically, has he found the same type of problems with his staff. Dr. Selby indicated that everyone is going to do one or more of these things wrong. However, in Dr. Shah's case this has been outside the norm and if this were happening with his staff there would be some type of reprimand action.

Dr. Selby was then questioned regarding his findings relative to CT of appendix. He reported that he had discussed this with Dr. Shah in his meeting with him earlier in the day. He indicated that Dr. Shah might need a CME course on CT of the appendix. Specifically, you would not expect to see this with someone with the level of experience as Dr. Shah.

Dr. Selby was asked to comment on the apparent lack of compassion for the patient who went through the lengthy procedure and urinated on herself while on the table and being forced to lie in her own urine. Members felt there was a serious disregard for the patient's feelings and the family as well. Dr. Selby agreed there was no excuse for this and it should be dealt with. That this was a situation where other alternatives could have been afforded. Further, that this is evidence of a deeper problem that exists regarding Dr. Shah's lack of relationship with the staff.



Additionally, he added that this is part of the responsibility of the physician and it does not measure up to the standards of other radiologists in the country.

Dr. Selby was questioned as to whether he felt the number of cases presented to the MEC is due to Dr. Shah's relationship with the other physician's and staff. He responded that he absolutely felt this to be the case. He reiterated that he did not feel that Dr. Shah is incompetent. However, he is someone who by his actions has put himself in the position for heavy scrutiny.

Dr. Selby was questioned if he had concerns regarding Dr. Shah's lack of documentation on invasive procedures. He reported that Dr. Shah has improved in his documentation; however, it still is not up to standard. He noted that this probably does speak to a larger issue of not being sensitive to patients and not being available to the staff. Additionally, he reported that Dr. Shah has spoken to him regarding the volume of business in the department and that some of this may be volume related.

Dr. Selby was questioned as to whether MUSC does random review. He noted that generally this is the method they follow. However, if they sense someone is being a problem they would do a focused review although this is very time and labor intensive.

Other areas of discussion included whether Dr. Shah is taking advantage of communication methods within the hospital, his changing of reports, and dictation on the wrong patient. Dr. Selby indicated that some of these are areas where Dr. Shah's relationship with the system is not helping him.

Dr. Selby was dismissed and Dr. Keisler opened the floor for discussion. Discussion was held regarding QA from the Radiology Department. Dr. Bayard indicated they do informal QA. Dr. Keisler has requested information for comparison with Dr. Shah and was told by Dr. Bayard that he has not had any complaints on the other radiologists. Following Dr. Keisler's report and discussion, motion was made, seconded and carried unanimously that the MEC requires the Department of Radiology to begin doing formal QA, effective March 1, 2004. Additionally, that the Department must submit a formal written report to the MEC within ninety days (June 1, 2004).

Dr. Keisler requested further input from the MEC regarding their interactions with Dr. Shah. This varied with some members indicating that Dr. Shah has been responsive and helpful and others reporting that there have been errors in the films he has read.

Dr. Keisler reported the various options available to the MEC as outlined in Addendum I, Article 1.5 of the Medical/Dental Staff Bylaws. Following a discussion, motion was made, seconded and carried unanimously to take corrective action against Dr. Shah and to afford Dr. Shah an appearance before the MEC prior to final action.

PHA/Shah  
005092

| Patient    | Date of Study | Referring Physician | Referring Physician | Referring Physician | Comments                                                                                                                                                                                         |
|------------|---------------|---------------------|---------------------|---------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| Patient 41 | 8/7/2005      | Fuerst              | Halbert             | Nighthawk           | Preliminary report does not mention any fracture; final report states "fracture of right scapula with probable fracture of left scapula"                                                         |
| Patient 42 | 7/8/2005      | Ford                | Mulznicks           | Nighthawk           | Wrong films sent w/ pt's name on them, therefore received wrong report                                                                                                                           |
| Patient 43 | 7/3/2005      | McHugh              |                     | Nighthawk           | Films read as no fracture seen; pt. actually had fracture of right transverse spinous process                                                                                                    |
| Patient 44 | 6/30/2005     | Moats               | Mulznicks           | Shah                | Initial CT report read as negative; pt actually had multiple rib fractures - resident spoke to Shah, who re-dictated report; also told resident he "did not have 2 hours to look at every scan." |
| Patient 48 | 6/29/2005     | Stanfield           |                     | Shah                | Initial CT report read negative for gallbladder; final report states "5 mm stone in gallbladder"                                                                                                 |
| Patient 46 | 6/28/2005     | Gerard              |                     | Shah                | CT read as "no trauma to abdomen and pelvis"; attending asked for re-read - came back as "bilateral tuboovarian abscesses"                                                                       |
| Patient 47 | 6/22/2005     | Moats               | Carleo              | Shah                | X-ray initially read as "no obvious evidence of any acute fracture or subluxation"; pt returned on 6/27/05 and was diagnosed with left ankle fracture                                            |
| Patient 49 | 6/8/2005      | McHugh              | Givens              | Shah                | Initial CT reading (given 2-3 hours after performed) had no mention of appendicitis; dictation done 18 hours later stated "suggestive of inflammatory bowel disease or acute appendicitis"       |
| Patient 50 | 6/1/2005      | Myslinski           | Givens              | Shah                | Hip x-ray read as "fracture of the right femoral neck"; pt returned on 6/4/05 and MRI of hip read as "no right hip fracture seen"                                                                |
| Patient 51 | 5/27/2005     |                     |                     | Shah                | Chest x-ray read as "normal PA and lateral chest"; pt had aspirated foreign body, which had to be removed                                                                                        |
| Patient 52 | 5/10/2005     | Hals                |                     | Nighthawk           | Preliminary report stated "No PE. No aortic dissection. No infiltrates"; reviewing radiologist stated + PE descending branches, RLL pulmonary arteries"                                          |
| Patient 45 | 5/10/2005     | Fuerst              | Kleiman             | Bayard              | CT performed ~ 3 PM; report finally received at 6:15 PM (after calling at 3:45, 4:30 and 5:15); pt very upset at wait, wanted to go AWOL                                                         |
| Patient 53 | 4/21/2005     | Shelton             |                     | Shah                | Portable chest x-ray read positive for left rib fractures and possible lung contusion; addendum states "no evidence of any acute disease"                                                        |
| Patient 54 | 4/5/2005      | Hunt                |                     | Shah                | Report states both that pt has "small comminuted fracture" and "no obvious evidence of acute fracture"                                                                                           |

2504

PH/Shah  
005246

tabbles

EXHIBIT  
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| Patient     | Date       | Referring Physician | Referring Physician | Referring Physician | Referring Physician                                                                                                                                                                                                                                           |
|-------------|------------|---------------------|---------------------|---------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| Patient 110 | 2/23/2005  | Stewart             |                     | Shah                | Wrong pt's information on preliminary chest x-ray report                                                                                                                                                                                                      |
| Patient 56  | 2/18/2005  |                     |                     | Caldwell            | Wrong reading on final wrist x-ray report                                                                                                                                                                                                                     |
| Patient 55  | 1/5/2005   | Cook/Moats          | Jones               | Shah                | Preliminary report of abdominal CT read as normal; final report notes thickening of sigmoid colon wall                                                                                                                                                        |
| Patient 60  | 12/15/2004 | Taylor              |                     | ?                   | CT head performed at 0737; report not back until 1055, despite repeated calls by attending                                                                                                                                                                    |
| Patient 61  | 12/10/2004 |                     |                     | Shah                | Preliminary report of leg x-ray read as normal; fracture noted in final report                                                                                                                                                                                |
| Patient 62  | 12/9/2004  |                     | Osborn              | Shah                | Portable chest x-ray read as normal (final report - 0718); second report (also final - 1746) notes "complete opacity" of right chest, probably due to "complete atelectasis with or without some pleural effusion."                                           |
| Patient 59  | 12/7/2004  |                     |                     | Caldwell            | Technique in preliminary report of CT Angiography states "There are vascular filling defects - suggestive of pulmonary embolus." Impression states "No pulmonary embolus."                                                                                    |
| Patient 58  | 12/6/2004  | Privette            | McClain-Carter      | Shah                | Preliminary report of hand x-ray read as avulsion fracture; final report read as normal                                                                                                                                                                       |
| Patient 65  | 11/30/2004 | Hunt                | Jennings            | Marchand            | Preliminary report of abdominal CT notes no abnormality; attending notes a mass in abdominal wall on 4 images                                                                                                                                                 |
| Patient 63  | 11/28/2004 | Stewart             | Clarkson            | Caldwell/Richmond   | CT of c-spine read as normal on preliminary report; blue sheet states "nonspecific lucent lesion of right C4 vertebral body - differential diagnosis of bone cyst or neoplasm"                                                                                |
| Patient 64  | 11/17/2004 | Stanfield           | Clarkson            | Shah                | Final report released 12/3/04; x-ray performed 11/17/04                                                                                                                                                                                                       |
| Patient 66  | 11/16/2004 | Privette            |                     | Kinchen             | Preliminary report (Nighthawk) of pelvis CT states no apparent fracture; final report (Caldwell) notes nondisplaced fracture                                                                                                                                  |
| Patient 67  | 10/23/2004 | Myslinski           | Jennings            | ?                   | Preliminary report of head CT does not identify nondisplaced fracture of orbital rim                                                                                                                                                                          |
| Patient 68  | 10/20/2004 | Gillen/Brown        | McClain-Carter      | DeJesus             | Trauma pt - CT head, neck, chest, abdomen, & pelvis done @ 1530; no reading back by 1730, attending called and received "very wet read" of normal. Requested blue sheet - received @ 1900 with reading of splenic laceration. Other abnormalities found later |

| Patient    | Date      | Referring Physician | Referring Physician | Referring Physician | Comments                                                                                                                                               |
|------------|-----------|---------------------|---------------------|---------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------|
| Patient 69 | 9/18/2004 | Stewart             |                     | Richmond            | Discrepancy between readings of head CT; radiologist read as atrophy only, ED attending read as old right-sided parietal infarct                       |
| Patient 70 | 8/13/2004 | Gillen/Stewart      |                     | Waldron             | Missed fracture - only one x-ray view reported                                                                                                         |
| Patient 71 | 8/26/2004 | Taylor              | Krusling            | Marchand            | Discrepancy between Marchand's and Nighthawk's reading of abdominal CT                                                                                 |
| Patient 72 | 8/1/2004  | Moats               | Holder              | MacPherson          | Radiologist misread of soft tissue mass                                                                                                                |
| Patient 76 | 7/26/2004 | Wade                | Holder              | Hyun                | Preliminary CT read by Nighthawk missed fracture                                                                                                       |
| Patient 75 | 7/23/2004 | Stewart             | Kruger              | Shah                | Report received 1 hour 30 min after CT was read and results confirmed                                                                                  |
| Patient 77 | 7/22/2004 | Stewart             | Osbon               | Shah                | Preliminary CT report indicated no gallstones; final did note the stones                                                                               |
| Patient 73 | 7/21/2004 | Hals                | Wood                | Shah                | Radiologist read CT as appendicitis; patient had had appendectomy several years before                                                                 |
| Patient 74 | 7/13/2004 | Wade/Myslinski      |                     | Marshall            | Discrepancy between x-ray and CT readings; CT done to rule out x-ray finding                                                                           |
| Patient 78 | 7/4/2004  | Gillen              |                     | ?                   | Radiologist name not given on preliminary head CT, indicated no fracture; final report 3 days later (Dr. Close) indicated possible fracture            |
| Patient 79 | 6/29/2004 |                     |                     | Dommers             | Comments on final report of head CT made in snide tone                                                                                                 |
| Patient 83 | 5/22/2004 | Lloyd               | Halbert             | Shah                | Preliminary report of abdominal CT read as "normal" and patient discharged; final report indicated cyst in right lobe of liver                         |
| Patient 84 | 5/20/2004 | Lloyd               | Halbert             | Waldron             | Preliminary report of head CT read as negative and patient was discharged; final report indicated possible multiple myeloma or bony metastatic disease |
| Patient 82 | 5/16/2004 | Gillen              | Clarkson            | Bayard              | Preliminary CT information reported on wrong patient's sheet                                                                                           |

| Patient     | Date      | Referring Physician | Referring Physician | Referring Physician | Referring Physician                                                                                                                                                                                                                               |
|-------------|-----------|---------------------|---------------------|---------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| Patient 81  | 5/15/2004 | Cook/Stewart        | Simmons             | Richmond            | Preliminary report of head CT delayed 5 1/2 hours                                                                                                                                                                                                 |
| Patient 80  | 5/8/2004  | Gillen/Harvey       |                     | Waldron             | Results of head CT delayed 6 hours                                                                                                                                                                                                                |
| Patient 86  | 5/5/2004  | Gerard/Stewart      |                     | Shah                | Abdominal CT read as possible early appendicitis; surgery consult indicated no evidence of appendicitis                                                                                                                                           |
| Patient 87  | 5/5/2004  | Wade                |                     | Shah                | Preliminary report of abdominal CT read as normal and patient discharged; final report (Williams) indicated ureteral calculi                                                                                                                      |
| Patient 90  | 4/27/2004 | N/A                 | N/A                 | Richmond            | Preliminary report of abdominal CT read as "dilated bladder, otherwise negative"; final report indicated ruptured appendix with periappendiceal abscess                                                                                           |
| Patient 89  | 4/10/2004 | Taylor              |                     | Caldwell            | Radiologist questioned ED attending's order for air contrast BE, asked that another physician be consulted; AC BE was read as normal by radiologist; abdominal CT performed 1 hour later read as "grossly abnormal" and indicated intussusception |
| Patient 88  | 4/9/2004  | Wade                | Holder              | Waldron             | Shoulder x-ray read by radiology as negative; missed clavicle fracture                                                                                                                                                                            |
| Patient 91  | 4/7/2004  | Brown               |                     | Shah                | Preliminary and final reports of hand x-ray read as normal by radiologist, ED attending disagreed; film reviewed by 2nd radiologist who confirmed fracture                                                                                        |
| Patient 92  | 3/25/2004 | Lloyd               | Brittain            | Kantsiper           | Preliminary and final reports of foot x-ray read as normal by radiologist; ED physicians noted a fracture and requested a review; review indicated non displaced fracture                                                                         |
| Patient 85  | 3/25/2004 | Brown               |                     | Shah                | Discrepancy between attending and radiologist readings of chest x-ray; preliminary report indicate no acute lung disease                                                                                                                          |
| Patient 97  | 3/9/2004  | Stanfield           |                     | Shah                | Final report released on 4/8/04 - positive fracture                                                                                                                                                                                               |
| Patient 107 | 2/11/2004 | McHugh              |                     | Shah                | Final report released on 3/9/04 - normal                                                                                                                                                                                                          |
| Patient 94  | 2/10/2004 | Cook                |                     | Richmond            | Foot x-ray read by radiologist as normal; ED attending asked for review by 2nd radiologist, which confirmed fracture                                                                                                                              |
| Patient 102 | 2/6/2004  | Bynoe               |                     | Shah                | Final report released on 3/9/04 - normal                                                                                                                                                                                                          |

| Patient ID  | Date       | Attending      | Referring | Radiologist | Reason                                                                                                                                                                                  |
|-------------|------------|----------------|-----------|-------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| Patient 103 | 2/2/2004   | Meadows        |           | Shah        | Final report released on 3/9/04 - positive fracture                                                                                                                                     |
| Patient 93  | 1/8/2004   | Brown          | Campbell  | Shah        | Discrepancy in readings of hand x-ray; radiologist read as no fracture, ED attending read as third and fourth digit phalanx fractures                                                   |
| Patient 95  | 1/7/2004   | Moats/Privette | Brittain  | ?           | Abdominal CT read by radiologist as negative; ED physicians' review indicated appendicitis, which was the confirmed diagnosis                                                           |
| Patient 104 | 1/4/2004   | Moats          |           | Shah        | Final report released on 3/3/04 - no acute lung disease, findings consistent with reactive airway disease                                                                               |
| Patient 105 | 1/4/2004   | Moats          |           | Shah        | Final report released on 3/3/04 - normal                                                                                                                                                |
| Patient 106 | 1/4/2004   | Moats          |           | Shah        | Final report released on 3/3/04 - subsegmental atelectasis in perihilar areas and lung base, underlying pneumonia not absolutely excluded but less likely, otherwise unremarkable       |
| Patient 96  | 12/26/2003 | Stanfield      |           | Shah        | CT and chest x-ray both read as normal by radiologist; ED attending questioned reading, asked for review; radiologist admitted to calcified lymph node, but final report was unchanged. |
| Patient 101 | 12/21/2003 | Taylor         |           | Shah        | Final report released on 3/5/04 - positive fracture                                                                                                                                     |
| Patient 99  | 12/19/2003 | Wade           |           | Shah        | Final report released on 3/5/04 - mild cardiomegaly, no acute lung disease                                                                                                              |
| Patient 100 | 12/18/2003 | Myslinski      |           | Williams    | Final report released on 3/5/04 - normal                                                                                                                                                |
| Patient 98  | 12/3/2003  | Wade           |           | Shah        | Final report released on 3/5/04 - positive fracture                                                                                                                                     |

2508

 PHA/Shah  
 005250





September 29, 2005

Greta R. Harper, M.D.  
Chief of Staff  
C/O Medical Staff Affairs  
Palmetto Health Richland  
5 Richland Medical Park Drive  
Columbia, SC 29203

Dear Dr. Harper,

Enclosed you will find the medical record review for June, July, August, and September for Paresch Shah, M.D. The medical record review was completed by the nurse manager for Radiology Service, using the same guidelines for the departmental medical record review performed on charts completed by all radiologists.

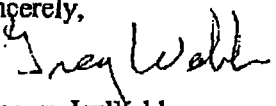
Also enclosed you will find the current report showing mis-interpretations since January, 2005.

Additionally, there is a new document that illustrates another issue with Dr. Shah that impacts services for patients and physicians. The "Q" Time report indicates the average number of hours a transcribed report sits in the queue to be released. As you can see, the is averaging 25 hours in queue with a total turn around time of 35 hours to get reports released. The target queue time for the department is 10 hours at present.

Finally, I would also like to make mention of complaints received by ED physicians regarding Dr. Shah's refusal to enter preliminary reports into PACS. It was agreed by vote in a called Department Meeting that radiologists will enter preliminary reports in PACs for ED patients. He continues to ignore this rule which results in delayed treatment for ED patients. This falls under the "administrative review" that Dr. Shah was also undergoing.

Please contact me if you have questions regarding the enclosed data.

Sincerely,

  
Gregory L. Webb  
Director, Radiological Services

Enclosures

Cc: Howard West, Legal Counsel  
Palmetto Health Corporate Offices

**CONFIDENTIAL**



Reviewer: [Signature]  
 Date of Review: 9/2/06  
 Y=Yes/Present  
 N=No/Absent  
 Neither block checked Indicates NA

Palmatort Health Richmond  
 Medical records Review  
 Focused Open Review

AS OF: 21

| Pr<br>Not<br>#1 | Clinical Observations<br>#9                   |                             |                               |                                  |                                                  |                                  |                                                             |                          |                                         |                 | Informed<br>Consent # 8 |                           |                      |                           |                         |                         |                                                            |                                                                     | History and<br>Physical<br>#2 |           | Ident<br>Data<br>#1 |         |                   |
|-----------------|-----------------------------------------------|-----------------------------|-------------------------------|----------------------------------|--------------------------------------------------|----------------------------------|-------------------------------------------------------------|--------------------------|-----------------------------------------|-----------------|-------------------------|---------------------------|----------------------|---------------------------|-------------------------|-------------------------|------------------------------------------------------------|---------------------------------------------------------------------|-------------------------------|-----------|---------------------|---------|-------------------|
|                 | Immediately after surgery<br>Post-op month. # | Pain Assessment<br>complete | Pain Assessment<br>Documented | Patient appropriate<br>candidate | Re-eval immediately<br>prior to initiation by MD | Pre-sedation<br>assessment by MD | Verification "Time Out" confirm<br>correct p/procure & site | Consent for<br>Treatment | Physician id r/b/a<br>discussed w/pl tm | Date<br>Present | Correct<br>Date         | Name of Doctor<br>Present | Procedure<br>Correct | Procedure Name<br>Present | Patient Name<br>Correct | Patient Name<br>Present | HAP completed within<br>30 days prior to surgery/admission | Accident/unexpected within seven<br>days prior to surgery/admission | Patient ID<br>Present         | Physician | Nursing<br>Unit     | Service | Account<br>Number |
| 1               | Y                                             | Y                           | Y                             | Y                                | Y                                                | Y                                | Y                                                           | Y                        | Y                                       | Y               | Y                       | Y                         | Y                    | Y                         | Y                       | Y                       | Y                                                          | Y                                                                   | Y                             |           |                     |         | 7/1/07            |
| 2               | Y                                             | Y                           | Y                             | Y                                | Y                                                | Y                                | Y                                                           | Y                        | Y                                       | Y               | Y                       | Y                         | Y                    | Y                         | Y                       | Y                       | Y                                                          | Y                                                                   | Y                             |           |                     |         | 7/1/07            |
| 3               | Y                                             | Y                           | Y                             | Y                                | Y                                                | Y                                | Y                                                           | Y                        | Y                                       | Y               | Y                       | Y                         | Y                    | Y                         | Y                       | Y                       | Y                                                          | Y                                                                   | Y                             |           |                     |         | 7/1/07            |
| 4               | Y                                             | Y                           | Y                             | Y                                | Y                                                | Y                                | Y                                                           | Y                        | Y                                       | Y               | Y                       | Y                         | Y                    | Y                         | Y                       | Y                       | Y                                                          | Y                                                                   | Y                             |           |                     |         | 7/1/07            |
| 5               | Y                                             | Y                           | Y                             | Y                                | Y                                                | Y                                | Y                                                           | Y                        | Y                                       | Y               | Y                       | Y                         | Y                    | Y                         | Y                       | Y                       | Y                                                          | Y                                                                   | Y                             |           |                     |         | 7/1/07            |
| 6               | Y                                             | Y                           | Y                             | Y                                | Y                                                | Y                                | Y                                                           | Y                        | Y                                       | Y               | Y                       | Y                         | Y                    | Y                         | Y                       | Y                       | Y                                                          | Y                                                                   | Y                             |           |                     |         | 7/1/07            |
| 7               | Y                                             | Y                           | Y                             | Y                                | Y                                                | Y                                | Y                                                           | Y                        | Y                                       | Y               | Y                       | Y                         | Y                    | Y                         | Y                       | Y                       | Y                                                          | Y                                                                   | Y                             |           |                     |         | 7/1/07            |
| 8               | Y                                             | Y                           | Y                             | Y                                | Y                                                | Y                                | Y                                                           | Y                        | Y                                       | Y               | Y                       | Y                         | Y                    | Y                         | Y                       | Y                       | Y                                                          | Y                                                                   | Y                             |           |                     |         | 7/1/07            |
| 9               | Y                                             | Y                           | Y                             | Y                                | Y                                                | Y                                | Y                                                           | Y                        | Y                                       | Y               | Y                       | Y                         | Y                    | Y                         | Y                       | Y                       | Y                                                          | Y                                                                   | Y                             |           |                     |         | 7/1/07            |
| 10              | Y                                             | Y                           | Y                             | Y                                | Y                                                | Y                                | Y                                                           | Y                        | Y                                       | Y               | Y                       | Y                         | Y                    | Y                         | Y                       | Y                       | Y                                                          | Y                                                                   | Y                             |           |                     |         | 7/1/07            |
| 11              | Y                                             | Y                           | Y                             | Y                                | Y                                                | Y                                | Y                                                           | Y                        | Y                                       | Y               | Y                       | Y                         | Y                    | Y                         | Y                       | Y                       | Y                                                          | Y                                                                   | Y                             |           |                     |         | 7/1/07            |
| 12              | Y                                             | Y                           | Y                             | Y                                | Y                                                | Y                                | Y                                                           | Y                        | Y                                       | Y               | Y                       | Y                         | Y                    | Y                         | Y                       | Y                       | Y                                                          | Y                                                                   | Y                             |           |                     |         | 7/1/07            |
| 13              | Y                                             | Y                           | Y                             | Y                                | Y                                                | Y                                | Y                                                           | Y                        | Y                                       | Y               | Y                       | Y                         | Y                    | Y                         | Y                       | Y                       | Y                                                          | Y                                                                   | Y                             |           |                     |         | 7/1/07            |
| 14              | Y                                             | Y                           | Y                             | Y                                | Y                                                | Y                                | Y                                                           | Y                        | Y                                       | Y               | Y                       | Y                         | Y                    | Y                         | Y                       | Y                       | Y                                                          | Y                                                                   | Y                             |           |                     |         | 7/1/07            |
| 15              | Y                                             | Y                           | Y                             | Y                                | Y                                                | Y                                | Y                                                           | Y                        | Y                                       | Y               | Y                       | Y                         | Y                    | Y                         | Y                       | Y                       | Y                                                          | Y                                                                   | Y                             |           |                     |         | 7/1/07            |
| 16              | Y                                             | Y                           | Y                             | Y                                | Y                                                | Y                                | Y                                                           | Y                        | Y                                       | Y               | Y                       | Y                         | Y                    | Y                         | Y                       | Y                       | Y                                                          | Y                                                                   | Y                             |           |                     |         | 7/1/07            |
| 17              |                                               |                             |                               |                                  |                                                  |                                  |                                                             |                          |                                         |                 |                         |                           |                      |                           |                         |                         |                                                            |                                                                     |                               |           |                     |         |                   |
| 18              |                                               |                             |                               |                                  |                                                  |                                  |                                                             |                          |                                         |                 |                         |                           |                      |                           |                         |                         |                                                            |                                                                     |                               |           |                     |         |                   |
| 19              |                                               |                             |                               |                                  |                                                  |                                  |                                                             |                          |                                         |                 |                         |                           |                      |                           |                         |                         |                                                            |                                                                     |                               |           |                     |         |                   |
| 20              |                                               |                             |                               |                                  |                                                  |                                  |                                                             |                          |                                         |                 |                         |                           |                      |                           |                         |                         |                                                            |                                                                     |                               |           |                     |         |                   |

Comments:

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PH/AShah  
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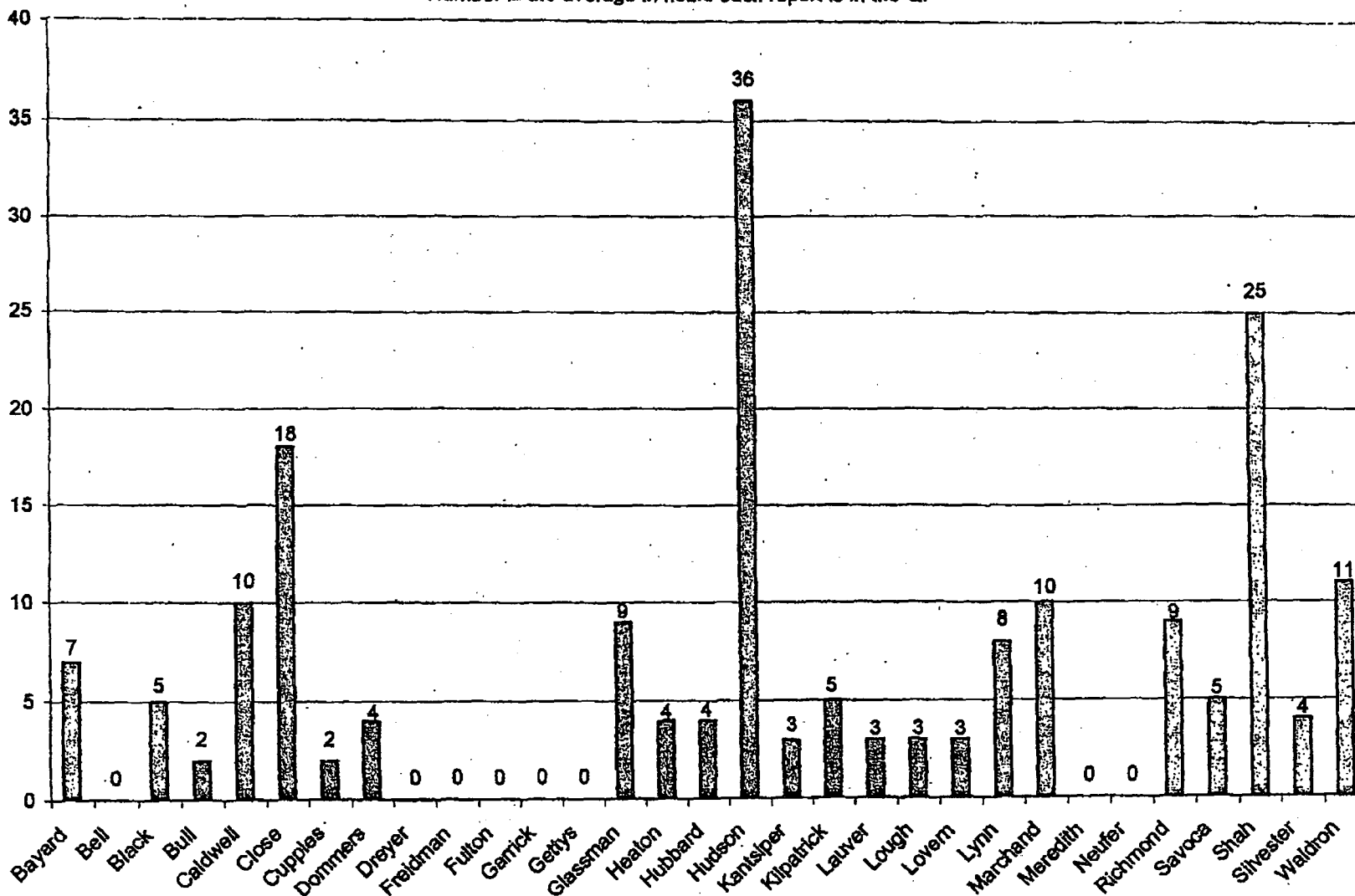


|                                                                 |                      |                                                                                   |            |                |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |
|-----------------------------------------------------------------|----------------------|-----------------------------------------------------------------------------------|------------|----------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| CXR - Dictation<br>April 22, 2005                               | MR#5152128           | Presented by ED physician as a misinterpretation.                                 | Dr. Shah   | April 22, 2005 | April 27, 2005 Dr. Shah gave an incorrect accession number for the dictation, the transcriptionist typed on the accession number provided and the report was sent out. Several of the transcriptionist have indicated that Dr. Shah has difficulties "seeing" 3s and 8s and have stated that they will be more careful when transcribing Dr. Shah's dictation. The CXR was re-dictated correctly. April 28, 2005. The ED physician did treat patient at time of visit based on a normal CXR. No adverse affect on patient care was indicated.                                                                                                                                                                                                                                                                                                                                 |
| CXR w/RL Decubitus<br>May 27, 2005                              | MR#11709086          | Occurrence report requested by ED Physician as a misinterpretation                | Dr. Shah   | May 27, 2005   | The ED physician (also parent of patient) did not agree with the Dr. Shah's interpretation of Normal. The patient's history indicates that the child had possibly aspirated a "nut". After consulting with Dr. Shah - Dr. Shah would not change his original interpretation. At some point another physician was brought into this case. I have received additional info from the ED that indicates the patient was admitted and did require surgery at which time a "nut" was removed. Dr. Bayard and another RAD has reviewed this case. Dr. Bayard has discussed this case with Dr. Stanfield. Also, forwarded to PHR-QA for additional review and follow up. June 9, 2005. Additional info may be required. June 10-All info re this patient has been sent to Pat Hickey - Risk Management for additional review and follow up. Additional review from Dr. Selby pending. |
| NO MISREAD<br>CT Abdomen & Pelvis<br>w/contrast May 10,<br>2005 | MR#10996722          | Report delay complaint from ED physician.                                         | Dr. Bayard | May 10, 2005   | Patient information indicates that the CT was completed at 12:45pm - however, the report was not available until (transcribed) 7pm. Concern is that this was an ED patient and the radiology report was not negative which delayed patient treatment. Dr. Bayard to review. 07-13-2005.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |
| Left Ankle<br>June 22, 2005                                     | MR#2844976<br>Baker  | ED challenged the preliminary report and the final report for this procedure.     | Dr. Shah   | June 22, 2005  | June 22, 2005 - ED physician thought the patient had a fx or some bony problem/process of the ankle and ask Dr. Shah to re-read, he did not change his initial interpretation (swelling and no fx). Another RAD looked at image and indicated that it was probably insignificant. June 23. The patient returned to the ED on June 27 because of ankle pain. After reassessment the ED physician concluded that the patient had a fx of the foot of the talus bone laterally, which appears to be an avulsion fx. Patient to follow up with ortho today. Dr. Bayard to review. No additional follow is available at this time...07-13-2005.                                                                                                                                                                                                                                    |
| CT Abdomen & Pelvis<br>w/contrast June 29,<br>2005              | MR#1132595<br>Wood   | ED challenged the preliminary report.                                             | Dr. Shah   | June 29, 2005  | Preliminary report indicated no trauma to abdomen or pelvis. Does not appear to be Dr. Shah's handwriting. ED ask for a re-read and was now read as "Bilateral Tuboovarian Abscesses". Fortunately the patient was in the ED and was referred to a Gyn person for appropriate follow up. To be reviewed by Dr. Bayard. July 13- 2005.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |
| CT Chest w/contrast<br>June 29, 2005                            | MR#9745188<br>Corbin | ED disagreed with exclusion of chest tube on preliminary report and final report. | Dr. Shah   | June 29, 2005  | The preliminary and final report did not include any reference to the "chest tube" position or the expansion of the patient's right lung. The chest tube has been reference on several CXRs since June 27, 2005. TO be reviewed by Dr. Bayard. July 13, 2005.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |

# "Q" TIME

Report has been transcribed and is in the Radiologist review Q awaiting review and release.

Number is the average in hours each report is in the Q.



SEPTEMBER 1 - 26, 2005

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PHA/Shah  
006785

The Hearing Committee also finds that the information from the Hospital's Emergency Department of Dr. Shah's misinterpretations during the probationary period further support the finding that Dr. Shah continued to suffer clinical deficiencies during the period of probation. *Transcript, Volume II, testimony of John Stewart, M.D., pgs. 40-43; Palmetto Exhibit 3 and Shah Exhibit 4.*

3. DR. SHAH FAILED TO ADHERE TO DEPARTMENT AND HOSPITAL ADMINISTRATIVE POLICIES AND PROCEDURES.

Gregory Webb, Director of Radiological Services at the Hospital testified that Dr. Shah continued to ignore Hospital policies and procedures during the period of probation. *Transcript, Volume II, pgs. 69-93.* Mr. Webb testified that Emergency Department physicians complained that Dr. Shah continued to refuse to enter preliminary reports into PACS, despite the vote in the Radiology Department that radiologists will enter preliminary reports in the PACS for Emergency Department physicians. *Transcript, Volume II, pgs. 69-93; Shah Exhibit 4.* This resulted in delayed treatment for Emergency Department patients. *Shah Exhibit 4.* Further, the evidence shows that the average time that Dr. Shah's transcribed reports sat in the queue for his review and release was 25 hours, which is significantly higher than all but one radiologist, and far in excess of the 10 hour target queue. *Transcript, Volume II, pgs. 69-93; Shah Exhibit 4.*

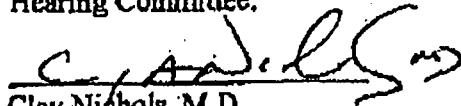
Here again, Dr. Shah presented no evidence to challenge the MEC on this issue. The Hearing Committee is particularly concerned with Dr. Shah's failure to adhere to the Department of Radiology's policy to enter preliminary reports into PACS. This has a direct impact on patient care and illustrates an apparent lack of regard for Hospital policy.

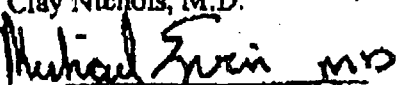
RECOMMENDATIONS

Based on the foregoing findings of fact and conclusions, the Hearing Committee unanimously recommends that the MEC uphold Dr. Shah's summary suspension and its recommendation to the Hospital's Board of Directors that Dr. Shah's clinical privileges be revoked.

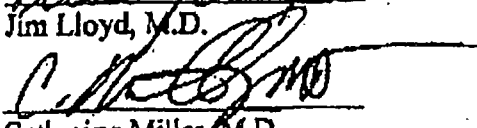
Hearing Committee:

December 30, 2005

  
Clay Nichols, M.D.

  
Michael Ervin, M.D.

  
Jim Lloyd, M.D.

  
Catherine Miller, M.D.

CONFIDENTIAL

STATE OF SOUTH CAROLINA  
COUNTY OF RICHLAND

)  
)  
)

IN THE COURT OF COMMON PLEAS  
FIFTH JUDICIAL CIRCUIT  
CASE NO.: 2006-CP-40-04035

Paresh Shah, M.D. and Paresh Shah, M.D.,  
P.A.,

)  
)  
)

Plaintiffs,

)  
)

vs.

)  
)

**AFFIDAVIT OF  
KAREN HART**

Palmetto Health Alliance d/b/a Palmetto  
Richland Memorial Hospital  
f/k/a Richland Memorial Hospital, et al.

)  
)  
)  
)

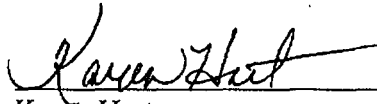
Defendants.

)  
)

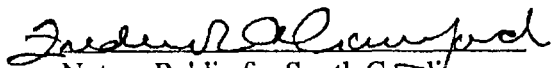
PERSONALLY appeared before me, Karen Hart, who, being duly sworn deposes and states that between January, 2000 and December, 2004, she was the Director of Quality at Palmetto Health Richland; that attached hereto is a true and correct copy of a report for the Department of Radiology at Palmetto Health Richland for the period January 1, 2000 through March 31, 2004 which was prepared by me in the ordinary course of business and in the ordinary course of my duties and responsibilities as an employee of Palmetto Health Alliance that lists all occurrences reported to me, the date of the occurrence, the patient name (except certain names have been redacted pursuant to the agreement of counsel) and medical record numbers and the radiologist's QAID number involved. Each radiologist, with privileges in the Department of Radiology at Palmetto Health Richland, was assigned a QAID number (quality assurance number) for the purposes of reporting. The QAID number for Paresh Shah, M.D. was 4314. As shown on the attached Report, I recorded 248 occurrences for the Department of Radiology. During the same period, as shown on the attached report, I recorded 82 occurrence reports involving Dr. Shah which represented thirty-three percent (33%) of the total occurrences for said period.

In my position as Director of Quality at Palmetto Health Richland, I also prepared similar reports  
for the other Medical Staff Departments.

Further Deponent sayeth not.

  
\_\_\_\_\_  
Karen Hart

SWORN to before me this 11<sup>th</sup>  
day of November, 2008.

  
\_\_\_\_\_  
Notary Public for South Carolina  
My Commission expires: 3-12-11



Palmetto Health Richland

by  
Radiology Department  
01/01/2000 thru 03/31/2004

| MR #      | Patient Name | Case # | Dept | QAID    | Occ Date   | QA category | Occurrence screen                                    |
|-----------|--------------|--------|------|---------|------------|-------------|------------------------------------------------------|
| 010483536 |              | 4114   | RAD  | 3385    | 07/16/2001 | 8           | Missed diagnosis ?                                   |
| 010537945 |              | 4036   | RAD  | 3385    | 09/03/2001 | 5           | Variance in interpretation                           |
| 5282768   |              | 6477   | RAD  | 3385    | 05/22/2002 | 1           | ASA score not documented prior to IV sedation        |
| 10976991  |              | 5907   | RAD  | 3385    | 04/16/2002 | 6           | Injury secondary to invasive procedure               |
| 9107014   |              | 2911   | RAD  | 3385    | 05/18/2001 | 6           | Injury secondary to invasive procedure               |
| 9131776   |              | 8153   | RAD  | 3385    | 10/02/2002 | 1           | ASA score not documented prior to IV sedation        |
| 10767537  |              | 5916   | RAD  | 3385    | 04/09/2002 | 1           | ASA score not documented prior to IV sedation        |
| 5787140   |              | 831    | RAD  | 3385    | 09/04/2000 | 5           | Variance in interpretation                           |
| 10252301  |              | 7579   | RAD  | 3385    | 08/19/2002 | 1           | ASA score not documented prior to IV sedation        |
| 0292148   |              | 1150   | RAD  | 3385    | 10/17/2000 | 5           | Interventional procedure complication                |
| 11378695  |              | 8834   | RAD  | 3385    | 01/22/2003 | 8           | Radiology results not communicated                   |
| 1302600   |              | 9496   | RAD  | 3385-12 | 04/15/2003 | 8           | Variance in interpretation                           |
| 10278835  |              | 6237   | RAD  | 3536    | 05/13/2002 | 1           | ASA score not documented prior to IV sedation        |
| 1349715   |              | 7282   | RAD  | 3536    | 08/19/2002 | 1           | ASA score not documented prior to IV sedation        |
| 1951006   |              | 315    | RAD  | 3536    | 01/24/2000 | 6           | Unplanned admission after OP procedure within 24 hrs |
| 010949889 |              | 5855   | RAD  | 3536    | 03/27/2002 | 1           | ASA score not documented prior to IV sedation        |
| 0626578   |              | 6644   | RAD  | 3536    | 06/21/2002 | 1           | H&P not dictated within 24 hours                     |
| 5443002   |              | 10020  | RAD  | 3536    | 07/01/2003 | 1           | Illegible documentation                              |
| 10982956  |              | 6945   | RAD  | 3536    | 07/16/2002 | 1           | ASA score not documented prior to IV sedation        |
| 10982956  |              | 6946   | RAD  | 3536    | 07/17/2002 | 1           | ASA score not documented prior to IV sedation        |
| 011028848 |              | 6265   | RAD  | 3536    | 05/22/2002 | 1           | ASA score not documented prior to IV sedation        |
| 5680768   |              | 5538   | RAD  | 3536    | 01/02/2002 | 1           | ASA score not documented prior to IV sedation        |
| 1709575   |              | 6868   | RAD  | 3536    | 06/28/2002 | 2           | Interventional procedure complication                |
| 9916289   |              | 941    | RAD  | 3536    | 04/30/2000 | 6           | Re-op X 2 bleeding s/p CABG or Valve                 |
| 002522670 |              | 7229   | RAD  | 3536    | 08/20/2002 | 1           | ASA score not documented prior to IV sedation        |
| 1317161   |              | 7881   | RAD  | 3536    | 10/16/2002 | 1           | ASA score not documented prior to IV sedation        |
| 6268053   |              | 375    | RAD  | 3536    | 01/30/2000 | 2           | Interventional procedure complication                |
| 11063049  |              | 6889   | RAD  | 3536    | 06/09/2002 | 1           | ASA score not documented prior to IV sedation        |
| 10064573  |              | 7242   | RAD  | 3536    | 08/19/2002 | 1           | ASA score not documented prior to IV sedation        |
| 0124290   |              | 4875   | RAD  | 3536    | 01/10/2002 | 2           | Interventional procedure complication                |
| 0124290   |              | 4878   | RAD  | 3536    | 01/10/2002 | 1           | Illegible documentation                              |
| 5471485   |              | 664    | RAD  | 3536    | 05/26/2000 | 6           | Adverse IV Sedation Event                            |
| 10347753  |              | 11147  | RAD  | 3536    | 06/08/2002 | 7           | Missed diagnosis ?                                   |
| 4204239   |              | 8204   | RAD  | 3536    | 11/25/2002 | 1           | ASA score not documented prior to IV sedation        |
| 10409808  |              | 7550   | RAD  | 3536    | 09/11/2002 | 1           | ASA score not documented prior to IV sedation        |
| 3972724   |              | 8652   | RAD  | 3536    | 01/13/2003 | 1           | Illegible documentation                              |

PHA/SHAH/0176  
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CONFIDENTIAL

DEFENDANT'S  
EXHIBIT

34

|           |      |     |      |            |   |                                                           |
|-----------|------|-----|------|------------|---|-----------------------------------------------------------|
| 7808292   | 6865 | RAD | 3536 | 07/19/2002 | 1 | ASA score not documented prior to IV sedation             |
| 7808292   | 6892 | RAD | 3536 | 07/19/2002 | 2 | Interventional procedure complication                     |
| 8959904   | 7005 | RAD | 3536 | 08/05/2002 | 1 | ASA score not documented prior to IV sedation             |
| 11138796  | 7309 | RAD | 3536 | 08/07/2002 | 1 | ASA score not documented prior to IV sedation             |
| 10449020  | 5554 | RAD | 3536 | 03/15/2002 | 1 | ASA score not documented prior to IV sedation             |
| 7847680   | 4063 | RAD | 3536 | 10/11/2001 | 1 | Illegible documentation                                   |
| 7847680   | 7616 | RAD | 3536 | 09/06/2002 | 1 | ASA score not documented prior to IV sedation             |
| 10837483  | 4763 | RAD | 3536 | 01/03/2002 | 6 | Interventional procedure complication                     |
| 10845459  | 5537 | RAD | 3536 | 01/07/2002 | 1 | ASA score not documented prior to IV sedation             |
| 011091998 | 6804 | RAD | 3536 | 07/05/2002 | 1 | ASA score not documented prior to IV sedation             |
| 11065186  | 6745 | RAD | 3536 | 06/13/2002 | 1 | ASA score not documented prior to IV sedation             |
| 11065186  | 6746 | RAD | 3536 | 06/13/2002 | 8 | Interventional procedure complication                     |
| 9362309   | 6538 | RAD | 3536 | 06/04/2002 | 1 | ASA score not documented prior to IV sedation             |
| 448277    | 8711 | RAD | 3536 | 01/22/2003 | 8 | Unexpected Death                                          |
| 448277    | 8712 | RAD | 3536 | 01/20/2003 | 1 | Illegible documentation                                   |
| 448277    | 8714 | RAD | 3536 | 01/22/2003 | 8 | Cardiac and/or Resp Arrest                                |
| 1055419   | 5536 | RAD | 3536 | 01/07/2002 | 1 | ASA score not documented prior to IV sedation             |
| 3321100   | 6852 | RAD | 3536 | 07/15/2002 | 1 | ASA score not documented prior to IV sedation             |
| 9459694   | 6753 | RAD | 3536 | 07/01/2002 | 1 | ASA score not documented prior to IV sedation             |
| 9385218   | 339  | RAD | 3536 | 02/14/2000 | 6 | Unplanned admission after OP procedure within 24 hrs      |
| 5874781   | 4823 | RAD | 3536 | 12/31/2001 | 2 | Interventional procedure complication                     |
| 1668221   | 6228 | RAD | 3536 | 05/14/2002 | 1 | ASA score not documented prior to IV sedation             |
| 10526956  | 5416 | RAD | 3536 | 10/01/2001 | 1 | ASA score not documented prior to IV sedation             |
| 1392050   | 6562 | RAD | 3536 | 06/06/2002 | 1 | ASA score not documented prior to IV sedation             |
| 000778222 | 5540 | RAD | 3536 | 01/08/2002 | 1 | ASA score not documented prior to IV sedation             |
| 0543680   | 9121 | RAD | 3536 | 02/18/2003 | 6 | Interventional procedure complication                     |
| 2109909   | 7919 | RAD | 3536 | 10/08/2002 | 1 | ASA score not documented prior to IV sedation             |
| 11091231  | 7121 | RAD | 3536 | 08/06/2002 | 1 | ASA score not documented prior to IV sedation             |
| 4793368   | 3388 | RAD | 3573 | 07/09/2001 | 6 | Injury secondary to invasive procedure                    |
| 5131987   | 8177 | RAD | 3573 | 05/30/2002 | 5 | Variance in interpretation                                |
| 10773822  | 6567 | RAD | 3573 | 04/17/2002 | 5 | Missed diagnosis ?                                        |
| 0532992   | 4108 | RAD | 3573 | 08/03/2001 | 5 | Missed diagnosis ?                                        |
| 3906020   | 889  | RAD | 3613 | 04/05/2000 | 2 | Missed diagnosis ?                                        |
| 0678445   | 5827 | RAD | 3613 | 03/05/2002 | 1 | ASA score not documented prior to IV sedation             |
| 005281879 | 6268 | RAD | 3613 | 05/24/2002 | 1 | ASA score not documented prior to IV sedation             |
| 4079891   | 6610 | RAD | 3613 | 06/04/2002 | 1 | ASA score not documented prior to IV sedation             |
| 0841463   | 6331 | RAD | 3613 | 04/12/2002 | 1 | ASA score not documented prior to IV sedation             |
| 011054265 | 6515 | RAD | 3613 | 06/02/2002 | 1 | ASA score not documented prior to IV sedation             |
| 010520567 | 4084 | RAD | 3613 | 08/20/2001 | 2 | Missed diagnosis ?                                        |
| 9498480   | 4128 | RAD | 3613 | 08/31/2001 | 8 | Missed diagnosis ?                                        |
| 4132385   | 5986 | RAD | 3741 | 04/18/2002 | 1 | ASA score not documented prior to IV sedation             |
| 9613825   | 4105 | RAD | 3741 | 07/30/2001 | 1 | Radiology results not communicated                        |
| 9620229   | 3350 | RAD | 3741 | 06/13/2001 | 2 | Interventional procedure complication                     |
| 9906804   | 997  | RAD | 3741 | 05/28/2000 | 6 | Interventional procedure complication                     |
| 6592680   | 6772 | RAD | 3741 | 07/08/2002 | 6 | Injury secondary to invasive procedure                    |
| 6592680   | 6775 | RAD | 3741 | 07/08/2002 | 1 | No 'written' (complete) procedure note immediately postop |

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[illegible]

Patient 8

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Patient 19

Patient 15

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### Patient 22

Patient 22

2 Patient 17

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### Patient 24

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Patient 26

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Patient 21

Patient 21

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Patient 34

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Unplanned admission after OP procedure within 24 hrs  
Injury secondary to invasive procedure  
ASA score not documented prior to IV sedation  
Missed diagnosis ?  
Interventional procedure complication  
Variance in interpretation  
Variance in interpretation  
Neuro deficit not present on admission  
ASA score not documented prior to IV sedation  
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ASA score not documented prior to IV sedation  
ASA score not documented prior to IV sedation  
Variance in interpretation  
Missed diagnosis ?  
Missed diagnosis ?  
ASA score not documented prior to IV sedation  
Variance in interpretation  
Interventional procedure complication  
ASA score not documented prior to IV sedation  
Missed diagnosis ?  
Other Invasive Procedure Complication  
ASA score not documented prior to IV sedation  
ASA score not documented prior to IV sedation  
Informed Consent Incomplete  
Questions Concerning Medical Management  
Interventional procedure complication  
ASA score not documented prior to IV sedation  
ASA score not documented prior to IV sedation  
ASA score not documented prior to IV sedation  
Questions Concerning Medical Management  
Interventional procedure complication  
Unplanned Readmission w/in 72 hours  
ASA score not documented prior to IV sedation  
ASA score not documented prior to IV sedation  
ASA score not documented prior to IV sedation  
ASA score not documented prior to IV sedation  
Injury secondary to invasive procedure  
Adverse IV Sedation Event  
Trauma - Missed injury  
Variance in interpretation  
ASA score not documented prior to IV sedation  
ASA score not documented prior to IV sedation  
ASA score not documented prior to IV sedation  
Missed diagnosis ?  
ASA score not documented prior to IV sedation

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Patient 3

Patient 3

Patient 3

Patient 3

Patient 3

|           |       |     |      |            |   |                                                      |
|-----------|-------|-----|------|------------|---|------------------------------------------------------|
| 9022209   | 4804  | RAD | 4314 | 02/25/2002 | 1 | No H&P in chart prior to surgery                     |
| 6559979   | 3357  | RAD | 4314 | 02/25/2002 | 1 | ASA score not documented prior to IV sedation        |
| 6559979   | 3358  | RAD | 4314 | 03/01/2002 | 1 | Informed Consent Incomplete                          |
| 6932994   | 5539  | RAD | 4314 | 03/01/2002 | 1 | No H&P in chart prior to surgery                     |
| 01248263  | 1306  | RAD | 4314 | 03/01/2002 | 1 | ASA score not documented prior to IV sedation        |
| 9227554   | 1307  | RAD | 4326 | 11/07/2001 | 6 | Interventional procedure complication                |
| 3082656   | 5344  | RAD | 4326 | 06/25/2001 | 6 | Cardiac and/or Resp Arrest                           |
| 010464610 | 4115  | RAD | 4326 | 06/25/2001 | 2 | Interventional procedure complication                |
| 10010970  | 846   | RAD | 4326 | 01/08/2002 | 1 | ASA score not documented prior to IV sedation        |
| 6191560   | 4123  | RAD | 4326 | 01/02/2001 | 5 | Interventional procedure complication                |
| 4502067   | 11033 | RAD | 4326 | 12/14/2000 | 6 | Interventional procedure complication                |
| 5415137   | 5317  | RAD | 4463 | 03/05/2002 | 1 | ASA score not documented prior to IV sedation        |
| 0997126   | 850   | RAD | 4463 | 06/28/2001 | 2 | Radiology results not communicated                   |
| 10808137  | 5526  | RAD | 4463 | 07/01/2000 | 2 | Missed diagnosis ?                                   |
| 11557487  | 10120 | RAD | 4631 | 08/13/2001 | 2 | Variance in interpretation                           |
| 5471485   | 663   | RAD | 4631 | 01/06/2004 | 6 | Adverse IV Sedation Event                            |
| 7279591   | 5504  | RAD | 4631 | 03/01/2002 | 1 | ASA score not documented prior to IV sedation        |
| 011262536 | 8139  | RAD | 4631 | 06/09/2000 | 2 | Interventional procedure complication                |
| 11166593  | 7232  | RAD | 4631 | 12/05/2001 | 1 | ASA score not documented prior to IV sedation        |
| 6912008   | 7349  | RAD | 4631 | 07/15/2003 | 8 | Interventional procedure complication                |
| 7362699   | 5656  | RAD | 4631 | 05/24/2000 | 6 | Unplanned admission after OP procedure within 24 hrs |
| 6557191   | 998   | RAD | 4631 | 11/02/2001 | 1 | ASA score not documented prior to IV sedation        |
| 010934425 | 5711  | RAD | 4631 | 10/18/2002 | 1 | ASA score not documented prior to IV sedation        |
| 010996706 | 6256  | RAD | 4631 | 08/20/2002 | 1 | ASA score not documented prior to IV sedation        |
| 11103970  | 6871  | RAD | 4631 | 08/22/2002 | 6 | Cardiac and/or Resp Arrest                           |
| 010559428 | 3881  | RAD | 4631 | 03/15/2002 | 1 | ASA score not documented prior to IV sedation        |
| 0926873   | 9537  | RAD | 4631 | 06/09/2000 | 6 | Interventional procedure complication                |
| 3321100   | 662   | RAD | 4631 | 03/13/2002 | 2 | Trauma - Missed injury                               |
| 3123337   | 6035  | RAD | 4631 | 05/01/2002 | 1 | ASA score not documented prior to IV sedation        |
| 9983665   | 851   | RAD | 4631 | 07/12/2002 | 1 | ASA score not documented prior to IV sedation        |
| 10016288  | 5507  | RAD | 4631 | 09/24/2001 | 2 | Interventional procedure complication                |
| 4314792   | 3236  | RAD | 4701 | 04/23/2003 | 1 | Illegible documentation                              |
| 010517091 | 4126  | RAD | 4829 | 02/23/2000 | 2 | Unplanned admission after OP procedure within 24 hrs |
| 6612887   | 11149 | RAD | 4829 | 04/29/2002 | 1 | ASA score not documented prior to IV sedation        |
| 010227666 | 4124  | RAD | 4829 | 07/07/2000 | 2 | Missed diagnosis ?                                   |
| 6617387   | 10922 | RAD | 4840 | 11/01/2001 | 1 | ASA score not documented prior to IV sedation        |
| 3324921   | 11152 | RAD | 4840 | 06/10/2001 | 2 | Variance in interpretation                           |
| 6079970   | 1034  | RAD | 4966 | 08/15/2001 | 2 | Missed diagnosis ?                                   |
| 010259676 | 1346  | RAD | 4967 | 06/07/2002 | 5 | Missed diagnosis ?                                   |
| 5435104   | 840   | RAD | 4967 | 07/31/2001 | 5 | Variance in interpretation                           |
| 5396874   | 1387  | RAD | 4971 | 09/09/2003 | 8 | Missed diagnosis ?                                   |
|           |       |     |      | 07/20/2002 | 5 | Variance in interpretation                           |
|           |       |     |      | 09/05/2000 | 6 | Interventional procedure complication                |
|           |       |     |      | 12/27/2000 | 2 | Cardiac and/or Resp Arrest                           |
|           |       |     |      | 09/04/2000 | 2 | Interventional procedure complication                |
|           |       |     |      | 02/22/2001 | 6 | Cardiac and/or Resp Arrest                           |

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Adverse IV Sedation Event  
ASA score not documented prior to IV sedation  
Injury secondary to invasive procedure  
ASA score not documented prior to IV sedation  
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Interventional procedure complication  
ASA score not documented prior to IV sedation  
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Missed diagnosis ?  
Injury secondary to invasive procedure  
ASA score not documented prior to IV sedation  
ASA score not documented prior to IV sedation

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The individual clinical review forms attached can stand on their own, but I feel three general conclusions can be drawn. I will list these and give some recommendations.

1. Dr. Shah does not show a willingness to proactively address concerns regarding compliance with the Rules and Regulations of the hospital. Instead he will often carry on extended debates about the appropriateness or necessity of a given policy. Although some of his arguments may be reasonable and the sentiment even shared by other physicians, they are irrelevant when there is a clear direction from medical staff bylaws, JCAHO requirements, or hospital rules and regulations. This pattern of behavior is disruptive at best and can cause greater problems at worst. I see two issues here: a.) failure or delay in complying and b.) the general attitude that he can decide what rules are worthy of compliance. This attitude was more widespread among physicians in the past and has represented a difficult adjustment for many, however, it can no longer be tolerated in the modern framework of healthcare delivery. Note that this is not necessarily finding of substandard care, but there must be a change or it could lead to that.

Recommendation: Education on all current administrative "rules" he is in violation of or needs constant reminders. Following this, there should be a finite time period (3 to 6 months) with review of all procedures with a set target compliance rate for filling out paperwork. I would suggest the failure rate should be less than 5%.

2. Breast biopsy procedures. This includes needle localizations and stereotactic breast biopsy. This is the one area I identified where the "administrative" deficiencies clearly appear to overlap into the medical care area. When multiple physicians perform the same procedures with the same equipment and the same support staff, it is important to have standardized protocols. This reduces the chance of mistakes when moving from one operator or assistant to another. Complete familiarity with the machines and equipment is also necessary for the primary operator. Over the period of time I reviewed Dr. Shah's performance with these procedures (2001-2002) there were continued complaints by the staff. I am sensitive to the fact that interpersonal relationships can often influence support staff to be overly critical of certain physicians while finding no wrong in others. I do detect an element of that in some of the complaints. However, I also feel there is objective evidence that Dr. Shah, while trained and capable of performing breast biopsies, did not become sufficiently familiar with the protocols or equipment in use at Palmetto Richlands during this period. This led to unnecessarily lengthy procedures with potential for adverse impact.

Recommendation: Suspension of needle localization and stereotactic breast biopsy procedures until and unless Dr. Shah is willing to undergo formal training on the PRH equipment. If he is, I would recommend that at least 10 consecutive biopsies be performed in the presence of another qualified physician before full privileges are restored.

PHA/Shah  
004687

7-15-03 Subby Rep 2523

**Patient**

Patient 2

**Case Details**

Difficult Breast Biopsy

**Category**

Hard to grade

**Comments**

Clearly procedure did not go as smoothly as desired-  
difficult to pinpoint exact causes e.g. unfamiliarity with  
equipment.

**Recommendations**

Suspend Breast Biopsy privileges pending education  
and monitored procedures.

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**Patient**

Patient 3

**Case Details**

Discoloration of face after embolization  
for epistaxis. Did not fill out H & P

**Category**

1

**Comments**

Known self limited side effect with embolization.

**Recommendations**

Must fill out paperwork

As  
Cornelia Tolenski Ex 36  
NPDB Report Ex 35  
\$ 200,000 Settlement

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000081

**Patient**

Patient 4

**Case Details**

Port Removal  
Paperwork not completed

**Category**

1

**Comments**

Pattern of poor documentation

**Recommendations**

Must fill out paperwork, education.

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000082

**Patient**

Patient 7

**Case Details**

TPA infusion started without labs in patient  
with GI bleed  
Referring physician aware of TPA  
Cause of death unknown  
No evidence bleeding was cause

**Category**

5

**Comments**

Probably needed more complete discussion of  
Risk/benefit before beginning TPA in a GI  
Bleed patient.

**Recommendations**

Review TPA orders to ensure labs must be checked

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000085

**Patient**

Patient 8

**Case Details**

Difficult decloot on dialysis patient  
Staff felt physician left them with difficult patient

**Category**

5

**Comments**

As with many of these issues, interactions with the staff are at least half the problem. There is definite tension between the physician trying to control the nurse/techs and the nurse/techs trying to control the physician. Through all this, the patient was managed appropriately

**Recommendations**

Dr. Shah to meet with nurse/tech staff with a facilitator present to discuss these issues. Since this case is older (Jan 02), this may not be useful at this point.

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**Patient**

Patient 10

**Case Details**

Unclear mammography report

**Category**

1

**Comments**

Conflicting report on a re-dictation. Etiology  
Unknown clerical?

**Recommendations**

Review and fix report

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000088

**Patient**

Patient 13

**Case Details**

Breast Biopsy, difficult

**Category**

5

**Comments**

Same pattern of unfamiliarity with machine/  
protocol/techs leading to overly complex  
procedure.

**Recommendations**

Suspension of biopsy privileges pending  
education, training.

1)

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**Patient**

Patient 14

**Case Details**

Patient experienced severe respiratory difficulties during arteriogram. Patient with history of allergy to IVP dye but Dr. Shah said not to give pre-med.

**Category**

3

**Comments**

There are many problems with this case. The chart has many places where other physicians/nurses have entered No Known Allergies, although the pre-printed form says IVP dye allergy. I find the forms themselves obscure the easy ability to determine allergy history. Regardless, there is no reason I can see to cancel the pre-meds, particularly in this day and age of defensive medicine. It is still not completely certain to me that this was an anaphylactic reaction as this patient had multiple medical problems. Yet, pre-meds should not have been cancelled.

**Recommendations**

Review hospital policy on pre-meds for allergy to contrast. All radiologists should follow the same rules! Ask Dr. Shah his rationale for canceling pre-meds. Trend this case to see if Dr. Shah does not use/believe in pre-medication.

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000092



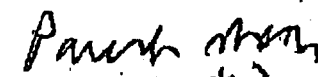
September 5, 2003

Dr. John Stewart  
Chief of Staff  
Palmetto Health Richland  
5 Medical Park Drive  
Columbia, SC 29203

Dear John,

As per our conversation on 9-4-03 in the Radiology department, I am writing this letter to you, for the last 1- $\frac{1}{2}$  years I do not qualify to do a stereotactic biopsy at the Breast Center. This privilege has been revoked because per ACR criteria I no longer qualify for breast biopsy. You can consider that I willing to give up the privileges of the breast biopsy.

Sincerely,

  
Paresh Shah  
Radiologist

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November 10, 2003

N. John Stewart, MD  
Chief of Staff  
Palmetto Richland Memorial Hospital  
3 Medical Park, Suite 200  
Columbia, SC 29203

Dear Dr. Stewart,

This represents my second Quality Assurance Review on Dr. Paresh P. Shah. This report is compiled following extensive review of the set of medical records and radiology films provided to me.

Attached you will find my specific review for each of the 8 charts presented to me. As previously, I would like to make some additional general comments.

First, whereas the initial review comprised records primarily from a few years ago, these records were more recent. In these recent records I did notice a clear effort by Dr. Shah to improve his documentation in the medical chart, including his procedure notes. This had been an administrative deficiency noted before. Second, an older record involving a mammography procedure involved issues dealt with previously and I so noted this. I did not see any recent mammography records leading me to believe that either the situation has improved or Dr. Shah has stopped doing these biopsies. Finally, this group of charts, as opposed to the first group, dealt more with actual "adverse outcomes" or radiological "misses". Obviously these will occur with any physician, so it becomes important to know the total number of procedures or films read in order to determine a percentage. I am not sure if this information is easily available, but if it is, it would be helpful.

Given the changing nature of review cases as noted above and based on conversations I have had with Dr. Shah, it seems appropriate to begin a process of transitioning his cases back to the normal quality assurance process conducted in the hospital by the peer group. When possible, this is always the preferred way to do quality assurance. The unusual circumstances in this instance necessitated deviating from that structure, but with two reviews behind us, I believe quality assurance can be effectively performed in the usual manner. If this is agreeable to all parties, I would suggest the following transition method. The next group of records for Dr. Shah will be handled in the usual fashion for any radiologist at Richland Memorial Hospital, but I will come up to Columbia and be part of the review group. If that results in a satisfactory process, I will remove myself from the process going forward. If there is another approach that any of the parties would prefer, I would be willing to entertain it. My main objective is to help move back to the standard process.

During this Quality Assurance Review I have tried to maintain a fair approach understanding that while there are differences in practice around the country, there are certain standards all can agree on. It is up to the Medical Staff Office to make a final

PHA/Shah  
004707

**Patient**

Patient 19

**Case Details**

Patient with metastatic breast cancer. MRI on 5-24 showed metastasis to L5 lumbar vertebrae. Abdomen/pelvis CT read by Dr. Shah on 5-26 did not mention bony abnormality

**Category**

5,7

**Comments**

This finding was clearly missed on the CT, subsequently an addendum was appropriately added to the report indicating the abnormality. However, it is better diagnosed by other studies than CT (MRI, nuclear medicine) and in fact had already been noted so there was no impact on outcome. The CT films I reviewed did not include bone windows that would have made the diagnosis more easily.

**Recommendations**

All CT studies in patients with suspected or known metastatic disease should have bone windows filmed for review by the radiologist. If bone windows are not filmed, the radiologist should review these on the CT work station.

PHA/Shah  
004709

**Patient**

Patient 21

**Case Details**

Patient with known 8 month pregnancy involved in trauma. Left clavicle fracture missed on initial chest X-ray and shoulder film. Discovered on clavicle film taken a few hours later. Also 8 month fetus interpreted as fibroids on abdomen/pelvis X-ray.

**Category**

5

**Comments**

Clear miss on clavicle fracture. Diagnosis on other films with no change in treatment. As previously noted, all radiologists do miss abnormalities from time to time and the important determinant is frequency. I do not see a trend with this type of error in the records I have been presented. The pelvis film showing the pregnancy was of exceedingly poor quality and should have been repeated.

**Recommendations**

Radiologist should not accept films of poor quality and should make technologist repeat them. I believe the pregnancy would easily have been seen on a better film, although it should have been noted anyway. Patient exam should have helped with the clavicle. It was clear in the record that the patient had severe pain in that region. I do not know if this information was available to the radiologist when they read it.

PHA/Shah  
004711

**Patient**

Patient 22

**Case Details**

Complaint is physician late to procedure and patient complaint about pain for procedure done over Christmas holidays, 2001. Not noted is that ureteral stent placed in wrong position requiring subsequent surgery.

**Category**

5

**Comments**

Interestingly, Dr. Shah had performed similar procedure (percutaneous nephrostomy) on this patient not long before this with no complaints. This is an older record and takes place during the time when there seemed to be increased friction between Dr. Shah and the staff. I believe some of this was personality related, but the increased pain may well have been due to the stent misplacement. I can make no decision about the complaint aspect, but I do feel the stent position should have been further investigated.

**Recommendations**

If stent malposition is suspected (as it was), the best time to fix it is immediately. In the future, additional maneuvers such as injection of contrast and even re-puncturing the collecting system should be performed to determine the exact position of the stent. If it is found to be outside the kidney, it should be snared and replaced.

PHA/Shah  
004712

**Patient**

Patient 24

**Case Details**

Breast Biopsy, radiologist not familiar with equipment.  
Another radiologist came and helped with procedure.

**Category**

5

**Comments**

Procedure from 9-02-identical to those discussed in first  
QA review.

**Recommendations**

Same recommendations as previously regarding breast  
biopsy.

PHA/Shah  
004714

**Patient**

Patient 25

**Case Details**

Alleged different reading of two chest X-rays taken fairly close together. Motorcycle accident with chest x-ray at 1415 hours read as rib fractures. Chest x-ray at 1804 hours read as bilateral infiltrates, no rib fractures mentioned.

**Category**

2

**Comments**

First x-ray correctly read as left rib fractures, clear lungs. Preliminary report also found in chart saying same thing. ER note also consistent. X-ray four hours later does show changes in lungs (infiltrate/atelectasis). The rib fractures are still visible on the later chest x-ray and should have been mentioned, but since all the initial readings by the same physician were correct, were communicated expeditiously, and were acted upon, this did not change patient care. Strictly speaking it is a "miss", but inconsequential given the course of events. The different reading of the lungs is correct.

**Recommendations**

Should be a little more compulsive in patients with multiple studies.

PHA/Shah  
004715

December 20, 2003

N. John Stewart, MD  
Chief of Staff  
Palmetto Richland Memorial Hospital  
3 Medical Park, Suite 200  
Columbia, SC 29203

Dear Dr. Stewart,

This represents my Quality Assurance Review of an additional case submitted for Dr. Paresh P. Shah. This report is compiled following extensive review of the set of medical records provided to me.

Attached you will find my specific review for the medical records presented to me. As previously, I would like to make some additional comments.

For physicians to be functioning members of any medical staff, their ability to show respect and compassion for their patients is at least as important as their medical knowledge. This case represents a serious breach. I have done lymphangiograms in the past, although they are infrequent these days due to the availability of other methods of diagnosis. They always did represent a difficult technical procedure involving the cannulation of tiny lymphatics in the foot with 30 gauge needles, the very slow injection of contrast over a number of hours, and then obtaining the highest quality films to evaluate the lymphatic system. For these reasons it is understandable that great care must be taken to prevent inadvertent dislodging of the needles once they have been placed. The patient or even the nursing and technology staff may not have appreciated these issues. In addition some of the times mentioned by the patient in her letter and by the technologist's letter appear to be longer than is indicated in the official nursing notes.

However, this does not detract from two basic findings. One, there were alternatives to having the patient urinate while lying on the table, and two, there was inadequate explanation by the physician to either the patient or staff for the reason for his decision. Either of these would have been simple to accomplish and the fact that they were not indicates a serious lack of "listening" to the patient.

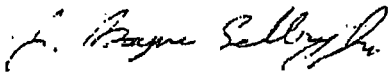
It is difficult to imagine how one would not expect a patient to need to void at least once during a 7-8 hour procedure. A Foley catheter should be placed prior to beginning the procedure if the patient will not be allowed to use the bedpan. Alternatively, if a catheter had not been placed, great care could have been taken in allowing the patient to either use the bedpan or to allow an experienced nurse to perform an in-out catheterization. This would include, if necessary, the physician himself helping move the patient on to the bedpan to ensure that the needles were not dislodged. The fact that none of these options was pursued, in the face of clear communication from both the patient and nursing staff, is unacceptable.

PHA/Shah  
004717

It is up to the Medical Staff to decide the appropriate response to this case. I will reiterate that I consider this to be equal if not more important than most medical issues as patient communication is always paramount in medical care. It does represent a deviation from the standard of care I would expect at any hospital.

During this Quality Assurance Review I have tried to maintain a fair approach understanding that while there are differences in practice around the country, there are certain standards all can agree on. It is up to the Medical Staff Office to make a final determination of any action(s) that is to be taken. I hope you find this review helpful. I remain available to review additional records as necessary.

Sincerely,



J. Bayne Selby, Jr., MD

PHA/Shah  
004718



|                        |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |
|------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <b>Patient</b>         | Patient 27                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |
| <b>Case Details</b>    | Lymphangiogram, in patient with bilateral leg swelling, diabetes. Prolonged procedure. Patient not allowed to use bedpan or in-out catheterization. Had to urinate on table and remain for 4-5 hours. Secondary issues of no post-procedure note, unclear insulin/blood sugar management during procedure.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |
| <b>Category</b>        | 3                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |
| <b>Comments</b>        | <p>Although this case review does not involve a medical risk, it is extremely serious as it raises concerns about dignity and basic respect for patients as human beings. Lymphangiograms are no longer done with any frequency and this may contribute to lack of standardized procedure. The procedure does involve delicate cannulation of small lymphatics in the foot and any patient movement must be kept to a minimum to keep the needles in place. However, there is no excuse in a procedure that lasts for 7-8 hours for not making some arrangements for the patient to urinate. The simplest would be to place a Foley catheter prior to beginning the procedure. However even during the procedure, either a bedpan or an in-out cath could be accomplished with care. There is no satisfactory explanation for this type of patient management. Subsequent discussion with the patient herself of the reasoning behind these decisions also shows lack of compassionate care. A shouting match between physician and patient the following day is described. Although secondary, it is also noted that there is no post-procedure note. The patient also has issues with her glucose control during this period when she was taking nothing by mouth. This appears to have been handled, but I find little in the notes to indicate exactly how. Again, discussion between physician and patient about this issue should have taken place. This does represent a deviation from what should be the <i>standard</i> of care in patient management.</p> |
| <b>Recommendations</b> | I think this is a serious case involving respect for and treatment of patients. Further action is of course up to the Medical Staff, but should include further review including direct discussion with the physician. The ultimate disposition of this case must send a clear message that this behavior is unacceptable and cannot only ever happen again, but should not have happened this time.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |

PHA/Shah  
004719

February 10, 2004

David L. Keisler, MD  
Chief of Staff  
Palmetto Richland Memorial Hospital  
3 Medical Park, Suite 200  
Columbia, SC 29203

Dear Dr. Keisler,

This represents my third Quality Assurance Review on Dr. Paresh P. Shah. This report is compiled following extensive review of the set of medical records and radiology films provided to me.

Attached you will find my specific review for each of the 8 charts presented to me. As previously, I would like to make some additional general comments.

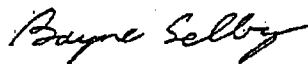
The nature of these records involves mostly straightforward radiological misses, which of course, even the best radiologists will have from time to time. The number does seem to be quite a few for this time period. It might be useful for the executive committee to compare this to other radiologists quality assurance records to ascertain what a "community standard" might be. However I am more concerned with two other aspects.

First, many of these could have been avoided by more compulsive work habits, primarily checking on other imaging studies performed at or around the same time. Second, two involve the CT characteristics of appendicitis and I am not sure how confident Dr. Shah is with this diagnosis. It has come along in the last ten years and should be well known by now, but has required additional training by most older radiologists (going to courses, self-study, etc) to be sure they are up on the findings.

The handling of these missed cases, particularly with regard to documentation, still needs work. None of these represent an egregious error, but taken together and with somewhat haphazard appearing follow-up, it does not present the best picture for confidence in the system or the future.

During this Quality Assurance Review I have tried to maintain a fair approach understanding that while there are differences in practice around the country, there are certain standards all can agree on. It is up to the Medical Staff Office to make a final determination of any action(s) that is to be taken. I hope you find this review helpful. I remain available to review additional records as necessary.

Sincerely,



J. Bayne Selby, Jr., MD

PHA/Shah  
004720

**Patient**

Patient 28

**Case Details**

Missed lumbar spine fractures and misalignment on plain films. CT scan demonstrated abnormalities.

**Category**

5

**Comments**

Clear miss. Diagnosis made on other study (CT) with no impact on patient care as a result. This does seem to indicate lack of thoroughness also as most radiologists would double check CT result against their plain film reading.

**Recommendations**

This case should be trended with other misses over the last year to find total number.

PHA/Shah  
004721

**Patient**

Patient 29

**Case Details**

Reported study on wrong patient. Referring physician called and questioned result. Review showed mistake. Corrected report issued.

**Category**

5,7

**Comments**

Clear error, but one that does happen anywhere from time to time and is almost always related to departmental procedures. It is not clear here exactly what happened. Were the films labeled incorrectly? Was the wrong paperwork present with the films? Some comments were made about the way the report was addended, but it was done in accordance with the rules at most hospitals, i.e., the original report cannot be removed. It was also mentioned that study might need to be repeated. If study was initially done correctly, there is no need to repeat and patient does not need any compensation.

**Recommendations**

Radiologist is the "captain of the ship" and therefore responsible for reports on wrong patient in this instance, however I am concerned about departmental procedures, particularly with the lack of safeguards to catch such an error. This will happen again some time to some radiologist. Recommend review of systems to ensure correct paperwork with correct films for each patient.

PHA/Shah  
004722

**Patient**

Patient 30

**Case Details**

Missed non-displaced fracture of tibial plateau. Did note talar fracture. Report addended appropriately.

**Category**

5

**Comments**

Clear miss, but fracture subtle. No impact on patient care as CT showed fracture better.

**Recommendations**

Trend for total misses.

PHA/Shah  
004723

**Patient**

Patient 31

**Case Details**

Small pneumothorax called on initial chest X-ray, subsequent CT showed no pneumothorax. Also question of ongoing pneumonia.

**Category**

1,5

**Comments**

Small overcall with initial pneumothorax. I'm not quite sure what the issue is here, however it does appear the written record could be improved upon. Patient was allowed to eat in the ER, so presumably some results were communicated, but not written down.

**Recommendations**

I am less concerned by the overcall than with a little sloppiness in not giving and following up with some recommendations on how to proceed imaging-wise.

PHA/Shah  
004724

**Patient**

Patient 32

**Case Details**

Abdomen/pelvis CT read as normal. Clinically  
appendicitis. Operation performed and found appendicitis.

**Category**

5

**Comments**

Appendix is edematous and in conjunction with clinical  
setting, this interpretation would have added weight to  
diagnosis. However, surgical judgement should take  
precedence over CT anyway and surgeon did act  
appropriately.

**Recommendations**

CT diagnosis of appendicitis is still relatively new. Dr.  
Shah should review appearance of appendicitis on CT, as  
this was not done at the time he trained and he may not be  
as comfortable with the diagnosis.

PHA/Shah  
004725

Redacted  
fhs

**PALMETTO HEALTH RICHLAND  
MEDICAL EXECUTIVE COMMITTEE  
SPECIAL CALLED MEETING  
February 25, 2004**

Minutes of the MEC's Special Called Meeting held Wednesday, February 25, 2004. The following members were present: Drs. Keisler, D. Smith, Stewart, Langston, Jones, Stinson, Buerkert, Dubuisson, Eden, Korrapati, Christmann, Felmly, Thompson, Catalano, Malone, Nottingham and Brugh. Mr. Jim Lathren and Mr. John Singerling (for radiology coverage discussion only).

Dr. Keisler, Chief, called the meeting to order and presided. He also stressed the confidentiality of the information that would be discussed.

**PURPOSE OF MEETING:** To continue the previous called meeting in order to review the most recent QA findings by Dr. Bayne Selby, outside reviewer for Dr. Paresh Shah. Additionally, to receive additional information from Dr. Selby who was invited to attend this meeting.

**REVIEW OF DR. SELBY'S LAST QA FINDINGS:** Members were given opportunity to review Dr. Selby's findings from the most recent QA review.

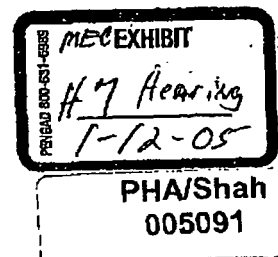
Dr. Keisler introduced Dr. Bayne Selby, an interventional radiologist from MUSC who is currently serving as Chair of the Radiology Department at MUSC. Dr. Selby has assumed responsibility as the outside reviewer of QA for Dr. Shah.

Dr. Selby indicated that he has tried to be balanced in his review and hopefully be helpful to the MEC. To date, he has reviewed three sets of records. He indicated that he has noticed a slight evolution from the first group of records where they appeared to be more administrative where Dr. Shah did not want to play by the rules. The second group of cases had to do more with interventional procedures and the last group appeared to be more diagnostic radiology. He then agreed to answer questions from members.

Dr. Selby was questioned regarding how to measure his findings. Specifically, has he found the same type of problems with his staff. Dr. Selby indicated that everyone is going to do one or more of these things wrong. However, in Dr. Shah's case this has been outside the norm and if this were happening with his staff there would be some type of reprimand action.

Dr. Selby was then questioned regarding his findings relative to CT of appendix. He reported that he had discussed this with Dr. Shah in his meeting with him earlier in the day. He indicated that Dr. Shah might need a CME course on CT of the appendix. Specifically, you would not expect to see this with someone with the level of experience as Dr. Shah.

Dr. Selby was asked to comment on the apparent lack of compassion for the patient who went through the lengthy procedure and urinated on herself while on the table and being forced to lie in her own urine. Members felt there was a serious disregard for the patient's feelings and the family as well. Dr. Selby agreed there was no excuse for this and it should be dealt with. That this was a situation where other alternatives could have been afforded. Further, that this is evidence of a deeper problem that exists regarding Dr. Shah's lack of relationship with the staff.





Additionally, he added that this is part of the responsibility of the physician and it does not measure up to the standards of other radiologists in the country.

Dr. Selby was questioned as to whether he felt the number of cases presented to the MEC is due to Dr. Shah's relationship with the other physician's and staff. He responded that he absolutely felt this to be the case. He reiterated that he did not feel that Dr. Shah is incompetent. However, he is someone who by his actions has put himself in the position for heavy scrutiny.

Dr. Selby was questioned if he had concerns regarding Dr. Shah's lack of documentation on invasive procedures. He reported that Dr. Shah has improved in his documentation; however, it still is not up to standard. He noted that this probably does speak to a larger issue of not being sensitive to patients and not being available to the staff. Additionally, he reported that Dr. Shah has spoken to him regarding the volume of business in the department and that some of this may be volume related.

Dr. Selby was questioned as to whether MUSC does random review. He noted that generally this is the method they follow. However, if they sense someone is being a problem they would do a focused review although this is very time and labor intensive.

Other areas of discussion included whether Dr. Shah is taking advantage of communication methods within the hospital, his changing of reports, and dictation on the wrong patient. Dr. Selby indicated that some of these are areas where Dr. Shah's relationship with the system is not helping him.

Dr. Selby was dismissed and Dr. Keisler opened the floor for discussion. Discussion was held regarding QA from the Radiology Department. Dr. Bayard indicated they do informal QA. Dr. Keisler has requested information for comparison with Dr. Shah and was told by Dr. Bayard that he has not had any complaints on the other radiologists. Following Dr. Keisler's report and discussion, motion was made, seconded and carried unanimously that the MEC requires the Department of Radiology to begin doing formal QA, effective March 1, 2004. Additionally, that the Department must submit a formal written report to the MEC within ninety days (June 1, 2004).

Dr. Keisler requested further input from the MEC regarding their interactions with Dr. Shah. This varied with some members indicating that Dr. Shah has been responsive and helpful and others reporting that there have been errors in the films he has read.

Dr. Keisler reported the various options available to the MEC as outlined in Addendum I, Article 1.5 of the Medical/Dental Staff Bylaws. Following a discussion, motion was made, seconded and carried unanimously to take corrective action against Dr. Shah and to afford Dr. Shah an appearance before the MEC prior to final action.

PHA/Shah  
005092

**PALMETTO HEALTH RICHLAND  
MEDICAL EXECUTIVE COMMITTEE  
EXECUTIVE EXECUTIVE SESSION  
October 31, 2005**

Minutes of the MEC's executive, executive session held Monday, October 31, 2005. The following members were present: Drs. Harper, Christiansen, Keisler, Langston, Jones, Reddy, Stewart, Fitzgibbon, Stinson, Buerkert, Pusey, L. Smith, Risinger, S. Thompson, Nottingham, Shipley, Ms. Celeste Jones, Mr. Fred Crawford and Mr. Howard West

**PARESH SHAH, MD:** Dr. Shah has completed his probation period of May 1, 2005 to October 1, 2005.

The following reports were distributed, reviewed and discussed by the Committee: 1) Dr. Bayne Selby's Quality Review for the period March through October, 2005; 2) Medical Record Review for June, July, August and September, 2005 submitted by Mr. Webb; Misinterpretations since January, 2005; and the "Q" Time Report for September 1-26, 2005 ("Q" Time: report has been transcribed and is in the Radiologists' review Q awaiting review and release. Number is the average in hours each report is in the Q.)

The terms of the Probation were reviewed and Dr. Harper reported that she has approached Dr. Shah regarding the recommendation that he be evaluated by Dr. Bill Burke and he has indicated that he has no plans for evaluation by Dr. Burke.

Dr. Harper additionally reported that on October 28, 2005 she received a letter of concern from a patient seen by Dr. Shah and in which he gave a wrong diagnosis pertaining to an ovarian mass reporting that it was an enlarged uterus. It was confirmed that the patient did in fact have an ovarian mass and underwent surgery a few days later and tested positive for cancer. Dr. Harper noted that this happened after Dr. Shah had completed the CME's requested by the MEC.

Dr. Harper summarized by noting that the MEC has information for various sources and the role of the MEC is to review the results and make a recommendation. Following a period of discussion, it was affirmed that the MEC's role is to ensure that quality patient care is provided in the hospital. Additionally, it was felt that Dr. Shah has not satisfactorily meet the requirements as outlined in his probation; specifically, his refusal to see the counselor as recommended by the MEC, and lack of improvement in quality data. Specifically, based upon the totality of information available for review, the members present did not feel comfortable with his interpretations. Motion was made, seconded and carried unanimously to summarily suspend Dr. Paresh Shah's clinical privileges and to recommend revocation of his clinical privileges at Palmetto Health Richland. Dr. Harper will communicate this information to Dr. Shah, Dr. Bull, Dr. Bayard and Mr. Webb.

The new complaint received by Dr. Harper will be referred to Dr. Selby for review.

**CONFIDENTIAL**

PHA/Shah/004  
000037

Patient 36

October 27, 2005

Dr. Greta Harper  
Chief of Staff  
Palmetto Health Richland  
Three Medical Park  
Columbia, SC 29203

Dear Dr. Harper:

I write this letter to bring a situation to your attention.

On August 26, I had a CT scan at the Lexington Medical Center in Sumter. What resulted from that test was a call from my family practitioner, Dr. Greg Konduras on August 29 telling me the shocking news that I have an ovarian mass. The radiologist report was given by Dr. Clements.

The following day I went to Palmetto Health Richland to have a biopsy done as suggested by my doctor, Greg Konduras. On August 30, I came to your hospital, had blood work done in your lab, and was placed on a gurney with a hospital gown. I was told that shortly I would receive an intravenous drug that would make me very drowsy before the biopsy.

Dr. Shah, I understand, is a staff radiologist in your hospital. He came to my bed and asked, "What are you doing here?" I said, "Haven't you looked at Dr. Clements' report and my scan that I brought with me?" He advised me that he did and that he even conferred with two other colleagues, and they all agreed that I had no mass but only an enlarged uterus. He further told me that he could not biopsy something that didn't exist and that I needed to get dressed.

My family was there with me, and we decided that obviously miracles still happen and that God has healed me. We all went out for a celebratory dinner.

But, before I left the hospital I told Dr. Shah that he should call Dr. Clements whose radiology report was so different and confer with him. Dr. Shah was unable to get him by phone. I then asked him to call my family doctor, Greg Konduras and discuss this with him. I gave him the number, and he did indeed relay the message to Dr. Konduras.

PHA/Shah  
004740

EXHIBIT

5

Dr. Greta Harper  
Page 2

Before I left, I told Dr. Shah that I needed his diagnosis in writing, which I have since forwarded to your hospital.

When I returned home, Dr. Konduras had called and I returned his call. He informed me that Dr. Clements' partner had read the scan and totally agreed with the first diagnosis. I, of course, was in a state of shock. I went to my neighbor's house and spoke to him as I knew he was a radiologist, and he held the scan up to a lamp on his desk and very quickly agreed that there was indeed a mass.

In summary, I have since had surgery on September 2 performed by Dr. Terry Smith, in which they removed all female organs, omentum, appendix and three lymph nodes of which two tested positive for cancer. I am currently in chemo treatment. I was told by Dr. Terry Smith that it was perhaps better that they didn't biopsy this mass, but that was not the reason that was given to me when I was told to leave.

I wanted to bring this issue to your attention. It baffles me how one of your doctors and two colleagues could be so wrong in a diagnosis.

It is possible that I could have heard that wonderful news... and wanting to believe it so badly, could have walked out of your hospital and not followed up.

Please know this letter is not in anyway, shape or form a predecessor to litigation. I have no intention of pursuing this further, since now it is in your hands.

Sincerely,

Patient 36

Rec: Mr. Howard West

PHA/Shah  
004741

807

Hearing

PHA-SHAH004741

To: Medical Chief of Staff  
Palmetto Richlands Hospital

December 2, 2005

I have performed of review of one additional quality assurance review case. The review form is attached. This case does represent a mis-interpretation with potential for impact on patient care (although none occurred for other reasons). As mentioned on the form, the findings on the scan are evident so I have to wonder if the correct films were reviewed or if there is some other piece of information of which I am unaware. If other films were reviewed, this would still represent a problem, albeit of a different nature (not identifying the patient correctly). These films should be reviewed with Dr. Shah to see what explanation he might have. As mentioned in the review, I did speak with Dr. Shah by telephone, but I feel full review in person with Dr. Shah is indicated. This will serve as a preliminary review pending that discussion.

Please feel free to contact me if you need any additional information.

Sincerely,

J. Bayne Selby, Jr., MD

**CONFIDENTIAL**

PHA/SHAH/010a  
000032

Clinical Review Form  
Preliminary

Occurrence: CT scan read as mass. When patient showed up for biopsy, was told there was nothing to biopsy, Subsequent re-interpretation read as mass. Surgery confirmed mass.

Case Details: 56 y.o. woman with recurrent abdominal pain underwent CT on 8-26-05 which was read as "pelvic mass with omental metastases", amenable to biopsy. Patient was called. Biopsy scheduled for following day. On day of exam, patient was told by radiologist who was to do biopsy that there was nothing to biopsy, no mass. By patient report, the radiologist said he conferred with two other colleagues who agreed. Patient felt better, but when she called her primary doctor, he had a second radiologist review the scan. He also agreed there was a mass. Patient underwent surgery on 9-2-05 at the request of her primary physician and metastatic carcinoma was found involving ovaries, lymph nodes, peritoneum.

Severity Index: 3

Comments: The CT scan shows an obvious pelvic mass with probable second mass as well as multiple deposits at other sites through abdomen. The pattern is most consistent with ovarian carcinoma with metastases. The initial reading was confirmed at surgery. It is difficult to understand how a review of the films at the time of scheduled biopsy could lead to an interpretation of no mass as this is not a subtle case. It is possible that a different set of films were reviewed. This would be the most obvious alternative explanation. In this case, there would be an obvious error of misidentifying the patient. In either case this was a deviation from standard of care that could have had an impact on outcome. In this case it didn't, since the primary care physician and patient immediately proceeded with surgery. It could even be argued that on the appearance of the CT the patient should have gone straight to surgery. Therefore the cancellation of the biopsy on the basis of no mass seen, while in error, did not ultimately result in any delay of treatment for the patient.

Recommendations: A complete review of this case is in order. This should definitely include a re-review of the CT scan by the biopsy radiologist to see if he feels this was the scan he saw originally.

I did speak with the radiologist by telephone and he indicated that he thought there was an enlarged uterus that did not need biopsy. He said he did show the images to other radiologists who agreed with his opinion. He also said he tried to get in touch with the referring physician to let him know his thoughts. I told him the best next step would be to review the films together to see if this was in fact the set of films he saw. It would

**CONFIDENTIAL**

PHA/SHAH/010a  
000033

probably be difficult to draw any further conclusions about what happened at the time of scheduled biopsy without reviewing this in person with the radiologist.

**CONFIDENTIAL**

PHA/SHAH/010a  
000034

To: Medical Chief of Staff  
Palmetto Richlands Hospital

February 21, 2006

In my review of the last case dated December 2, 2005, I indicated that I would like to review those films in person with Dr. Shah. I have subsequently had a telephone conversation with Dr. Shah in which he said that his privileges at Palmetto Richlands have been revoked, effective November, 2005. For this reason he saw no reason to do any further review. I concur. Therefore my last report, which I had issued as preliminary, should be amended to final report.

Please feel free to contact me if you need any additional information.

Sincerely,

J. Bayne Selby, Jr., MD

Cc: Paresh Shah, MD

**CONFIDENTIAL**

PHA/SHAH/010a  
000041



**PALMETTO HEALTH RICHLAND**

**REPORT OF FAIR HEARING COMMITTEE TO  
MEDICAL EXECUTIVE COMMITTEE**

**In the Matter of Paresh Shah, MD**

This is the report of the Palmetto Health Richland Fair Hearing Committee consisting of C. Osborne Shuler, III, M.D., Eva Jane Rawl, M.D., J. Kevin Baugh, M.D., and Stephen C. Stanfield, M.D. Initially Mark Locke, M.D. had been appointed to serve on the Committee but was unavoidably detained at the time of the first hearing due to a patient emergency, and the parties mutually agreed to proceed without him. Pursuant to the Fair Hearing Plan of the Medical Staff Bylaws, Ernest J. Naul, Jr., Esquire was appointed as the Hearing Officer. Under the Fair Hearing Plan, the Hearing Officer Serves as chair and a member of the Committee but does not vote.

Hearings were held in this matter on December 6, 2004, December 9, 2004, January 12, 2005, and February 1, 2005, at which times the affected practitioner, Paresh Shah, M.D., was present and represented by counsel, Joel W. Collins, Esquire, who intermittently was assisted by other attorneys in his office. The Medical Executive Committee was represented by Celeste Jones, Esquire and Frederick A. Crawford, Esquire.

By stipulation of the parties, the time deadlines set forth in the Fair Hearing Plan were waived. The parties stipulated that even though the Fair Hearing Plan established a burden of proof by clear and convincing evidence, judicially that burden of proof has been chanted to the greater weight or preponderance of the evidence.

Following the conclusion of testimony on February 1, 2005, due to the length of the hearing, the Committee reconvened on February 21, 2005 to deliberate. Prior to adjournment of the final hearing, the Hearing Officer informed the parties that at the request of the Hearing Committee he would be present during their deliberations and assist in drafting their Report, even though he emphasized to the parties that he did not have to vote. It would appear from the Transcript of Hearing no objection was made. Subsequently, Dr. Shah's attorney did file a written objection. For all of the reasons set forth in the Hearing Officer's letter of February 8, 2005 to Mr. Collins, the Hearing Committee believes it could not have reached the appropriate results without his assistance and affirmatively represents he did not participate in the deliberations or in any way attempt to influence the results. It is extremely important to each member of the Hearing Committee that Dr. Shah be treated fairly in this matter. Because none of the Committee members have any experience in proceedings of this type and are unfamiliar with how the legal process works, it was necessary to have the assistance of the Hearing Officer during deliberations to ensure that the proper standard of proof was applied and that it adhered to the evidence presented.

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### FINDINGS OF FACT

Upon careful review and consideration of all of the evidence presented, particularly the reports and testimony of Dr. Bayne Selby, the Fair Hearing Committee finds and concludes the clinical deficiencies and pattern of conduct on the part of Dr. Shah warrant further remedial action. Of significance to the weight of Dr. Selby's conclusions and recommendations is the fact Dr. Shah himself acknowledges their validity and quality. Considering the totality of the record in these proceedings, the Committee finds and concludes that the Medical Executive Committee ("MEC") has met its burden of proof and that the greater weight or preponderance of the evidence supports the following findings of fact:

1. Early in the proceedings Dr. Shah asserted that the action by the MEC was racially motivated. This is a serious allegation and, if proven, should not be taken lightly. However, the Committee finds and concludes this assertion is unsupported by any evidence whatsoever. Furthermore, there is nothing in the record of these proceedings which would even remotely suggest there is any basis in fact for this allegation. The Committee finds and concludes the actions of the MEC were based solely on legitimate quality of care concerns and nothing else.
2. Throughout these peer review proceedings, Dr. Shah has contended that he has been treated unfairly and in a different manner than other radiologists in the Department. This simply is not true. The cases which were reviewed by Dr. Selby fell into the following categories: (a) untoward outcomes, (b) occurrence reports involving a physician [Dr. Shah], (c) patient complaints concerning Dr. Shah, and (d) staff complaints concerning Dr. Shah. The occurrence of any one of these events, singularly or in combination, serves as the same basis for peer review of other physician members of the Medical Staff.
3. None of the conditions imposed by the MEC have been fulfilled by Dr. Shah. Because of this he has really not served a period of probation. The imposition of probation is not viewed by the Committee as punitive in nature, but intended to assist a practitioner in the remediation of clinical practice patterns or behavioral deficiencies. In the view of the Committee, probation is significant only when the affected practitioner fails to meet any of the conditions which may be imposed as remediation measures. In light of the other recommendations being made in this Report, the Committee feels that Dr. Shah should serve a six month period of probation to run concurrently with reviews set forth below. The Committee hopes Dr. Shah will view this finding and conclusion in consonance with its intended objective.
4. The Committee is of the belief that a fairer measurement of whether Dr. Shah has benefitted from the peer review process would be to commence a period of review from this point forward.

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10. Conscious of the fact that Judge William Keesley has directed that all quality review be conducted by Dr. Bayne Selby, the Committee finds and concludes that review should continue until such time as Dr. Shah may agree that it will be performed in the Radiology Department.
11. There is sufficient evidence in the record regarding errors in diagnosis or inconsistent interpretations of films regarding the same patient that Dr. Selby should review a reasonable sample of films read by Dr. Shah for the period March 1, 2005 to September 1, 2005. This should be done on a monthly basis and is designed to look for discrepancies between interpretation and the actual results of the films. Recognizing that under Medicare guidelines, five percent (5%) of the charts should be reviewed, due to the Committee's other recommendations regarding reviews of other procedures, the Committee believes that two and one-half percent (2 ½ %) would be a sufficient, representative number of films. Again, in light of Judge Keesley's Order, the selection of the films to be reviewed must be under the direction of Dr. Selby.
12. The Committee believes that patient safety and well-being are potentially in jeopardy when the performing radiologist is not physically present when invasive radiological procedures are being performed by him or on a patient for whom he is responsible.
13. From the totality of the evidence presented, it is apparent to the Committee that Dr. Shah does not enjoy the best of communication skills, has well established instances of insensitivity to patients and staff, lacks insight into his own deficiencies, and has poor conflict resolution skills. The Committee feels something dramatic must be done to ensure that Dr. Shah's relationships with patients, other physicians and radiology department staff is improved. Although this is viewed as a behavioral deficiency, if allowed to continue without resolution, it could potentially affect the quality of patient care. The Committee acknowledges that this is likely not malicious or intentional on Dr. Shah's part, but instead may be a deficiency which is readily remedied with appropriate counseling. The Committee is aware of the role that Dr. Bill Burke has fulfilled for the South Carolina Board of Medical Examiners in similar situations involving behavioral problems and finds such would be appropriate in this instance. An evaluation by Dr. Burke would enable the MEC to make an informed decision as to whether any further action should be taken in that regard. Consequently, Dr. Shah should arrange to be seen by Dr. Burke, at his own expense, within the next thirty (30) days. Dr. Burke should conduct such testing as in his judgment is necessary to enable him to make any recommendations to the MEC for such further follow-up he feels may be appropriate. Dr. Burke should provide a report to the Chief of Staff as quickly as possible concerning the results of his evaluation and any recommendations for further counseling. In order to minimize the dissemination of this kind of sensitive medical information, access to any report from Dr. Burke shall be restricted to the Chief of Staff and only his

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recommendations, if any, disclosed to the members of the MEC in executive session.

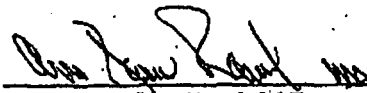
14. Dr. Shah, by his own admission, lacks any degree of familiarity with the policies and procedures of the Radiology Department of Palmetto Health Richland or the Palmetto Health Richland administrative policies and procedures, particularly with regard to physician activities and/or responsibilities. Therefore, Dr. Shah should review these policies and procedures with a member of the active Medical Staff selected by the MEC.
15. The Committee rejects Dr. Shah's assertion that the standard of care at Palmetto Health Richland is less than at other facilities, particularly at ~~Roper Hospital~~ <sup>NYSC</sup> where Dr. Bayne Selby practices. The standard of care required of a physician is a national standard that ensures that the same level of care is provided to patients without regard to where they may reside.

Based on the foregoing findings of fact and conclusions, the Committee makes the following recommendations to the Medical Executive Committee regarding Dr. Shah:

1. He should be placed on probation for a period of six (6) months from March 1, 2005 to September 1, 2005, in order to allow the MEC a fair opportunity to address all relevant issues regarding Dr. Shah.
2. The period of probation should run concurrently with the fulfillment of the review and evaluation requirements being recommended in this Report.
3. A random audit of fifteen percent (15%) of the invasive procedures performed by Dr. Shah for the period March 1, 2005 to September 1, 2005 should be conducted on a monthly basis, with a ninety-five percent (95%) rate of documentation required. The selection of the random sampling shall be under the direction of Dr. Bayne Selby, as required by Order of Judge William Keesley.
4. If an evaluation of all of the radiology procedures in the Palmetto Health Richland Emergency Medicine Department ("ED") for alleged reading discrepancies has not been completed, that it be done for the period March 1, 2005 to September 1, 2005. The specific results of the evaluation, including any related to Dr. Shah, should be reported to the MEC.
5. He is required to remain with the patient for all invasive radiological procedures performed by him or for which he is responsible.
6. He is required to satisfactorily complete a CME course in the CT diagnosis of organ system diseases no later than July 1, 2005, with proof of completion to be provided to the MEC.

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7. He not be allowed to interpret a CT of the abdomen or pelvis until the CME course is satisfactorily completed.
8. Quality review shall continue to be conducted by Dr. Bayne Selby, until such time as Dr. Shah may agree that it can be performed in the Radiology Department.
9. Dr. Selby shall review, on a monthly basis, two and one-half percent (2 ½ %) of all other radiological reports dictated by Dr. Shah or for which he remits or remitted a charge, with a comparison of the actual films to interpretations. Again, Dr. Selby should oversee or direct the selection process.
10. He must, at his own expense, be evaluated by Dr. Bill Burke, in Summerville, South Carolina and fulfill any recommendations for further counseling as Dr. Burke may suggest. A report regarding the initial evaluation and any recommendations should be provided to the Chief of Staff by Dr. Burke. To aid Dr. Burke in his evaluation, if this recommendation is approved by the MEC, a copy of this full Report should be provided to him.
11. He must within forty-five (45) days review all departmental and administrative policies and procedures with regard to physician activities and/or responsibilities. This should be accomplished with a member of the active Medical Staff selected by the MEC.

  
Eva Jane Rawl, M.D.  
for the Hearing Committee

March 14, 2005.

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**PALMETTO HEALTH RICHLAND**

TO: Medical Executive Committee  
FROM: Hearing Committee  
RE: In the Matter of Paresch Shah, M.D.  
DATE: December 30, 2005

This is the report and recommendation of the Hearing Committee appointed by the Chief of the Medical Staff of Palmetto Health Richland ("Hospital") to hear Dr. Shah's challenge to the Medical Executive Committee's ("MEC") decision of October 31, 2005 to summarily suspend his clinical privileges and recommendation that his clinical privileges be revoked ("Decision"). The Hearing Committee consists of Clay Nichols, M.D., Michael Ervin, M.D., Jim Lloyd, M.D., and Catherine Miller, M.D. The Hearing Committee appointed Dr. Nichols to serve as its Chairman. Pursuant to the Hospital's Medical /Dental Staff Bylaws, Rules and Regulations ("Bylaws"), Ralph W. Barbier, Esquire was appointed as the Hearing Officer.

The hearing was held on December 13, 14, and 15, 2005. During the first two hearing days, the MEC was represented by David Kelsler M.D., and in his absence on the third day, the MEC was represented by Fred Shipley, M.D. Dr. Shah was present and represented himself in the hearing. The MEC called four witnesses during its presentation. Thereafter, Dr. Shah called eighteen witnesses during his presentation. Both parties introduced numerous exhibits into the hearing record.

At the start of the hearing the parties were notified by the Hearing Officer that Article 6.7 of the Bylaws sets forth the burden of proof in this matter. However, the Hearing Officer further notified the parties and instructed the Hearing Committee that although the Bylaws establish a burden of proof on Dr. Shah of "clear and convincing evidence", that such a burden is inconsistent with South Carolina law and that the burden to be applied in this hearing is "by a preponderance of the evidence".

At the close of the hearing on December 15, 2005, the Hearing Committee commenced its deliberations. The Hearing Committee concluded deliberations on December 30, 2005. The Hearing Committee requested that the Hearing Officer participate in the deliberations and act as its legal advisor.

**FINDINGS OF FACT**

The MEC satisfied its obligation to present to the Hearing Committee evidence to support the Decision. Thereafter, Dr. Shah failed to prove by a preponderance of the evidence that the grounds upon which the MEC made its Decision lacked any factual basis or that

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Initials of Hearing Committee

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~~such basis or the conclusions drawn therefrom are either arbitrary, unreasonable, or capricious.~~ Specifically, the Hearing Committee finds:

**1. DR. SHAH VIOLATED ITEM # 10 OF THE TERMS OF PROBATION ADOPTED BY THE MEC ON APRIL 18, 2005. PALMETTO EXHIBIT 1, TAB 5.**

Greta Harper M.D., the Chief of the Medical Staff, testified that on numerous occasions she discussed with Dr. Shah his obligation to be evaluated by Dr. Bill Burke, and that Dr. Shah informed her that he had no intention of complying with this term of probation. *Transcript, Volume I, pgs. 40-50; Palmetto Exhibits 6, 13 and 14.* Dr. Shah presented no evidence to refute Dr. Harper's testimony on this issue, nor did he present any evidence establishing compliance with Item # 10. Rather, Dr. Shah made considerable efforts during the hearing to challenge the need for him to be evaluated by Dr. Burke. The Hearing Committee is struck by Dr. Shah's apparent brazen attitude toward his obligation to comply with all terms of probation. The Hearing Committee concludes that Dr. Shah's violation of Item #10 of the terms of probation, standing alone, merited the MEC's Decision.

THE STATE OF SOUTH CAROLINA  
In the Court of Appeals

APPEAL FROM RICHLAND COUNTY  
Court of Common Pleas  
Doyet A. Early, III, Circuit Court Judge

Case No. 1996-CP-40-0271

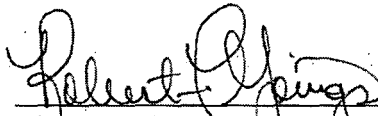
Paresh Shah, M.D. and Paresh Shah, M.D.,  
P.A. ....Appellants,

v.

Palmetto Health.....Respondent.

CERTIFICATE OF COUNSEL

Pursuant to Rule 210 (g), SCACR, the undersigned hereby certifies the Record on Appeal in the above-captioned matter contains all material proposed to be included by any of the parties and not any other material.



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March 8, 2011

THE STATE OF SOUTH CAROLINA  
In the Court of Appeals

APPEAL FROM RICHLAND COUNTY  
Court of Common Pleas  
Doyet A. Early, III, Circuit Court Judge

Case No. 1996-CP-40-0271

Paresh Shah, M.D. and Paresh Shah, M.D.,  
P.A.....Appellants,

v.

Palmetto Health.....Respondent.

CERTIFICATE OF COMPLIANCE

The undersigned counsel hereby certifies that the Record on Appeal, Volumes, I, II and III comply with Rule 211(b) SCACR, and the August 31, 2007 Order from the South Carolina Supreme Court entitled "Interim Guidance Regarding Personal Identifiers and Other Sensitive Information in the Appellate Court Filings."



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March 8, 2011



THE STATE OF SOUTH CAROLINA  
In the Court of Appeals

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APPEAL FROM RICHLAND COUNTY  
Court of Common Pleas  
Doyet A. Early, III, Circuit Court Judge

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Case No. 1996-CP-40-0271

---

Paresh Shah, M.D. and Paresh Shah, M.D.,  
P.A. ....Appellants,

v.

Palmetto Health.....Respondent.

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APPELLANTS' BRIEF

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### **STATEMENT OF ISSUES ON APPEAL**

I. Did the Circuit Court err by failing to consider evidence of contempt which was properly before the Court?

II. Did the Circuit Court err in ruling the relief sought is not available as a matter of law?

III. Did the Circuit Court err in ruling the settlement orders applied only to the initial Quality Assurance Review and not to the subsequent corrective actions initiated by the Hospital?

IV. Did the Circuit Court err in ruling the settlement orders did not require the Hospital to follow its Bylaws?

V. Did the Circuit Court err by misapplying the evidence it considered in ruling the Hospital had not violated the settlement orders?

VI. Did the Circuit Court err in ruling it was improper for it to be involved in the "intricacies" of the Hospital's business?

## STATEMENT OF THE CASE

On March 14, 2006, Palmetto Health Hospital ("Hospital") terminated Dr. Paresh Shah's ("Dr. Shah") medical staff privileges based on a corrective action preceding which stemmed from the peer review or quality assurance ("QA") review of some of Dr. Shah's medical cases. Dr. Shah alleged this action was taken in violation of the provisions of a Confidential Consent Order of Settlement and a Supplemental Order (collectively "Settlement Orders") and the Hospital's Medical/Dental Staff Bylaws, Rules, and Regulations ("Bylaws"). These Settlement Orders set forth in detail how Dr. Shah's QA process was to be conducted. *Inter alia*, the Settlement Orders required a mutually-selected Independent Outsider Reviewer ("Outside Reviewer").

Shortly after the QA process began, Dr. Shah repeatedly complained the Settlement Orders were not being followed. He filed his first Petition for a Rule to Show Cause on September 19, 2005, an Amended Petition for Rule to Show Cause on December 19, 2005, and a Third Petition for Rule to Show Cause on April 13, 2006. These petitions alleged the Hospital repeatedly failed to comply with terms of the Settlement Orders and provisions of the Bylaws.

Despite Dr. Shah's repeated requests, the Circuit Court never scheduled a hearing on these Petitions. After he was eventually terminated, Dr. Shah commenced a new lawsuit, captioned Paresh Shah, M.D. et al. vs. Palmetto Health Alliance, et al., C/A No. 2006-CP-40-4035 ("2006 Action"), on July 13, 2006. The 2006 Action asserted causes of action for civil compensatory contempt, breach of the settlement agreement, and breach of the Hospital's Bylaws. In the 2006 Action, the parties engaged in discovery on issues related to the Hospital's alleged violations of the Settlement Orders.

On February 14, 2008, the 2006 Action was designated complex and referred to the Honorable Doyet A. Early III. A day certain trial was set for the weeks of November 10 and 17, 2008. At a motions hearing on November 4, 2008, the parties agreed in open court to proceed with a non-jury hearing on the Petitions for Rule to Show Cause, including the issues raised in the 2006 Action, since both matters dealt with allegations of failure to comply with the Settlement Orders. {R. 302-303} The parties subsequently entered into a Consent Order to dismiss the 2006 Action (“Order of Dismissal”). It provided that in exchange for dismissal of the 2006 Action, there would be a Rule to Show Cause hearing on Dr. Shah’s outstanding Petitions on all issues. The 2008 Order allowed Dr. Shah to assert additional grounds, to present additional evidence of violations discovered in the course of the 2006 Action, and to submit a “memoranda in support....and argue and rely on such information, documents and discovery from the 2006 action, and affidavits of Drs. Shah, Close and Waldron.” {R. 24} As the Circuit Court noted, the hearing would involve “the same issues basically raised in [the 2006 Action]”. {R. 303, ll. 2-3}

The Circuit Court hearing on Dr Shah’s three Petitions for Rule to Show Cause was held on November 10, 12, and 13, 2008. As stipulated by the parties, the hearing was bifurcated. The Court was to first decide whether the Hospital violated the Settlement Orders. If a violation was found, the Court would schedule a subsequent hearing to determine any appropriate relief. {R. 554} On February 23, 2009, the Circuit Court issued its Order denying Dr. Shah’s Petitions for Rule to Show Cause. Despite the terms of the Order of Dismissal, the Circuit Court refused to consider evidence of violations revealed in the 2006 Action as well as evidence gathered during the discovery process.

## STATEMENT OF FACTS

This dispute began in 1995. Dr. Shah is a board certified vascular and interventional radiologist, a highly specialized hospital-based practice. {R. 704, ¶ 2-3} Prior to the termination of his hospital privileges on March 14, 2006, Dr. Shah had enjoyed full privileges at the Hospital for over twenty-nine (29) years. (Id.). He had one of the largest and most profitable independent radiology practices at the Hospital. (Id.).

### **a) The Underlying Litigation**

In 1995 the Hospital decided to award an exclusive contract to one radiology group to render all radiological services for the Hospital. At that time, Dr. Shah and two other independent radiologists maintained privileges. {R. 704, ¶¶ 2-3} The Hospital undertook to remove those independent radiologists from the Hospital. The plan is best summarized by statements attested to by a physician and attributed to the then Chief Executive Officer of the Hospital, Kester Freeman, on November 14, 1995. According to the physician, Freeman stated:

- (1) “[W]e are going to get rid of [Dr. Shah and the other independent radiologists] for QA”;
- (2) “it [was] all worked through with Howard West [the Hospital’s in-house counsel] to be able to accomplish what they wanted”; and
- (3) the Hospital would “starve them [Dr. Shah and the other independent radiologists] out in legal fees in 18 months.”

{R. 831-836}

On December 13, 1995, the Hospital instituted a quality assurance/corrective action proceeding against Dr. Shah. The Hospital claimed Dr. Shah mishandled the treatment of six patients. After a full hearing, all six allegations were ruled to be unfounded. {R. 705, ¶ 5} In January 1996, the Hospital again sought to remove Dr. Shah from the radiology department by excluding him and two other independent radiologists from the duty rotation



schedule.<sup>1</sup> This move would have effectively denied these independent radiologists their practice privileges. On January 19, 1996, Dr. Shah filed the present lawsuit. He alleged the Hospital and others engaged in a malicious and conspiratorial peer review and actively denied his rights to practice. {R. 705-706, ¶ 6} Dr. Shah obtained an injunction preventing the Hospital from removing him and the other independent radiologists from the duty rotation schedule. {R. 706, ¶ 7} On the day of trial, July 31, 2001, after a jury was selected, the parties reached a settlement.

**b) The Consent Order of Settlement**

On November 28, 2001, The Honorable William P. Keesley signed and entered the Consent Order of Settlement (“Consent Order”). {R. 1-11}. In addition to confidential financial compensation paid to Dr. Shah, the Consent Order contained binding terms and conditions specifically designed to protect Dr. Shah from future discriminatory, unfair, or malicious QA and corrective action proceedings. The Consent Order outlined the procedure the Hospital was required to follow as it conducted future QA reviews of Dr. Shah’s medical cases. Most importantly, the Consent Order provided QA reviews would be conducted by a mutually-selected Independent Outside Reviewer who would “have oversight authority over the case selection process, as well as the cases themselves.” {R. 2}. The Order ensured “that the selection process is performed consistent with Palmetto Richland Memorial Hospital’s established Quality Assurance protocols and not in a discriminatory fashion.” (Id.). The Consent Order also prohibited the Hospital from removing Dr. Shah from the duty rotation schedule.

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<sup>1</sup> Independent radiologist practices are highly dependent upon receiving patients through the duty rotation schedule, since they do not often admit patients and rarely serve as primary care physicians. {R. 704-705, ¶ 3}

**c) The Supplemental Order and the Order on Reconsideration**

In 2002 the Hospital unilaterally sent charts of Dr. Shah's medical cases to a Myrtle Beach radiologist, Dr. Wunder, for review. {R. 851} Dr. Shah objected because Dr. Wunder was not "mutually selected." {R. 707, ¶ 10} The Hospital filed a Petition with the Court to obtain further clarification regarding the process required by the Consent Order. {R. 55-56}

On January 7, 2003, Judge Keesley entered a Supplemental Order. It provided more explicit instructions regarding the selection process and role of the Independent Outside Reviewer. {R. 12-20} The Order required the Hospital to follow its Bylaws regarding Dr. Shah's QA review and outlined the specific process to conduct Dr. Shah's QA review. It clearly defined and differentiated between administrative matters and medical cases. Administrative matters were ordered to be reviewed by the Chief of the Radiology Department, not the Independent Outsider Reviewer. Medical cases were ordered to be reviewed exclusively by the Independent Outside Reviewer. (Id.)

On January 14, 2003, Dr. Shah moved to Alter or Amend the Supplemental Order in order to clarify several provisions. Thereafter, on October 1, 2003, Judge Keesley entered an Order on Reconsideration that reasoned:

What the court has tried to fashion is the substantial equivalent of the standard methodology, with procedures designed to provide a means for having Dr. Shah and the defendants treated evenly and fairly, while allowing the hospital and the medical professionals to comply with medical standards and legal requirements....[the Court Orders] should stabilize the relationship, if the parties make a diligent effort to let it evolve.

{R. 22}

**d) Dr. Selby selected as Independent Outside Reviewer - Review of “Stockpiled” Cases**

On April 8, 2003, the Hospital and Dr. Shah mutually agreed on Dr. Bayne Selby, a radiologist with the Medical University of South Carolina to serve as the Independent Outside Reviewer. {R. 852-853} After he was selected, the Hospital sent batches of medical cases to Dr. Selby for review. Dr. Selby performed reviews of these cases and rendered reports on July 15, 2003, November 10, 2003, December 20, 2003, and February 10, 2004. These medical cases had been selected by the Hospital without any input or oversight by Dr. Selby. A hospital employee described these cases as being “stockpiled” against Dr. Shah and then forwarded to Dr. Selby. {R. 1558, ll. 4-11}

In his July 15, 2003 report, Dr. Selby reviewed eighteen (18) medical cases. Based on Dr. Selby’s written assessment, a number of these cases involved “administrative” issues including medical record documentation and timely completion of reports. {R. 854-874} Dr. Selby’s review involved cases dating back as far as early 2001, before the entry of the Consent Order of Settlement. Of the cases sent for review, six (6) medical cases involved breast biopsies, a procedure Dr. Shah voluntarily discontinued performing a year and a half prior to this review. {R. 854-875}

Of the 18 cases referenced in his July 15, 2003 report, Dr. Selby found only one case, referred to as Patient 14, on which he opined there was a deviation from the standard of care. {R. 870} This medical case dated back to August 14, 2001. In this case, Dr. Selby was critical of Dr. Shah’s decision to cancel premedication before conducting an arteriogram procedure. (*Id.*) Dr. Shah attested he canceled the premedication because the patient advised him she had a past allergic reaction to these drugs. {R. 1055-1056} Dr. Selby concluded his report by stating he did “not find any evidence of technical or judgmental deficiencies that

should prevent Dr. Shah from practicing Interventional Radiology.” Dr. Selby added he “did not see a pattern of deviation from the standard of care” and found “no evidence that would justify withdrawal of privileges.” {R. 856}

In his November 10, 2003 report, Dr. Selby reported on his review of eight (8) additional medical records and charts selected by the Hospital. He reported none of these cases involved a potential deviation of any standard of care. Dr. Selby noted these records were more recent and he noticed “a clear effort by Dr. Shah to improve his documentation in the medical chart, including his procedure notes.” {R. 876} Dr. Selby added he “did not see any recent mammography records[,] leading [him] to believe that either the situation has improved or Dr. Shah has stopped doing these biopsies.”<sup>2</sup> Dr. Selby concluded some radiological misses “obviously will occur with any physician, so it becomes important to know the total number of procedures or films read in order to determine a percentage. I’m not sure if this information is easily available, but if it is, it would [be] helpful.” (Id.).

On December 20, 2003, Dr. Selby rendered a report on his review of the medical record of Patient 27. This patient underwent a lymphangiogram procedure on July 17, 2003. During this lengthy procedure, the patient had to void into a towel because if she moved from the surgical table she would disrupt the delicate cannulation of tiny needles placed in the small lymphatic vessels of her feet. Dr. Selby commented that requiring a patient to void into a towel during this procedure was embarrassing and therefore constituted a breach of the standard of care. {R. 886-888}

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<sup>2</sup> There is no evidence Dr. Selby was provided with a copy of the September 5, 2003 letter from Dr. Shah to John Stewart, M.D. indicating he had not performed any breast biopsies for one and a half years, since he and other radiologists no longer met the criteria for these procedures. {R. 875}

Dr. Shah presented evidence demonstrating Dr. Selby reached this conclusion without discussing or reviewing this case with Dr. Shah or any other radiologist in the department. He failed to learn the department's standard of care for such instances. {R. 1056-1057; ¶ 3-4} The Chief of the Radiology Department, Dr. John Bayard, as well as Dr. Timothy Close, Dr. Edmund Richmond, and Dr. Alan Kantsiper of the Radiology Department, all consistently testified Dr. Shah properly followed standard departmental procedures by requiring his female patient to void into a towel during a lymphangiogram procedure so needle access to the tiny vessels would not be lost. Their testimony was unrefuted. These radiologists all testified they have proceeded, or would have proceeded, in the exact same manner in the treatment of this patient. They testified Dr. Shah exercised sound medical judgment consistent with departmental practices and standards. {R. 889-903}

On February 10, 2004, Dr. Selby rendered another report based on his review of eight (8) additional medical cases. Dr. Selby found none of these cases involved a deviation from the standard of medical care and concluded the "nature of these records involve[d] mostly straightforward radiological misses, which of course, even the best radiologists will have from time to time." {R. 904} He further stated "[i]t might be useful for the executive committee to compare this to other radiologist quality assurance records to ascertain what a 'community standard' might be." (*Id.*). Evidence in the record demonstrated the Hospital failed to establish or provide a community standard in order to compare Dr. Shah with other radiologists in the department. {R. 913-915; 920-921; 1066, ¶ 23}

Dr. Shah stated he was never given a meaningful opportunity to meet with Dr. Selby, as is typically done during traditional QA reviews. {R. 1059-1060, ¶ 10} Such meetings

afford the opportunity for physicians to discuss medical cases prior to the forming of an opinion about the reviewed physician's medical care.

During this period of time, and at all relevant times thereafter, Dr. Shah was the *only* radiologist subject to any QA reviews at the Hospital. {R. 1071, ¶ 38} In fact, he was subjected to three (3) QA reviews in a four (4) month period. No QA was performed on the other radiologists for a period of eighteen (18) months. {R. 913-915; 920-921; 1060-1061, ¶ 11; 1066, ¶ 22; 1853}

**e) The Hospital's Placement of Dr. Shah on Probation as Corrective Action**

On February 25, 2004, the Hospital's Medical Executive Committee ("MEC") voted to initiate a corrective action against Dr. Shah based on Dr. Selby's reports. {R. 913-915} On April 5, 2004, the MEC voted to place Dr. Shah on a ninety-day (90) probation, which was extended for six (6) months on April 27, 2004. {R. 920-921; 923-924}

Dr. Shah appealed this decision, thus invoking his right to a hearing pursuant to the Bylaws. Dr. Shah contended he was placed on probation without being advised of any specific finding of a violation of a recognized standard of medical care. He contended his probation was imposed without a finding that his standards were lower than those of the Medical Staff as required by the Bylaws. {R. 708-710 ¶¶ 13-17; 1059 ¶ 9; 1849-1850} Dr. Shah complained he was placed on probation based on the Hospital requiring Dr. Selby to review: (a) administrative issues, (b) stale medical cases dating back to 2001, and (c) medical cases involving a procedure he was no longer performing (i.e. breast biopsies). Most importantly he complained there was never any recommendation or suggestion of probation by Dr. Selby. Dr. Shah contended his reviews were not "as similar as possible to the

customary and prevailing procedure followed for any other person on the Medical Staff,” as required by the Settlement Orders. {R. 17-18}

**f) The MEC Probation Committee Hearing**

On the evenings of December 6, 2004, December 9, 2004, January 12, 2005, and February 1, 2005, the Hospital conducted “Fair Hearing Committee Probation” hearings. Dr. Shah wrote to the Hearing Committee complaining he had “yet to receive a list of the specific cases upon which the MEC based its decision to sanction [him]” and he had “not been told exactly what [he] supposedly did wrong....[and] was never given the opportunity to discuss [his] cases with the physician hired to conduct [his] peer review.” {R. 929-930}

Dr. Shah called numerous witnesses to vouch for his competency and practices. These witnesses included: (1) Michael Shiah, a registered nurse; (2) Susan Thomas, a Senior CT Scan Technologist; (3) Jack Morris, Manager of Diagnostic Radiology; (4) Carol Norman, Imaging Manager for Special Procedures; (5) Dr. Robert Waldron; and (6) Dr. Edmund Richmond, both board certified radiologists at the Hospital. Not one member of the Department testified against Dr. Shah. {R. 953-974}

During this hearing, Dr. Selby testified: “I [did] not find in any of these cases things that were, you know, clear evidence of chronic, technical, or judgmental, deficiency or inadequate training or something, even though there were problems, you know, that were identified in these cases.” {R. 938} Dr. Selby did not recommend Dr. Shah for corrective action. {R. 942}

**g) The Report of the Probation Committee – Imposing “Psychological Evaluation” and “Fairer Measurement” Reports**

Following this hearing, on March 14, 2005, the Probation Hearing Committee issued its report upholding the decision to place Dr. Shah on probation. However, the Probation Hearing Committee added an additional requirement to Dr. Shah's probation, namely that he undergo a psychological evaluation by Dr. Bill Burke at his own expense. Dr. Shah claimed this later added requirement was arbitrary and unfair. He was never put on notice of any mental, emotional, or psychological issues before the Probation Hearing Committee hearing and was never given the opportunity to defend against these allegations. Dr. Shah claimed he was never given any "Statement of Charges" detailing the specific allegations against him, as required by Article 5.2<sup>3</sup> of the Bylaws. {R. 710, ¶ 17; 1023-1024}

Second, the Committee concluded Dr. Selby should have had oversight authority in the case selection process pursuant to the Settlement Orders. The Committee concluded a "fairer measurement" of Dr. Shah's competence would be to perform a random audit of invasive procedures from that point forward, rather than a retrospective review of cases that were allegedly "stockpiled." {R. 977} This was a tacit acknowledgement that the Hospital had not followed the case selection process called for by the Settlement Orders.

Dr. Shah appealed the decision of the Probation Hearing Committee to the Board of Directors pursuant to the Bylaws. The Board upheld the probation. {R. 1006}

**h) The "Fairer Measurement" Reports and the Hospital's Concealment of Their Findings**

In accordance with the March 14, 2005 report of the Probation Hearing Committee requiring Dr. Selby to perform a review based on a "Fairer Measurement" of selecting Dr.

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<sup>3</sup> Article 5.2 of the Bylaws entitled "Statement of Charges" provides: "The notice of hearing required by Section 5.1 shall contain a concise statement of the Practitioner's alleged acts or omissions, a list by number of the specific or representative patient records in question and/or the other reasons or subject matter forming the basis for the hearing." {R. 928}



Shah's cases, Dr. Selby issued three subsequent reports: (1) April 8-9, 2005; (2) June 10, 2005; (3) October 5, 2005.

On April 8 and 9, 2005, Dr. Selby issued a report after reviewing 163 randomly selected imaging studies performed by Dr. Shah. {R. 991} This review consisted of various x-rays, CT scans, and angiograph procedures. Dr. Selby concluded "[i]n my review of these cases I did not find any significant misinterpretations." (Id.) (emphasis added). Dr. Shah testified this report was not sent to him. {R. 713-714, ¶ 27}

On June 10, 2005, Dr. Selby issued a report on five (5) additional cases. {R. 994-999} Dr. Selby found no problems or deviations from the standard of care in Dr. Shah's treatment of these patients. (Id.).

On October 5, 2005, Dr. Selby issued yet another report on randomly selected cases. This comprehensive review involved 91 invasive procedures and 374 diagnostic studies cases performed from March through October 2005. Of the invasive procedures, Dr. Selby found only "one case (1.1%) where there was no final picture." {R. 1007} Of the diagnostic studies, Dr. Selby found "9 cases (2.4%) where the impression contained a discrepancy with the films [but he] found no change in patient care as a result of these discrepancies." (Id.). In this report, Dr. Selby stated "I should point out that whenever QA reviews are done over a large number of cases, discrepancies are always found." (Id.). Other physicians testified that during QA reviews radiologists often disagree with each other. {R. 843-844, ¶¶ 17-18}

Even though the Fair Hearing Committee assured Dr. Shah "a fairer measurement of clinical competenc[y] would be a random audit of invasive procedures...forward," the Hospital did not consider these last three comprehensive reports by Dr. Selby in determining Dr. Shah's clinical competency. Chief of Staff Greta Harper later testified "we did not

address competency in terms of [Dr. Selby's report on October 5, 2005]. Our conclusion was that there were no significant adverse findings during this review by Dr. Selby." {R. 1008}

In each of these "Fairer Measurement" reviews, in which Dr. Selby controlled the selection process of all 533 medical cases, Dr. Selby found no deviation from the standard of care. {R. 991; 994-999; 1007} Evidence in the record is overwhelming that the Hospital took actions to disregard these reports. In fact, the Hospital went so far as to conceal these reports from members of the Hearing Committee. During the termination hearing proceeding, the MEC representative told the hearing panel that Dr. Selby had only rendered *four* reports in his QA review of Dr. Shah's medical cases. {R. 739-740} Dr. Selby's first four reports were the only reports included in a binder offered by the Hospital. {R. 742; 744-789} These were the previous reports in which Dr. Selby was not involved in the case selection process. This binder also contained a "Chronology Index" which showed the timeline of all events during Dr. Shah's QA process and corrective action. The first four reports were placed on the chronology index. The more recent and much more comprehensive "Fairer Measurement" Reports, which were all highly favorable to Dr. Shah, were not included and not even referenced. {R. 744-746}

**i) The Letter from "Patient X"**

On October 27, 2005, after the Hospital received these "Fairer Measurement" Reports, the Chief of Staff received a letter from a patient complaining Dr. Shah and two other radiologists at the Hospital had incorrectly read her x-ray, depicting her large (12 cm) ovarian mass as an enlarged uterus. {R. 1009-1010} The Hospital referred to this case as "Patient X."<sup>4</sup>

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<sup>4</sup> "Patient X" is also referred to as Patient 36 in the record.

Several days later, on October 31, 2005, the MEC met to discuss Dr. Shah's completion of his probationary terms. At that time, the case of Patient X was presented to the members of the MEC for their review and consideration. After discussing the case, reviewing the films and reaching an internal decision that Dr. Shah breached a standard of care, the MEC members voted to terminate Dr. Shah's medical staff privileges. {R. 1011-1012} The MEC minutes of this meeting prove the Hospital conducted its own internal QA review of Patient X by reading, reviewing, and analyzing the x-rays and medical records in question and concluding that Dr. Shah misdiagnosed Patient X. (Id.). This case had neither been selected nor reviewed by Dr. Selby. Dr. Shah appealed the decision to suspend and revoke his privileges.

**j) Dr. Selby's Preliminary Report on "Patient X"**

Not until after Dr. Shah's privileges were suspended, on November 2, 2005, did the Hospital send the "Patient X" case to Dr. Selby for review. {R. 1013-1014} Dr. Selby issued a "Preliminary Report" on December 13, 2005, the same day the Fair Hearing Committee hearing was scheduled to commence. {R. 1018}

In his Preliminary Report, Dr. Selby advised he did not have enough information to make a substantive conclusion. {R. 1015-1017} Dr. Selby wrote "[a] full review in person with Dr. Shah is indicated" and "these films should be reviewed with Dr. Shah to see what explanation he might have." (Id.). He added "the best next step would be to review the films together to see if this was in fact the set of films he saw. It would probably be difficult to draw any further conclusion about what happened at the time of scheduled biopsy without reviewing this in person with the radiologist." (Id.). Dr. Selby stated he needed to determine "if the correct films were reviewed or if there is some other piece of information of which I

am unaware.” (Id.). Having reviewed over 500 of Dr. Shah’s cases, Dr. Selby had an understanding about Dr. Shah’s competence in reading x-rays.

Dr. Selby opined “[i]t is possible that a different set of films were reviewed. This would be the most obvious alternative explanation...This should definitely include a re-review of the CT scan by [Dr. Shah] to see if he feels this was the scan he saw originally.” (Id.). Dr. Selby’s Preliminary Report concluded, “[a] complete review of this case is in order...This will serve as a preliminary review pending that discussion [with Dr. Shah].” (Id.).

Notwithstanding Dr. Selby’s Preliminary Report and recommendation indicating his need to further review these films and consult with Dr. Shah prior to rendering any Final Report, the Hospital concluded Dr. Shah misread the film. It went forward with the hearing to ratify the decision to terminate his privileges. {R. 1011-1012; 1018; 1019-1021}

**k) The Termination Hearing of December 13-15, 2005**

As a result of Dr. Shah’s appeal, the Hospital conducted a hearing on the evenings of December 13, 14, and 15, 2005. Dr. Selby’s Preliminary Report of Patient X was given to the Hospital on the same day this hearing commenced. {R. 1018}

During this hearing, the Hospital relied upon its internal determination of the reading of the film of Patient X. The Hospital also considered an *additional 35 medical cases* from the Emergency Department which were neither selected nor reviewed by Dr. Selby. {R. 2052-2053} They also had the initial reports of Dr. Selby dated July 15, 2003, November 10, 2003, December 20, 2003, and February 10, 2004. {R. 747-789}

At this hearing, Dr. Keisler misrepresented to members of the hearing committee there had been “dozens of complaints by patients” against Dr. Shah. {R. 821, ll. 20-21} Dr.

Shah was never provided documents substantiating these “dozens of complaints from patients” despite the clear requirement that all patient complaints were to be documented. {R. 719, ¶ 40}

Further, several statements made at the Termination Hearing prove the unfair and discriminatory attitude towards Dr. Shah by representatives of the Hospital. Former Chief of Staff, and head of the Emergency Department, Dr. John Stewart stated, “you [Shah] wanted to be arrogant and try your best to snub your nose at the Medical Staff...And so what you’re doing is paying the price for it.” {R. 2033, ll. 20-23} Dr. Stewart later told Dr. Shah on the record “you’re wasting everybody’s time....Well, you’ve wasted our time” {R. 2051, l. 24-2052, l. 1). Dr. Stewart was the Hospital representative who presented the 35 Emergency Room cases to the hearing panel. Dr. Stewart claimed these cases represented “misreads,” but admitted these cases had *never* been selected or reviewed by Dr. Selby as required by the Settlement Orders. {R. 2052, l. 17 – 2053, l. 8}

During this hearing, Dr. Shah called eighteen (18) witnesses, including five (5) radiologists from the Hospital. Each witness testified to Dr. Shah’s competency. No radiologist from the department gave contrary or adverse opinions about Dr. Shah. Some of the radiologists questioned the Hospital’s unfair treatment of Dr. Shah. In particular, a hearing panel member asked Dr. Edmund Richmond “what has happened over the past five years to have Dr. Shah fall out of favor with the MEC when other people from the staff have confidence in his ability?” Dr. Richmond answered, “You know, it’s – it seems a little bit, almost ludicrous to me, that after 27 years, or whatever it’s been, that this is just now coming up for the first time. And I’m not exactly sure why it is. I mean, there’s certainly – nothing’s changed drastically about the way he practices or – the business about the psychiatrist I

certainly don't understand that. I mean, that's – that's kind of out there as far as I'm concerned. But you asked me. So I've thought about that too. But I think that's ridiculous.”  
{R. 2241, l. 17 - 2242, l. 6}

**I) The Hospital's Determination to Uphold Revocation of Privileges**

On December 30, 2005, the Hospital's Fair Hearing Committee issued its Report upholding the decision to terminate Dr. Shah's privileges. According to the Hearing Committee's Report, Dr. Shah's termination was justified on three grounds:

- (1) Dr. Shah's failure to undergo a Psychological Evaluation;
- (2) The Hospital's review of Patient X and 35 Emergency Room Cases; and
- (3) Dr. Shah's alleged failure to comply with administrative policies and procedures.

{R. 1019-1021}

As to his failure to undergo a psychological evaluation, the Hospital found Dr. Shah “had no intention of complying with this term of probation” and “Dr. Shah made considerable efforts during the hearing to challenge the need for him to be evaluated by Dr. Burke,” even though he claimed this requirement was imposed in violation of the Settlement Orders. (Id.) Further, the Hospital claimed it was “struck by Dr. Shah's apparent brazen attitude towards his obligation to comply with [the psychological evaluation] terms of probation” and concluded, “Dr. Shah's violation of Item #10 [psychological evaluation] of the terms of probation, standing alone, merited the MEC's Decision [to terminate his privileges].” (Id.).

The Hospital further concluded “Dr. Shah's failure to note an obvious pelvis mass of 12cm [referring to Patient X's films] in and of itself establishes deficiencies in his clinical skills” and this “standing alone, supports the MEC's Decision.” The Hospital also found “the

information from the Hospital Emergency Department [i.e. 35 emergency room cases] of Dr. Shah's misinterpretations during the probationary period further supports the finding that Dr. Shah continued to suffer clinical deficiencies during the period of probation." (Id.).

The Hospital cited the testimony of Mr. Gregory Webb, Director of Radiological Services that "Dr. Shah continued to ignore Hospital [administrative] policies and procedures during the period of probation." (Id.) There was no supporting testimony from the Chief of the Department, the individual assigned the duty by the Settlement Orders to address and handle administrative matters. Instead, the Chief of the Department, Dr. John Bayard, testified many radiologists in the department -- besides Dr. Shah -- had encountered problems pertaining to documentation and completion of reports. {R. 2216, l. 18 - 2219, l. 4}

**m) The Appellate Review Hearing Before Board of Directors**

In accordance with the Bylaws, Dr. Shah appealed the termination of his privileges to the Board of Directors of the Hospital. He appeared before the Board of Directors at its meeting on March 14, 2006. Dr. Shah advised the Board his privileges were terminated through a procedure he contended was discriminatory and in violation of the Settlement Orders. At that time, the Chief of Staff acknowledged she never provided Dr. Shah with any written documentation evidencing issues requiring a psychological evaluation or notifying Dr. Shah that his mental stability had been discussed by the MEC or would be an issue before any hearing panel. {R. 735-737; 1023-1024} Dr. Harper also claimed there was "an attempt to follow that Court Order." (Id.).

On April 4, 2006, Dr. Shah was notified the Board of Directors had affirmed the decision to terminate his medical staff privileges. {R. 1025}

**n) The Ruling of the Circuit Court after the Rule to Show Cause Hearing**

After the Rule to Show Cause hearing on November 10, 12 and 13, 2008 the Circuit Court entered its Order denying Dr. Shah's Petitions. Dr. Shah's Rule 59 motion was also later denied. {R. 54} This appeal follows.

**STANDARD OF REVIEW**

A finding of contempt rests within the sound discretion of the trial court and will be reversed only if the trial court abused this discretion. Ex parte Bland, 380 S.C. 1, 14, 667 S.E.2d 540, 546 (2008) (citing Brandt v. Gooding, 368 S.C. 618, 627, 630 S.E.2d 259, 263 (2006)). "An abuse of discretion occurs when the trial court's ruling is based upon factual conclusions that are without evidentiary support or when the trial court's decision is based upon an error of law." Id. (citing Fontaine v. Peitz, 291 S.C. 536, 539, 354 S.E.2d 565, 566 (1987)). If, on appeal, the appellate court determines that a party did violate a consent court order, an appellate court may determine that contempt lies and remand for a determination of damages. Id.

**LAW/ANALYSIS**

**I. THE CIRCUIT COURT ERRED IN FAILING TO CONSIDER EVIDENCE OF CONTEMPT PROPERLY BEFORE THE COURT.**

**A. Applicable Standard for Violation of a Court Order**

The 2001 Consent Order stated "[s]hould a dispute arise regarding....this settlement, the parties agree that this matter may be brought before this Court in the form of a Petition for a Rule to Show Cause." {R. 2} To that end, Dr. Shah filed three (3) Petitions for a Rule to Show Cause as to why the Hospital should not be held in contempt for violating the Settlement Orders by engaging in a discriminatory QA process in contravention with the Settlement Orders.



“The power to punish for contempt is inherent in all courts and is essential to preservation of order in judicial proceedings.” Browning v. Browning, 366 S.C. 255, 262, 621 S.E.2d 389, 392 (Ct. App. 2005). Without the power to find individuals in contempt of court, “the administration of the law would be in continual danger of being thwarted by the lawless.” Miller v. Miller, 375 S.C. 443, 453-54, 652 S.E.2d 754, 759 (Ct. App. 2007) (citing In re Terry, 128 U.S. 289, 303, 9 S.Ct. 77, 32 L.Ed. 405 (1888)).

To prevail in a proceeding for contempt based upon violation of a court order, the moving party must show the existence of a court order and the facts establishing the non-moving party’s non-compliance with the court order. Floyd v. Floyd, 365 S.C. 56, 74-75, 615 S.E.2d 465, 475 (Ct. App. 2005) (citing Hawkins v. Mullins, 359 S.C. 497, 501, 597 S.E.2d 897, 899 (Ct. App. 2004)). The movant bears the burden of proving civil contempt by clear and convincing evidence. Durlach v. Durlach, 359 S.C. 64, 596 S.E.2d 908, 912 (2004). “Once the movant makes a *prima facie* showing by pleading an order and demonstrating noncompliance, the burden shifts to the respondent to establish his defense and inability to comply.” Floyd, 365 S.C. at 74-75, 615 S.E.2d at 475 (citing Eaddy v. Oliver, 345 S.C. 39, 42, 545 S.E.2d 830, 832 (Ct. App. 2001)).

Contempt occurs when a party willfully disobeys a court order. Curlee v. Howle, 277 S.C. 377, 382, 287 S.E.2d 915, 918 (1982). An act is willful if it is “done voluntarily and intentionally with the specific intent to do something the law forbids, or with the specific intent to fail to do something the law requires to be done; that is to say with bad purpose either to disobey or disregard the law.” Cheap-O’s Truck Stop, Inc. v. Cloyd, 350 S.C. 596, 607-08, 567 S.E.2d 514, 521 (Ct. App. 2002).

**B. The Circuit Court Erroneously Found Evidence of Five Violations of the Settlement Orders Was Not Properly Before It**

The Circuit Court erroneously disregarded clear and convincing evidence of issues properly before it. The Circuit Court found “[t]o the extent Plaintiff asserts contempt grounds or seeks relief not previously made in these pending motions, *they are not properly before me* under the express terms of the 2008 dismissal order and are denied.” (emphasis added) {R. 30} The Circuit Court stated “[m]y 2008 Dismissal Order in the 2006 lawsuit was a consent order, and specifically provided: ‘Plaintiffs will proceed in the 1996 action on the *pending* petitions for rule to show cause and memoranda in support.’” This was clear error. The Circuit Court went on to erroneously state “the only permissible grounds and the only permissible relief for contempt are those set forth in the September 2005 motion, the September 2005 Amended Memorandum, and December 2005 motion and Supplemental Memorandum, and the April 2006 motion and memorandum. These were the only pending motions at the time of the 2008 Dismissal Order.” {R. 30-31}

This ruling constitutes a clear error of law and is a direct contradiction of the agreement reached by the parties and the unequivocal language of the 2008 Consent Order of Dismissal. {R. 302-304; 687-688} This Order allowed Dr. Shah to submit a “*memoranda in support ... and argue and rely on such information, documents and discovery from the 2006 action, and affidavits of Drs. Shah, Close and Waldron.*” {R. 24} (emphasis added). In fact, prior to the hearing Judge Early recognized the Rule to Show Cause hearing “would be the same issues basically raised in the [2006 Action].” {R. 303, ll. 2-3} He planned to “let [the parties] make the record like you want it make it” and allow the parties “to make a full and complete transcript.” {R. 304-305}

After the Petitions for Rule to Show Cause were originally filed, the parties conducted extensive discovery over the continuing dispute in the 2006 lawsuit. In the Order of Dismissal, Dr. Shah expressly reserved the right to raise issues and present evidence of additional contemptuous conduct that was revealed through discovery in the 2006 action. During the circuit court hearing, Dr. Shah did just that. He submitted a memorandum captioned "Memorandum in Support of Consolidated Petitions for Rule to Show Cause and Reply to Defendant's Memorandum in Opposition." {R. 233-261} He submitted two personal affidavits. {R. 704-722; 1055-1074} Drs. Close and Waldron submitted affidavits. {R. 837-846; 847-850} In the presentation of his case, Dr. Shah properly relied on documents and information obtained in discovery in the 2006 Action. The circuit court's Order erroneously found these matters were not properly before it.

The Hospital also relied on documents and information obtained in discovery in the 2006 Action. During the circuit court hearing, the Hospital never raised any objection to these matters being presented. It never claimed any matter was not properly before the court on the grounds such matter was an issue relating only to the 2006 action rather than the petitions for Rule to Show Cause in this action. The parties consented to presenting at the hearing matters relevant to the 2006 action. It was not until the Circuit Court entered its order that evidence was characterized as "not properly before the Court." {R. 30, 39, 40, 41 and 43}

As a result, the Circuit Court refused to consider evidence of five (5) violations listed in Dr. Shah's memorandum. This evidence compellingly demonstrates the Hospital's deliberate pattern of non-compliance and conscious disregard of the Settlement Orders. As discussed below, these violations were either before the Court on the pending motions,

developed through discovery in the 2006 action, or tried by the parties by consent and without objection. A cardinal rule of law in South Carolina edifies: “When issues not raised in the pleadings are tried by consent, they will be treated as if they had been raised in the pleadings.” McCurry v. Keith, 325 S.C. 441, 447, 481 S.E.2d 166, 169 (Ct. App. 1997).

***(1) Evidence Related to Improperly Selected and Stockpiled Breast Biopsies Should Have Been Addressed by the Circuit Court.***

In the Circuit Court’s Order, “Violation #1” refers to evidence that breast biopsy cases were sent to Dr. Selby for review. {R. 41} This evidence supports Dr. Shah’s allegations that the Hospital failed to grant the Independent Outside Reviewer oversight authority in the case selection process as required by the Settlement Orders. All issues and arguments raised regarding breast biopsies constitute *prima facie* evidence demonstrating the Hospital did not afford Dr. Selby the authority to select which of Dr. Shah’s cases would be reviewed. The Hospital’s selection of medical procedures which Dr. Shah was no longer performing (for almost 2 years) for review by Dr. Selby, is a clear indication of the Hospital’s attempt to deny Dr. Shah a fair QA review.

The Circuit Court Order further misstates the facts surrounding Dr. Shah’s relinquishment of breast biopsy privileges. {R. 30} The Court’s ruling that Dr. Shah continued to perform breast biopsies after Dr. Selby’s first review is factually incorrect. {R. 875} The evidence shows Dr. Shah did not perform this procedure, as he was not eligible per ACR criteria to perform breast biopsies and had voluntarily ceased performing them long before he was asked by the Hospital to relinquish this privilege. (*Id.*) Further, the Court’s ruling that Dr. Shah only “formally relinquished this privilege rather than satisfy the other conditions imposed for keeping this privilege” is factually erroneous and not supported by any evidence. {R. 41}

***(2) Violations of the Settlement Orders Related to 35 Emergency Room Cases Never Reviewed by the Independent Outside Reviewer Should Have Been Addressed by the Circuit Court.***

The Circuit Court erred in wholly failing to consider evidence the Hospital relied on an unauthorized and suspect review of 35 emergency room cases as a basis for terminating Dr. Shah's privileges, referred to as "Violation #2" in the Circuit Court Order. {R. 41-42} This evidence was properly before the Court, as it was revealed through discovery in the 2006 Action. Before the hearing, the Hospital briefed this issue and submitted evidence in an attempt to justify its position in favor of considering these 35 cases. {R. 227-228} Never once did the Hospital take the position that its review of the 35 emergency room cases were not before the Circuit Court on the Rules to Show Cause.

The evidence is undisputed that Dr. Selby neither selected nor reviewed these cases. The Hospital conducted an internal review of these 35 cases and determined that Dr. Shah violated the standard of care. Utilizing these cases against Dr. Shah in the QA process is a patent violation of the letter and spirit of the Settlement Orders. The Settlement Orders grant the sole authority of all QA reviews of Dr. Shah's cases to the Independent Outside Reviewer. They do not allow for any internal QA reviews of Dr. Shah. Admittedly, the removal of Dr. Shah's QA reviews from physicians at the Hospital is one of the major stated purposes of the Settlement Orders. The Hospital's use of these 35 cases as a basis for Dr. Shah's termination of privileges is a demonstration of the Hospital's conscious disregard for the clear requirements of the Settlement Orders. Thus, the Circuit Court erred when it arbitrarily refused to address this violation.

***(3) Violations of the Settlement Orders Related to the Handling of Administrative Issues Should Have Been Addressed by the Circuit Court.***

The issue of the Hospital improperly considering administrative issues (referred to as “Violation #3” in the Circuit Court Order) was specifically addressed in Plaintiffs’ Memorandum in Support of the Third Rule to Show Cause and further developed through discovery. {R. 109-111} The Hospital defended its actions on this matter in its Memorandum in Opposition. {R. 229-231} Additionally, the Hospital presented evidence at the circuit court hearing in an attempt to justify why it failed to handle administrative matters as required by the Settlement Orders. (Id.). Accordingly, the Circuit Court erred in failing to consider evidence of this violation. Such evidence reveals that Hospital acted in contravention of the Settlement Orders.

***(4) Violations of the Bylaws Specifically Addressed in the Settlement Orders Related to the Imposition of a Psychological Evaluation Should Have Been Addressed by the Circuit Court.***

The Circuit Court erred in failing to consider evidence that the imposition of a required psychological evaluation was in contravention with the Settlement Orders (referred to as “Violation #4” of the Circuit Court Order). Dr. Shah addressed this specific issue in his Memorandum in Support of the Petition for Rule to Show Cause dated December 19, 2005. It was further developed through discovery in the 2006 Action. During the Circuit Court hearing, the Hospital never advanced the position that this issue was not properly before the court. Both parties presented evidence and case law advocating their respective positions about whether the psychological evaluation requirement constituted a violation of the Settlement Orders. {R. 453-459; 497-498; 502-504; 532-534; and 625-629} Moreover, at the end of the hearing, the Circuit Court specifically stated this was an issue before the Court. {R. 678-679} This statement contradicts the Order the court entered. The Court erroneously

ruled, “this issue is not properly before me as it was not raised until after the 2008 Dismissal Order.” {R. 43} This ruling is without evidentiary support and constitutes an error of law.

***(5) Violations of the Settlement Orders Related to the Discriminatory QA Process Should Have Been Addressed by the Circuit Court.***

Finally, the Circuit Court should have considered evidence presented at the hearing that the QA Process was discriminatory in nature, referred to as “Violation #5”. The Court erroneously concluded “Violation #5....asserts several new grounds that were not asserted in the ‘pending motions.’” {R. 43} Specifically, the Circuit Court ruled the Hospital’s failure to compare Dr. Shah with other radiologists, the failure to establish a community standard, and evidence showing the Hospital routinely sent Dr. Shah’s medical cases to high-ranking hospital administrators was not properly before the Court. According to the Circuit Court, “the alleged discovery issue arose in the 2006 lawsuit, not the lawsuit at issue here, and the 2006 lawsuit has been dismissed with prejudice (thereby mooted any pending discovery disputes in that lawsuit).” {R. 43-44} This was an error of law.

Without a doubt, these matters constitute *prima facie* evidence the Hospital subjected Dr. Shah to a discriminatory and unfair QA process. The Settlement Orders required that “every effort should be made to make the review as similar as possible to the customary and prevailing procedure followed for any other person on the Medical Staff.” {R. 17-18} The Hospital understood these issues were before the Court. It addressed these issues in its Memorandum to the Court. {R. 212-222; 229-231} The Hospital’s failure to establish a community standard was initially raised in Plaintiffs’ Memorandum in Support of Third Petition for Rule to Show Cause. {R. 103-106} The documentation evidencing the Hospital improperly sent Dr. Shah’s medical cases to high-ranking hospital administrators for review

was revealed through discovery in the 2006 lawsuit. Accordingly, the Circuit Court erred as a matter of law in ruling these matters were not properly before the court.

## **II. THE CIRCUIT COURT ERRED IN RULING THE RELIEF SOUGHT IS NOT AVAILABLE AS A MATTER OF LAW.**

The Circuit Court ruled Dr. Shah's petitions must be denied because the relief sought was not available as a matter of law. {R. 30} This was an error of law. Dr. Shah sought all equitable relief provided under the contempt powers of the Circuit Court. Relief for contemptuous conduct is designed to "return [the] aggrieved party to the status quo" which may include reinstatement, lost profits, loss of reputation, humiliation, and mental distress arising out of a contemnor's violation, including recovery of litigating the court's order, costs, and attorneys' fees. Curlee v. Howle, 277 S.C. 377, 287 S.E.2d 915 (1982); Jarrell v. Petoseed Co., Inc., 331 S.C. 207, 500 S.E.2d 793 (Ct. App. 1998).

The Circuit Court stated in its Order, "[a]n award of damages is not available to Plaintiff due to the immunity from damages provided by the Health Care Quality Improvement Act ("HCQIA"), which is a federal law that pre-empts any state law claim that would allow such damages." {R. 31} The Circuit Court went on to state, "restoration of privileges is not available to Plaintiff under South Carolina's doctrine of non-review, which essentially deprives the courts of jurisdiction to grant this relief." (Id.)

The Circuit Court committed errors of law in reaching these conclusions. First, the determination of any appropriate remedy was *never* before the Court. The Court expressly bifurcated the issues of contempt and available relief. Judge Early specifically stated:

I think we all are working under the same objective which is to get whether or not there was a contempt matter. If I rule that there- that you [Hospital] are in contempt, you and your client, then we would have a separate proceeding where the doctor [Shah] would then present his evidence on damages and y'all would have rights on



however you want to do on that. When I say that, I mean whatever evidence you want to present. I mean, it would be a whole separate proceeding.”

{R. 554}

For the Circuit Court to rule later that no relief is available because of HCQIA or because of the doctrine of non-review is clearly erroneous. This finding was materially prejudicial in the Circuit Court’s underlying conclusion. If there is no relief available as a matter of law, there can be no purpose in holding a contempt hearing. If there are no ramifications for a party’s disregard for directives contained in an order, then the Court Order become a dead letter.

**(A) Health Care Quality Improvement Act (“HCQIA”)**

The Circuit Court’s finding that damages are precluded under HCQIA is an obvious misstatement of the law. First, HCQIA does not override or preclude the terms of the Circuit Court Order specifying how a physician must be treated. The HCQIA provides *rebuttable* qualified immunity if, and only if, a Hospital proves a corrective action was instituted: (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).

If a finding of contempt is made, it is ineluctable the rebuttable qualified immunity afforded by HCQIA has been overcome. Stated differently, the Hospital could not violate the Settlement Orders and, at the same time, be afforded immunity for acting “reasonably.”

Further, HCQIA does not statutorily bar this Court from an equitable finding of contempt. There is no authority to support a ruling that HCQIA is a bar to any relief for violating a court order. Any relief sought for contempt is equitable in nature. See Browning v. Browning, 366 S.C. 255, 262, 621 S.E.2d 389, 392 (Ct. App. 2005). Such a ruling would improperly place this Hospital above the law and beyond the contempt power of the Circuit Court. This ruling was, therefore, an error of law.

**(B) Doctrine of Non-Review**

The doctrine of non-review does not deprive the Circuit Court of *jurisdiction* to reinstate or restore privileges as part of the remedy if it finds a party in contempt of a court order. Under the doctrine of non-review, "it is improper for the courts to review the decisions of governing boards of private hospitals concerning the staff privileges of practitioners." Wood v. Hilton Head Hosp., Inc., 292 S.C. 403, 405, 356 S.E.2d 841, 842 (1987). This doctrine is rooted in subject matter jurisdiction principles. Id. The doctrine of non-review is inapplicable in this case because the Consent Order of Settlement specifically states "[t]he parties agree that no jurisdictional defense will be raised with regard to any enforcement action brought before this Court on any aspect of this Consent Order." {R. 2-3} Accordingly, the Hospital expressly waived the defense of the doctrine of non-review. Despite such waiver and prior order, the Circuit Court erroneously ruled this specious jurisdictional defense precluded all relief.

Even if there was no waiver, the Circuit Court misapplied the doctrine of non-review. There is no legal authority supporting the extension of this doctrine to a contempt proceeding. This doctrine does not, and should not, prevent either this Court or the Circuit Court from enforcing the terms and conditions of the Settlement Orders. The purpose of civil

contempt is to restore an aggrieved party to the *status quo ante* and to use its equitable power to remedy a violation of a directive of the court. Application of the doctrine of non-review would result in the underlying Settlement Orders becoming a nullity and a dead letter to Dr. Shah and the Court. The Hospital would be at liberty to unfairly terminate a physician's privileges in violation of a court order without any threat of recourse. Accordingly, the Circuit Court erred in ruling the jurisdictional defense and the doctrine of non-review precluded any relief.

**III. THE CIRCUIT COURT ERRED IN RULING THE SETTLEMENT ORDERS APPLIED ONLY TO THE "INITIAL QA REVIEW" AND NOT TO SUBSEQUENT CORRECTIVE ACTIONS INITIATED BY THE HOSPITAL.**

The Circuit Court erred in ruling the Settlement Orders applied only to the initial QA process and not to any following proceedings such as a corrective action. Contrary to the Circuit Court's ruling, the Settlement Orders do not provide their requirements "only [apply to] the first stage of this five stage [QA] process." {R. 34, 53} Not only is this ruling without evidentiary support, it illustrates the error in the Circuit Court's refusal to consider relevant evidence of contempt by the Hospital. At the hearing, the Hospital neither advanced the position nor presented any evidence supporting the proposition that the Settlement Orders only govern the "first stage" of QA. The Hospital never asserted that QA and corrective action were separate and distinct procedures. This notion was advanced for the first time in the Order under appeal.

To the contrary, the record overwhelmingly demonstrates the QA process and the corrective action process are one and the same. The corrective action process is a continuation of the QA process, as a corrective action may follow an adverse QA review. The Hospital asserted the authority of both the Order and the Bylaws when Dr. Shah was sent

for corrective action. In the letter to Dr. Shah the Chief of Staff wrote, "the Medical Executive Committee ("MEC") . . . pursuant to the Order and Addendum I to the Medical/Dental Staff Bylaws, Rules and Regulations ("Medical Staff Bylaws") voted . . . to initiate corrective action against you." {R. 723-724} Corrective action cannot be separated from QA. Corrective action is QA. In fact, at the hearing the Hospital admitted into the record all transcripts, hearing committee reports, correspondence, and other materials related to the corrective action proceeding instituted against Dr. Shah. Additionally, throughout the QA and corrective action process the MEC (in their meetings), the Hearing Committees (during the hearings and in their reports), and the Chiefs of Staff (in their testimony and correspondence) all made reference to the need for compliance with both the Bylaws and the Settlement Orders. {R. 904-912; 916-917; 920-921; 923-924; 925-927; and 975-980} Moreover, the CEO of the Hospital boasted of the plan to "get rid of Dr. Shah . . . for QA." {R. 832} This can only be done through corrective action.

The result of this erroneous ruling resulted in the Circuit Court's failure to consider or address clear and convincing evidence of the Hospital's contemptuous conduct. By ruling that the Settlement Orders only applied to the "first stage" of QA, the Circuit Court disregarded evidence of the Hospital's reliance on 35 emergency room cases not reviewed by Dr. Selby, the Hospital's failure to obtain a final report and opinion from Dr. Selby on the case of Patient X, and the unfair imposition of a required psychological evaluation in clear violation of the Bylaws. These are the very issues the Circuit Court earlier found to be properly before it at the hearing and which were to be addressed on the merits. {R. 678-681}

**IV. THE CIRCUIT COURT ERRED IN RULING THE SETTLEMENT ORDERS DID NOT REQUIRE THE HOSPITAL TO FOLLOW ITS BYLAWS.**

The Circuit Court erred in ruling violations of the Hospital's Bylaws cannot be grounds for a finding of contempt. The Circuit Court's Order states: "Plaintiff's true argument is based on alleged violations of the hospital's Bylaws and Policies, which cannot be the basis for contempt." {R. 43, fn. 7} This ruling overlooks the clear requirement in the Settlement Orders that the Hospital must follow its Bylaws in its dealings with Dr. Shah. {R. 13-15}

The Hospital's disregard for the provisions of the Bylaws and the procedures contained therein resulted in clear violations of the Settlement Orders. The Supplemental Order provided "the Hospital advises that its [Bylaws] . . . are generally applicable to members of the Department . . . all physicians on the Hospital's Medical Staff must follow these Bylaws" and "Administrative Requirements should be addressed through the procedures set forth in the Bylaws and Policies." {R. 13-14} The Settlement Orders additionally required the Independent Outside Reviewer be provided with a copy of the Bylaws in conjunction with his review of Dr. Shah's medical cases. {R. 18}

At the hearing, the Hospital did not argue the Settlement Orders did not require compliance with the Bylaws. To the contrary, the record is replete with evidence the Hospital knew and understood the Settlement Orders required it to comply with its Bylaws. For example, counsel for the Hospital stated at the hearing "[i]f I'm reading the Supplemental Order correctly and reading the references to the Bylaws, the Hospital is required to handle administrative requirements in accordance with the Bylaws." {R. 562}

The Bylaws also apply to the issue of the required psychological evaluation. Pursuant to the Bylaws, a physician must be notified of any allegation of disruptive conduct against him through a Statement of Charges. {R. 928} This Article required the Hospital to place

Dr. Shah on notice of any alleged act or omission to be addressed by the committee at the probation hearing. There is no evidence Dr. Shah was placed on proper notice that issues regarding his mental state or psychological stability would be considered by the hearing panel. Dr. Shah testified he was never provided with a Statement of Charges as required by the Bylaws. {R. 711, ¶ 19-20, 22; 928} It is also undisputed Dr. Shah was not advised of any psychological issue before the MEC Probation Hearing Committee ordered in their report that he be required to undergo psychological evaluation. {R. 711, ¶ 19-20, 22; 975-980; and 1023-1024} This lack of notice resulted in Dr. Shah's inability to defend himself. There was a clear violation of the Bylaws.

Accordingly, the Circuit Court erred in ruling violations of the Hospital's Bylaws could not be grounds for a finding of contempt.

**V. THE CIRCUIT COURT MISAPPLIED THE EVIDENCE IT CONSIDERED IN RULING THE HOSPITAL HAD NOT VIOLATED THE SETTLEMENT ORDERS.**

In its Order, the Circuit Court addressed on the merits only three (3) general allegations of contempt. {R. 44-52} Those issues are: (1) The QA Case Selection/Process; (2) The Psychological Evaluation Requirement; and (3) The Patient X Matter. The Circuit Court erred by limiting itself to these three narrow issues. It disregarded, failed to address, and misapplied the evidence relating to the numerous other issues properly before it. Furthermore, the Circuit Court erred in its analysis of the three issues it chose to address.

**(A) The QA Case Selection and Process**

The Settlement Orders contemplated case selection authority would be given to the mutually selected outside reviewer. {R. 2} From the outset, the manner in which the Hospital conducted Dr. Shah's QA was in violation of the Settlement Orders. Dr. Selby was

not granted oversight authority in the case selection process. Rather, Hospital administrator, Karen Hart, gathered certain medical cases, which spanned an extended period of time, for Dr. Selby's review. During a hearing at the hospital, Dr. Selby and other physicians admitted Dr. Selby did not select Dr. Shah's medical cases for review. {R. 939; 949-950} According to Dr. Selby, "In addition to reviewing the specific records I was given - and I did not request any records. They said here is what you look at. These are cases that have been selected by whatever method. Could you look and see what you think of these as questionable cases?" {R. 937}

The evidence presented during the Circuit Court hearing demonstrated some of the medical cases sent to Dr. Selby for review were old cases. They were selected to create a pejorative impression about Dr. Shah. Another vascular and interventional radiologist, Dr. Timothy Close stated in his affidavit that a review of a selected group of his cases gathered over the years would make him appear incompetent {R. 844, ¶ 18} The purpose of QA is to review current cases handled by a physician with the goal of improving patient care. {R. 841, ¶ 10} Dr. Selby was asked to review and render opinions on procedures Dr. Shah was no longer performing, such as breast biopsies. Dr. Selby was also improperly sent cases involving issues which were administrative in nature and, pursuant to the Settlement Orders, should have been sent exclusively to the Chief of the Radiology Department. {R. 15}

The Circuit Court erroneously ruled Dr. Shah presented no evidence that "Karen Hart deviated from the established selection protocols and procedures," with regard to the selection of cases for QA review by Dr. Selby. {R. 46} The Settlement Orders substantiate Dr. Shah's position regarding case selection. These Settlement Orders unequivocally grant the outside reviewer oversight authority with regard to the selection of cases to ensure they

are selected in a manner that is consistent with Hospital policies and to eliminate discrimination. {R. 2} Dr. Selby's testimony indicating the cases were selected by "whatever" method clearly proves he was not involved in the selection of cases for review, and in fact, had no knowledge about what the selection process entailed. {R. 937} Therefore, it can not be said the Settlement Orders were complied with and that fairness and impartiality were exercised with regard to the selection of Dr. Shah's medical cases for QA review.

Additionally, in the report issued by the Probation Hearing Committee, the panel members acknowledged the old medical cases sent to Dr. Selby for review were not a fair measurement of Dr. Shah's clinical skills. Accordingly, they found "a random audit of invasive procedures performed by Dr. Shah from this point forward would, in the judgment of the Committee, be a *fairer measurement of clinical competence than a retrospective review looking back from this point in time.*" {R. 977} The Probation Hearing Committee ordered "a random audit of fifteen percent (15%) of all invasive procedures should be carried out ... *as required by Judge Keesley's Order*, the selection shall be done under the direction of Dr. Bayne Selby." (*Id.*) (emphasis added). This is a tacit admission the Orders had not been previously followed. After this report, the Dr. Selby selected Dr. Shah's cases. This resulted in the four "Fairer Measurement Reports" discussed previously herein<sup>5</sup>. The report issued by the Probation Hearing Committee and the subsequent change of procedure for selection of the cases is an acknowledgement by the Hospital that the Settlement Orders' requirements were not met.

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<sup>5</sup> See Section The "Fairer Measurement" Reports and the Hospital's Concealment of Their Findings, supra.



The Settlement Orders required the Hospital to conduct Dr. Shah's QA "as similar as possible to the customary and prevailing procedure" followed for all other persons on the medical staff. {R. 17-18} The Hospital should have utilized a "community standard" to compare Dr. Shah to his peers. {R. 1071, ¶ 37} Prior to the MEC's decision to recommend Dr. Shah for corrective action, Dr. Selby specifically requested members of the MEC establish a "community standard" to fairly compare Dr. Shah to his peers. {R. 904} Dr. Selby stated knowing the total number of procedures performed by Dr. Shah would enable him to determine a more accurate percentage of misreads {R. 876} He added "it might be useful for the executive committee to compare this [Dr. Shah's QA results] to other radiologists quality assurance records to ascertain what a 'community standard' might be." {R. 904}

The Hospital knew such comparative data was necessary and important. MEC meeting minutes of January 21, 2004, February 2, 2004 and February 25, 2004 reflect the committee's expressed desire to receive data from the radiology department in order to compare Dr. Shah to his colleagues. {R. 914; 917-918} These requests for comparative data were made by the MEC prior to their initiation of corrective action on April 5, 2004.

Despite this representation, the Hospital failed to gather such comparative data. MEC meeting minutes of April 5, 2004, detail a discussion between the members regarding the fact that no other radiologist at the Hospital was being subjected to formal QA reviews. {R. 921} The Chief of Staff admitted during the Termination Hearing that comparative data was not evaluated in order to determine whether Dr. Shah's standards were lower than those of his colleagues prior to the initiation of his corrective action. {R. 1849-1850} This is in direct

contradiction of the edicts of the Bylaws and the directive of the Settlement Orders. {R. 13-15; 19 and 919}

The Circuit Court refused to consider this evidence. Rather the Circuit Court mischaracterized the issue by stating Dr. Shah complained that “his review was done by a single reviewer rather than a group of radiologists.” {R. 47} This statement is clearly incorrect. It is also factually unsupported. Dr. Shah never asserted any such complaint either in his Petitions or during the Circuit Court hearing. Dr. Shah agreed for his QA to be done by a single Independent Outside Reviewer so long as the process was fair and done in a manner comparable to the process used for the other radiologists. This was the express purpose of the Settlement Orders. The evidence proves this was not done. As such, the Circuit Court failed to consider evidence related to the initial case selection process which violated the Settlement Orders.

**(B) Dr. Shah Was the Only Radiologist Subjected to QA Review**

Regular and proper QA is required by hospital licensing authorities and is a prerequisite for participation in federally-funded health care programs. The purpose of the Settlement Orders was to ensure Dr. Shah would not be discriminated against during the QA process. However, during the relevant extended period of time, Dr. Shah was the only radiologist subjected to QA review. The Radiology Department was not performing any QA reviews. {R. 914; and 921} The Circuit Court’s justification for there being no QA by or on any of the other radiologists was “*ongoing controversy among the radiologists.*” {R. 47}(emphasis added). There is no evidence in the record to support this gratuitous part of the Order. When the MEC was made aware there was no other QA in the radiology department, it instructed the department to begin formal QA reviews so comparative data could be

obtained. This was not done. Despite this directive, other members of the radiology department were still not required to undergo formal QA reviews. {R. 914; 921; and 1853}

**(C) Psychological Evaluation Requirement<sup>6</sup>**

The Circuit Court erroneously found the late imposition of a psychological evaluation requirement on Dr. Shah was not a violation of the Settlement Orders because “nothing in the Settlement Order imposes any limitations or requirement on the FHC’s or MEC’s power or discretion to impose conditions of probation.” {R. 49} This finding is wholly inconsistent with the evidence and the underlying settlement orders.

The Hospital’s imposition of a psychological evaluation on Dr. Shah was a direct violation of the Settlement Orders, because the Hospital was required to follow the Bylaws. The Bylaws include a procedure for handling such matters. As the Hospital’s counsel pointed out, “if I’m reading the Supplemental Order correctly...the Hospital is required to handle administrative requirements in accordance with the Bylaws.” {R. 562} Likewise, the Hospital was required by the Settlement Orders to follow the Bylaws in mandating Dr. Shah undergo a psychological evaluation. {R. 14-15}

Issues regarding alleged behavioral problems exhibited by a physician are not traditionally included in the medical QA process. The Circuit Court recognized this fact when the Settlement Orders were entered. The Supplemental Order defined Administrative Requirements to include: “(a) medial record documentation; (b) *behavioral guidelines*; (c)

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<sup>6</sup> It is important to note the imposition of a psychological evaluation is highly stigmatizing to a physician. Applications for privileges and recertification of privileges routinely require disclosure of any such testing or treatment. {R. 992} Physicians are forced to defend against psychological evaluations in future applications for employment and privileges. Other radiologists agreed this requirement would stigmatize Dr. Shah’s practice and his reputation and that it had been unfairly required of him. They also agreed Dr. Shah was justified in refusing to undergo this evaluation. {R. 711-712, ¶ 21; 725-734}

staff interaction and utilization; (d) responses to requests for information; (e) timely completion of reports; and (f) timely response to complaints.” {R. 14} (emphasis added). The Supplemental Order went on to state, “such Administrative Requirements should be addressed though the procedures set forth in the Bylaws and Policies.” (Id.)

The Bylaws specifically required the Hospital to place Dr. Shah on notice of any behavioral issues which would be addressed at the hearing by the committee. {R. 928} The Hospital did not comply with this requirement. In fact, the Hospital Chief of Staff admitted Dr. Shah was never given notice of any behavioral issues. {R. 1023-1024} The first “notice” Dr. Shah received of such issues was when the Hearing Committee rendered its report requiring him to undergo psychological evaluation. {R. 978; 980} During the circuit court hearing on this matter, the Hospital never disputed the claim Dr. Shah did not receive proper notice. Instead, the Hospital argued, “He didn’t get notice of the ultimate decision. Actually, nobody on the MEC or at the hospital got notice of the ultimate decision until this fair hearing committee report came out after they deliberated and put that term of probation in there. He [Dr. Shah] got the same notice the hospital did in that regard.” {R. 628} Of course the notice requirement was Dr. Shah’s right, not the Hospital’s. The evidence shows the Hospital had been contemplating some sort of evaluation and therapy for Dr. Shah for quite some time. {R. 659-661}

The Hospital claimed Dr. Shah was a “disruptive” physician and should have known this was an issue. {R. 625-627} This does not meet the notice requirement contemplated by the Bylaws. If Dr. Shah was a disruptive physician, the Hospital had a clearly-detailed and well-established policy contained in the Bylaws entitled the “Disruptive Conduct Policy,” which should have been utilized to deal with such behavior. {R. 932-936} This Policy

contains specific provisions and procedures that had to be followed in dealing with alleged behavioral problems. Those procedures included a meeting with the physician and documentation of such occurrences constituting the alleged disruptive behavior. (Id.). MEC meeting minutes establish the Hospital routinely used the Disruptive Conduct Policy in dealing with other physicians. In those cases it provided providing a written notice of the behavior requiring remedy. {R. 931} The Hospital failed to comply with the Court Orders because it did not follow the notice requirements contained in the Bylaws. It also never referred this issue to the Chief of the Department. The Court Circuit erred in failing to consider this evidence. Its ruling is without evidentiary support.

The actions of the Hospital are analogous to the situation in Huellmantel v. Greenville Hospital System, 303 S.C. 549, 402 S.E.2d 489 (Ct. App. 1991). In Huellmantel, the Court of Appeals held the hospital failed to provide Dr. Huellmantel with due process to challenge the imposition of a psychiatric evaluation. Dr. Huellmantel was not put on notice of any claim warranting psychological care and was not afforded the opportunity to refute this allegation with witnesses, testimony, or evidence. Dr. Huellmantel's only recourse was the hospital's internal "appellate review," which did not allow for the presentation of additional evidence.

The same is true here. As in Huellmantel, after the Hospital imposed the requirement of psychological evaluation, Dr. Shah appealed this decision to the Hospital's Board pursuant to the Bylaws. This appeal was an internal "appellate review" that did not allow Dr. Shah to present evidence<sup>7</sup>. At the hearing before the Board, Dr. Shah was not afforded the

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<sup>7</sup> Addendum I, Section 9.1 of the Bylaws provides, "The proceedings by the review body shall be in the nature of an appellate review based upon the record of the hearing before the

opportunity to refute the issue of psychological evaluation by the presentation of witnesses, testimony, or evidence. Just as the Greenville Hospital System failed to provide Dr. Huellmantel due process, the Hospital denied Dr. Shah the due process rights contractually provided by the Bylaws, as required by the Court Orders. In the end, the Hospital upheld Dr. Shah's termination, in part, for his failure to comply with this requirement, notwithstanding the fact it was wrongfully imposed. {R. 1020} It even claimed this matter "standing alone" warranted Dr. Shah's termination. (Id.).

**(D) "Patient X"**

The facts related to this matter are discussed elsewhere herein (p.14). The Hospital's handling of the case of Patient X represents clear evidence of contempt. In reaching its conclusion the Hospital did not violate the Settlement Orders as to Patient X, the Circuit Court misapplied the evidence. {R. 49-53} Its ruling is without evidentiary support.

Initially, the Circuit Court found "Plaintiff never contacted or met with the Outside Reviewer" {R. 51} This finding is clearly incorrect. Dr. Selby's Preliminary Report indicates he conferred via telephone with Dr. Shah, but agreed an in-person review (with the films present) was required before any conclusion could be drawn. {R. 1015-1017} However, the Hospital chose to ignore this recommendation for an in-person review and proceeded with their December 13, 2006 hearing to uphold the termination of Dr. Shah's medical staff privileges based in part on this decision.

The Circuit Court erred in failing to consider the evidence that the Hospital determined Dr. Shah breached a standard of care without first obtaining a decision from Dr. Selby. In his Preliminary Report, Dr. Selby explained his cursory review of this case

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hearing committee, that committee's report, and all subsequent results and actions thereon." {R. 1005}

revealed Dr. Shah was most likely presented with the wrong x-rays by Hospital personnel. (Id.) Having by then reviewed hundreds of Dr. Shah's accurate x-ray readings, Dr. Selby had a basis to make this statement. The Supplemental Order required the Outside Reviewer to review all cases and then render a "Decision." The Supplemental Order provided, in relevant part:

The outside reviewer shall use his best efforts to complete the review process, complete the written clinical review forms, and deliver a written report with recommendations (where appropriate) (collectively, the "Decision") within the customary time frames.

Upon receipt of the Decision, the MEC shall determine what action, if any, should be taken, pursuant to section 10.2.2(b) of the Bylaws, including, but not limited to, whether or not the matter should be referred for corrective action in accordance with Addendum 1 to the Bylaws.

If a corrective action, pursuant to Addendum 1 of the Bylaws, is initiated by the MEC or otherwise initiated from matters previously evaluated by the outside review, the actions required by the Chief or the Department in sections 1.2, 1.3 and 1.4 of Addendum 1 to the Bylaws shall be deemed to have been satisfied by the Decision.

Similarly, if a corrective action is initiated against Dr. Shah pursuant to Addendum 1 to the Bylaws that involves a QA matter not previously evaluated by the outside reviewer, the MEC shall send the matter to the outside reviewer, pursuant to the QA Process outlined above, and his Decision will be deemed to satisfy the obligations of the Chief and/or the Department under sections 1.2, 1.3, and 1.4 of the Bylaws.<sup>8</sup>

{R. 19-20}

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<sup>8</sup> Sections 1.2, 1.3 and 1.4 of the Hospital Bylaws deal specifically with the appropriate steps to be taken by the Chief of the Department during the initiation of a corrective action. {R. 919} Per the Supplemental Order, the Independent Outside Reviewer would be involved in this process in lieu of the Chief of the Radiology Department. During the initiation of a corrective action, the Hospital would still be required to comply with Addendum I, Section 1.1.

The Hospital disregarded this procedure and ignored Dr. Selby's request to meet with Dr. Shah. Without any "Decision" per the Bylaws, the Hospital voted to summarily suspend Dr. Shah and recommended revocation of his clinical privileges based upon the Patient X case. The Hospital's decision to circumvent Dr. Selby and terminate Dr. Shah based upon its own conclusion about Patient X is overwhelmingly violative of the Settlement Orders.

The evidence reveals that prior to sending this case to Dr. Selby for review, the Hospital—through its own review of the x-rays and medical records of Patient X—prematurely determined Dr. Shah had breached a standard of care. {R. 1011} After Dr. Selby rendered his Preliminary Report, the Hospital arbitrarily concluded Dr. Shah had deviated from the standard of care without obtaining a final "Decision" from Dr. Selby, as required. Evidence affirming the Hospital's use of the Patient X case is included in the Report of the Fair Hearing Committee: "During deliberations, *the Hearing Committee reviewed the CT film of [Patient X's] abdomen and pelvis . . . and [found] that Dr. Shah's failure to note an obvious pelvis mass of 12 cm in and of itself establishes deficiencies in his clinical skills.*" {R. 1020} (emphasis added). The Hospital unilaterally made this finding without the requisite input of Dr. Selby.

Pursuant to the provisions in the Supplemental Order, any corrective action stemming from the Patient X case could have occurred only after Dr. Selby rendered his "Decision." The only opinion given by Dr. Selby was, essentially, no medical conclusions could be drawn until after further review of the case. The Hospital failed to comply with the Supplemental Order because it totally disregarded the role of the Independent Outside Reviewer.



For these reasons, the Circuit Court erred in concluding the Hospital did not violate the Settlement Orders in terminating Dr. Shah's privileges based on its review of the "Patient X" case.

**VI. THE CIRCUIT COURT ERRED IN RULING IT WAS IMPROPER FOR THE COURT TO BE INVOLVED IN THE "INTRICACIES" OF THE HOSPITAL'S BUSINESS**

The Circuit Court concluded it "cannot, and will not become involved in the 'intricacies'" of the Hospital and failed to address issues it perceived as falling into this category. {R. 40; 49; and 53} The Circuit Court also found the directives set forth in the Settlement Orders were too general to support a contempt claim. {R. 37} These findings ignore the purpose of the Settlement Orders. The Hospital expressly and voluntarily agreed to the Consent Order of 2001. The subsequent Supplemental Order arose from the Hospital's request for clarification of issues contained in the Consent Order. The Order also erroneously refers to these Settlement Orders as the "unappealed Settlement Orders." {R. 49} These Settlement Orders were *consent* orders, agreed to by both parties. Terms of a consent order are not subject to appeal. Johnson v. Johnson, 310 S.C. 44, 425 S.E.2d 46 (Ct. App. 1992) (a consent order is an agreement of the parties, under the sanction of the court, and is to be interpreted as an agreement and cannot be attacked by the parties on direct appeal). Additionally, the Settlement Orders set forth the procedure to be followed should the parties have a dispute, namely a Petition for Rule to Show Cause. To find now that Dr. Shah's failure to "appeal" these Settlement Orders bars the Court from intervening to ensure compliance with their stated terms is an illogical mischaracterization of their nature and purpose. It also constitutes a clear error of law.

The Circuit Court also improperly concluded it was not to be “involved in the intricacies” when the Court created and agreed to oversee a proper framework for the treatment of Dr. Shah in the future with regard to the QA process. {R. 40} The Court specifically maintained jurisdiction and expressly allowed the parties to seek court intervention, in the form of a Rule to Show Cause, should a dispute arise over compliance with the terms of the Settlement Orders. {R. 2} Without the Court’s involvement and ability to enforce the terms of the Settlement Orders, a settlement such as this is rendered meaningless. Dr. Shah was not asking the Court to act as an “administrator” of the Hospital; rather, he was petitioning the Circuit Court to require the Hospital to comply with the terms of the Settlement Orders it voluntarily entered into to settle the earlier case Dr. Shah brought against it.

The Circuit Court’s ruling undermines the over-arching and stated purpose of these orders. The Hospital agreed to treat Dr. Shah fairly in the future as part of the settlement of his lawsuit. Since Dr. Shah had the largest and most profitable radiology practice at the Hospital and read more x-rays than any other radiologist, the planned exclusive contract with a new group of radiologists would be frustrated by his continued large practice. {R. 704, ¶¶ 2-4; 843-844, ¶ 17} The Settlement Orders were designed to protect Dr. Shah from the Hospital’s attempt to remove his privileges through a malicious peer review proceeding. Finally, after fifteen years, the Hospital obtained what it initially sought to achieve, namely to remove Dr. Shah and to “starve him out in legal fees.” {R. 836}

## CONCLUSION

Judicial enforcement of court orders, especially consent orders, which create rights of the citizens, should be swift and sure. Anything less undermines the rule of law.

Despite the requirement of the Settlement Orders that all future QA reviews of the medical cases of Dr. Shah would be reviewed by a mutually-agreed upon Independent Outside Reviewer, the Hospital unilaterally conducted its own QA review on 35 emergency room cases. None of these cases were selected or reviewed by Dr. Selby, the Independent Outside Reviewer.

Despite the requirement of the Settlement Orders that any matter sent for corrective action not previously reviewed by the Independent Outside Reviewer must be sent to him for a "Decision" in order to fulfill the requirements of the Hospital Bylaws, the Hospital decided Dr. Shah mishandled the case of "Patient X." The Hospital utilized this internal determination as a basis upon which to terminate Dr. Shah's privileges. The Hospital disregarded the Preliminary report of Dr. Selby requesting further review and never obtained his "Decision" as required by the Settlement Orders.

Despite the requirement of the Settlement Orders that all Administrative Requirements, including behavioral guidelines, be handled by the Chief of the Department in accordance with the Bylaws, the Hospital imposed a requirement for a psychological evaluation on Dr. Shah. The imposition of this requirement came without the requisite notice and proper documentation Dr. Shah was entitled to under the Bylaws.

This is a case about a Hospital which waged a relentless attack on a highly competent, twenty-nine year veteran, well-respected, highly qualified vascular and interventional radiologist with the most successful practice at the Hospital. The Hospital continued its

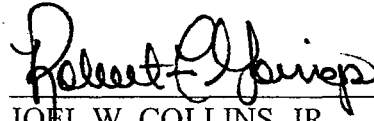
admitted campaign to starve Dr. Shah out in legal fees using the QA process. Having such a highly successful independent radiologist in the Department was not consistent with the Hospital's plan to award an exclusive contract for all radiological services to a single group.

The rulings of the Circuit Court contain factual findings which lack evidentiary support. These rulings were also based on errors of law. Affirming the Circuit Court's flawed rulings would be a blow to the rule of law and the fair administration of justice in the Courts of South Carolina.

**[SIGNATURE PAGE TO FOLLOW]**

Respectfully Submitted,

COLLINS & LACY, P.C.

A handwritten signature in black ink, appearing to read "Robert F. Goings", is written over a horizontal line.

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APPELLANTS' BRIEF

Columbia, South Carolina  
March 29, 2011

THE STATE OF SOUTH CAROLINA  
In the Court of Appeals

---

APPEAL FROM RICHLAND COUNTY  
Court of Common Pleas  
Doyet A. Early, III, Circuit Court Judge

---

Case No. 1996-CP-40-0271

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Paresh Shah, M.D. and Paresh Shah, M.D.,  
P.A.....Appellants,

v.

Palmetto Health.....Respondent.

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**PROOF OF SERVICE**

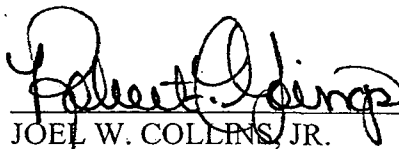
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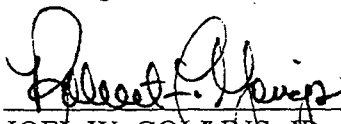
Palmetto Health.....Respondent.

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CERTIFICATE OF COUNSEL

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The undersigned certifies that Appellants' Brief compiles with Rule 211(b) SCACR and the Supreme Court Order of August 13, 2007.



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March 29, 2011



THE STATE OF SOUTH CAROLINA  
In the Court of Appeals

APPEAL FROM RICHLAND COUNTY  
In the Court of Common Pleas

Deputy A. Early, III, Circuit Court Judge

Case No. 1986-CP-46-2271

Patrick Shah, M.D., and Patrick Shah, M.D., F.A., .....Appellants,

v.

Palmetto Health, .....Respondent.

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## STATEMENT OF ISSUES

1. Judge Early correctly ruled that the Settlement Orders are the law of this case.
2. Judge Early correctly interpreted his 2008 Consent Order and the Settlement Orders by Judge Keesley to hold that: (1) the only matters before him were the issues raised in the pending contempt motions filed in the 1996 Action; and (2) the judicial intrusion into the Peer Review Process was limited to the first step in that process, i.e., the QA review of Shah's cases.
3. Judge Early correctly stated South Carolina's law on contempt and correctly found that Shah had failed to prove the essential element of willfulness in all of his contempt claims.
4. Judge Early correctly held that state and federal law precluded Shah's requested relief, even if one assumed Shah had proven his claims.
5. Judge Early correctly held that South Carolina law precluded Shah's contempt claims based on alleged violations of Hospital's Bylaws.
6. Judge Early correctly rejected Shah's contempt claims.

## STATEMENT OF CASE

This contempt action arises from litigation that began in 1996. Appellant (Shah) sought a finding of contempt against Respondent (Palmetto) for alleged violations of three court orders related to the 1996 litigation. After a full evidentiary hearing, the trial court held that Shah had not proven the elements of contempt by the requisite clear and convincing evidence. Shah appeals.

Shah was a radiologist with privileges at a hospital operated by Palmetto. A dispute arose between them, and Shah sued Palmetto in 1996. The parties ultimately settled this litigation, and the settlement included the entry of a Confidential Consent Order of Settlement (R. 1-11) that altered the ordinary Quality Assurance (QA) review of Shah's cases. The parties could not agree on the implementation of the 2001 Consent Order, so Palmetto moved for clarification of the Consent Order and, after a contested

hearing, the court issued a 2003 Supplemental Order. Shah moved for reconsideration, which the court denied in its 2003 Reconsideration Order. Shah did not appeal the Supplemental Order or the Reconsideration Order.

Shah filed three motions for contempt against Palmetto, alleging Palmetto had violated the three prior orders (“the Settlement Orders”). The court never heard the motions and Shah again sued Palmetto in 2006. Shah’s 2006 complaint repeated the allegations made in the three contempt motions and also made additional allegations. Discovery proceeded in the 2006 action, and it was scheduled for trial on November 10, 2008. At a November 4, 2008 motions hearing in the 2006 Action, the parties announced they had agreed to dismiss the 2006 Action and proceed on the contempt motions in the 1996 Action. The trial court entered a 2008 Consent Order to this effect<sup>1</sup> and later heard the contempt claims. Shah submitted affidavits but did not testify at the hearing. The trial court denied all motions for contempt. (R. 29-53). Shah moved for reconsideration, and the trial court denied the motion. (R. 262-277; 54). Shah timely appealed.

### STANDARD OF REVIEW

The issue of contempt for violation of a court order resides solely in the discretion of the trial court and will not be reversed absent an abuse of discretion. *Ex parte Cannon*, 685 S.E.2d 814, 823 (S.C. App. 2009). A trial court abuses its discretion when its decision is based upon an error of law or its decision is wholly without any evidentiary support. *Id.* at 823. The appellant bears the burden of proving the trial court’s decision was controlled by an error of law or wholly without any evidentiary support. *Id.*

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<sup>1</sup> Shah’s “Statement of the Case” violates Rule 208(b)(1)(C), SCACR, in that he argues disputed matters in his Statement, to-wit: the meaning of the 2008 Consent Order. (Init. App. Br. 3).

On appeal, Shah correctly cites the standard of review but ignores it in his appellate arguments. His recitation of the evidence focuses on the evidence that he presented and his spin on the meaning of and inferences from that evidence. Such is not the stuff of reversible error under the abuse of discretion standard. Shah must demonstrate that there is no evidence supporting the trial court's findings, and he must also demonstrate that the evidence presented, as a matter of law, established every element of contempt by clear and convincing evidence. As shown below, the trial court's findings have evidentiary support, the trial court correctly applied the law, and Shah has failed to carry his heavy burden of proving contempt so conclusively that the trial court was required, as a matter of law, to find contempt.

## **STATEMENT OF FACTS AND PROCEDURAL HISTORY**

The 1996 Action began as a dispute between Shah and against Palmetto, Palmetto's President and CEO, Palmetto's Department of Radiology, and three radiologists who were members of the Department of Radiology. Shah and Palmetto settled the 1996 Action in July 2001, and the settlement included entry of the "Confidential Consent Order of Settlement" (R. 1-11). The parties could not agree on how to implement the 2001 Consent Order, which led to two additional orders collectively referred to herein as the "Settlement Orders."

### **A. The "Settlement Orders"**

#### **1. The 2001 Consent Order**

Paragraph 3 of the 2001 Consent Order is relevant here. It first noted that Shah had radiologist staff privileges at Palmetto and was thus required to participate in the Quality Assurance program, which was ordinarily conducted within Palmetto's



Radiology Department by other radiologists, most of whom were members or employees of Palmetto's Radiology Department. (R. 2). Paragraph three altered the typical Quality Assurance (QA) review process by providing that Shah's QA review was removed from Palmetto's Radiology Department and would be performed by a radiologist mutually selected by Shah and Palmetto. This "outside reviewer" would have oversight authority over the process for selecting cases for QA review to insure that cases were selected consistent with Palmetto's established protocols and not in a discriminatory manner. (R. 2, ¶ 3).<sup>2</sup> The order continued the complex civil litigation designation of the 1996 Action as being assigned to Judge Keesley, and it provided the parties could use a "Petition for a Rule to Show Cause" if any dispute arose regarding paragraph three (3) of the order. (Id.).

The parties could never agree on an Outside Reviewer, which resulted in there being no QA review of Shah's cases. To break this impasse, Palmetto petitioned Judge Keesley to resolve the dispute between the parties. (R. 13). Palmetto also sought to resolve the dispute over what matters should be sent for QA review and what matters should be handled under administrative procedures. (R. 13). Judge Keesley resolved these disputes in a 2003 Supplemental Order. (Id.).

## 2. The 2003 Supplemental Order

Judge Keesley first observed that the intent and goal of the 2001 Consent Order was to remove the QA review of Shah's cases from Palmetto's Department of

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<sup>2</sup> The precise language in paragraph three was: "Part of the settlement agreement in this case requires that the Quality Assurance review of Dr. Shah's medical cases *will be removed from the responsibility of the Radiologists who are members of or employed by RRC*. Beginning July 31, 2001, the parties have agreed that *a Radiologist mutually selected by [Palmetto and Shah] will conduct the Quality Assurance reviews of Dr. Shah's cases*. This outside reviewer will have *oversight authority over the case selection process* as well as the cases themselves. The outside reviewer will *insure that the selection process is performed consistent with [Palmetto's] established Quality Assurance protocols and not in a discriminatory manner*. (R. 2, ¶ 3) (emphasis added).

Radiology. (R. 13-14).<sup>3</sup> As to administrative issues, the Chief of the Radiology Department would decide if a matter should be reviewed under the QA Process or through administrative action. (R. 15). The order observed that administrative deficiencies could compromise patient care or Palmetto's ability to conduct its business and, in either case, QA proceedings or corrective action could be instituted. (R. 15, n.1). The Chief had discretion to refer any administrative matter to Palmetto's Chief of Staff or the Medical Executive Committee (MEC) for handling by them. (R. 15). Finally, if an administrative corrective action was commenced, the Chief would handle it initially but had the right to refer the matter back to the MEC. (R. 20).

QA matters and complaints involving deviations from the standards of patient care would be handled by an "outside reviewer" to be selected under procedures set forth in the 2003 Supplemental Order. (R. 15). The review by the "outside reviewer" was to mirror as closely as possible the procedures used for any other person on the Medical Staff. (R. 17-18). To that end, the outside reviewer could, at his option, meet with Palmetto's radiologists, the Chief, and Palmetto's employees involved in the QA process to gain an understanding of how QA reviews were traditionally conducted in the Department of Radiology. (R. 18). The outside reviewer and Shah were to meet at a mutually agreeable time to discuss the cases and complaints assigned for QA review, but if they could not agree, the meeting would be set and held under procedures set forth in the order. (R. 18).

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<sup>3</sup> Judge Keesley specifically stated: "The *QA Process* approved, in the [2001] Consent Order, was intended to provide an independent and impartial QA review of Dr. Shah's cases that *would not involve* the other radiologists within [Palmetto's] Department of Radiology ... who have been litigants in this case. (R. 13) (emphasis added). He later reiterated: "The *stated goal* of the [2001] Consent Order is to *remove* [Palmetto's Radiology Department] and the Chief of the Department ... *from involvement in the QA Process* to ensure fairness, impartiality, and to remove any claim of bias." (R. 14) (emphasis added).

The outside reviewer was to issue a Decision after his QA review, which was deemed to satisfy certain requirements of the Bylaws. The Decision would be sent to the MEC, which would determine whether any action should be taken. (R. 19). If a corrective action was started against Shah involving a QA matter not previously reviewed by the outside reviewer, the matter would be sent to the outside reviewer under the QA Process outlined in the order, and his Decision would be deemed to satisfy certain requirements of the Bylaws. (R. 19-20).

Judge Keesley closed the 2003 Supplemental Order by expressly holding that nothing in the order, or in the 2001 Consent Order, precluded the initiation of any administrative action. (R. 20). Nothing in either order limited the ability of Palmetto to take any administrative action it deemed necessary for the proper administration or management of the hospital or to assure quality patient care. (*Id.*). Shah moved to alter or amend the 2003 Supplemental Order, which Judge Keesley denied in the 2003 Reconsideration Order.

### 3. The 2003 Reconsideration Order

In his motion to alter or amend, Shah's principal complaint was the use of an out-of-town radiologist to be the outside reviewer and the removal of all persons in the Radiology Department (including the Chief) from the QA review process. (R. 57-58 at ¶¶ 2, 4). He made this complaint despite having specifically agreed in the 2001 Consent Order that his QA review would be conducted by a single radiologist. (R. 2, ¶ 3). Shah also complained that not all Decisions by the outside reviewer should be sent to the MEC, and the Chief of the Radiology Department should not be allowed to refer matters to the

Chief of Staff or MEC. (R. 58 at ¶¶ 5-6). At bottom, Shah wanted to be treated like every other doctor at Palmetto.

Judge Keesley denied Shah's motion to alter or amend. (R. 21-22). He observed it was not possible to treat Shah like every other doctor due to the 1996 litigation, but his primary goal in the prior orders was to make it as close as possible to the standard methodology. (R. 21-22). Doing so was difficult due to the complexities in the medical field and the need to fit the solution within the overlay of governmental regulations, medical and hospital standards, and patients' rights. (R. 22). The court could not go any further, because it was "not equipped to function as a doctor or a hospital administrator," and it did not know "all the intricacies involved." (R. 22). Shah did not appeal the 2003 Supplemental Order or the 2003 Reconsideration Order, and these orders therefore became the law of this case. This is important because, as shown below, many of Shah's subsequent complaints and contempt motions were based on his disagreement with the procedures set forth in these three orders (which are often referred to jointly as "the Settlement Orders").

On April 8, 2003, the parties agreed upon a Charleston radiologist (Dr. Selby) to serve as the outside reviewer under the Settlement Orders. (R. 852-853). This marked the beginning of protracted Peer Review Proceedings and Shah's reactions of filing three motions for contempt.

#### **B. The Motions for Contempt**

Shah's First Contempt Motion: On September 19, 2005, Shah filed the first of three contempt motions alleging violations of the 2001 Consent Order and the 2003 Supplemental Order. (R. 59-60; 74-86). These three contempt motions are styled as

a “Petition for Rule to Show Cause” pursuant to the language used in the 2001 Consent Order. (R. 2). In the order appealed here, the court noted that these petitions were more properly viewed as contempt motions (R. 30, n.1), and that term is used herein.

Shah made seven (7) complaints in his September 2005 contempt motion. His basic complaint, already rejected by Judge Keesley in the unappealed 2003 Supplemental Order and 2003 Reconsideration Order, was that his QA review was being done differently than the QA of other radiologists and physicians at Palmetto. Shah’s specific complaints are summarized below.

(1) Shah complained that the results of his QA review by the outside reviewer (Dr. Selby) were being sent directly to the Medical Executive Committee (MEC), and this was not done with other physicians. (R. 85). This is precisely what Judge Keesley ordered in the unappealed 2003 Supplemental Order. (R. 19). Shah made this same complaint to Judge Keesley in his motion to alter or amend the 2003 Supplemental Order (R. 58, ¶ 5), and Judge Keesley denied it in the unappealed 2003 Reconsideration Order.

(2) Shah complained that his QA review, unlike the QA review for other radiologists, did not include a discussion amongst and vetting by other radiologists in Palmetto’s Department of Radiology. (R. 82-85). The use of a single reviewer without any involvement by other radiologists in Palmetto’s Department of Radiology is precisely what Judge Keesley ordered in his unappealed 2003 Supplemental Order. Shah made this same complaint to Judge Keesley in his motion to alter or amend that order (R. 57-58, ¶¶ 2, 4), which Judge Keesley denied in the unappealed 2003 Reconsideration Order.

(3) Shah complained that he was placed on probation despite the absence of any such recommendation by the outside reviewer. (R. 77-78). Judge Keesley’s

unappealed 2003 Supplemental Order expressly provided that the MEC would decide whether any action should be taken, including but not limited to corrective action, based on the report and decision by the outside reviewer. (R. 19). Nothing in this order, or any other order, required a recommendation from the outside reviewer as a condition precedent to the MEC taking any such action. The outside reviewer was free to make recommendations "where appropriate," but such was not required for any MEC action. (*Id.*). Nothing in any of the Settlement Orders limited the MEC's authority in any way.

(4) Shah complained that the outside reviewer never met with Palmetto's Radiology Department to discuss the QA process and standards. (R. 84). Nothing in the Settlement Orders required the outside reviewer to do so. Judge Keesley's unappealed Supplemental Order stated the outside reviewer could do so, but this was "at his option" and only "if he so desires." (R. 18).

(5) Shah complained that he was being subjected to QA review by the outside reviewer at a time when QA reviews were not being done in Palmetto's Radiology Department for other radiologists. (R. 83-84). Nothing in the Settlement Orders conditioned the QA review of Shah's cases upon there also being QA review of other radiologists being conducted at the same time in the Radiology Department. As shown later, such QA's were being conducted when possible.

(6) Shah complained that the outside reviewer did not select the cases to be reviewed by him and did not exercise any oversight authority over case selection. (R. 78-81). Nothing in any of the Settlement Orders required the outside reviewer to select the cases. The 2001 Consent Order gave him "oversight authority" over the case selection process for the express and sole purpose of insuring that cases were selected in the same

fashion as selected for other physicians at Palmetto. (R. 2 at ¶ 3. Here, Judge Early found the cases were selected in a manner consistent with that used for all other physicians and in compliance with Palmetto's protocols and procedures, which is the only requirement imposed by Judge Keesley's unappealed orders. As shown later, ample evidence supports this finding, and this satisfies the any evidence standard of review applicable here. Moreover, assuming any failure by the outside reviewer to properly oversee the case selection process, that duty was imposed upon him and any failure by him to do so cannot be the basis for contempt against Palmetto, as also found by Judge Early. Judge Early also found that Palmetto fully complied with any requests by the outside reviewer.

(7) In a related matter, Shah complained the cases had been selected by Karen Hart, and that she had "stockpiled" cases against him to be reviewed by the outside reviewer. (R. 79-80). As shown later, these "stockpiled" cases were the cases that accumulated under the standard case selection process between the 2001 Consent Order, which required review by an outside reviewer, and the ultimate selection of the outside reviewer after the 2003 Supplemental Order. Nothing in the Settlement Orders required the outside reviewer to select the cases, and nothing in the Settlement Orders prohibited case selection in the ordinary manner by the person charged with doing so for other physicians. To the contrary, the 2001 Consent Order expressly required that the cases be selected in the same manner as other physicians, and the outside reviewer's "oversight authority" was given to insure this happened. Here, Judge Early found Karen Hart had properly selected the cases in compliance with Palmetto's standard procedures, and that the "stockpiled" cases were accumulated in accordance with those same procedures during the hiatus of QA review caused by the delay in selecting an outside reviewer.

Ample evidence supports this finding, and this satisfies the any evidence standard of review applicable here.

Shah's Second Contempt Motion: On December 20, 2005, Shah filed his second contempt motion. (R. 87-94). This motion added new complaints to the seven (7) complaints presented under the September 2005 motion, contending these new complaints showed violations of the Supplemental Order on the handling of administrative matters. (R. 87, 89). Shah's specific complaints are summarized below.

(1) The MEC had accepted the outside reviewer's recommendation that Shah receive education on all current administrative rules that he constantly violated with a subsequent review for compliance at a failure rate of less than 5%. Shah complained that the outside reviewer should not have been asked to hear and decide administrative issues, and that doing so violated the 2003 Supplemental Order. Rather, those issues should have been referred to the Chief of the Radiology Department. (R. 91-92). As shown later, the Chief approved sending the cases to the outsider reviewer for QA review, and this was the only thing required under the Settlement Orders.

(2) Shah complained that the imposition of the psychological evaluation requirement violated the 2003 Supplemental Order in that it involved an administrative issue that should have been handled by the Chief of the Radiology Department. (R. 92-93). He further complained that the MEC's November 2005 recommendation to revoke privileges was based on his failure to abide by the psychological evaluation requirement (it being undisputed that Shah refused to undergo the required evaluation). (R. 93). As shown later, the MEC acted properly.



(3) Shah's overriding complaint was that all of the foregoing matters were administrative issues that "were exclusively within the purview and jurisdiction of the Chief of the Radiology Department" under the 2003 Supplemental Order, and that the procedures set forth in that order had not been followed. (R. 93-94). He complained these matters were never referred to the Chief, and the Chief never referred these matters back to the MEC for outside review. (R. 91). As shown later, there was no contemptuous conduct by Palmetto.

Shah's Third Contempt Motion: This April 2006 motion restated complaints from the prior motions and added new complaints. (*Id.*). Shah's complaints are summarized below.

(1) In his "Violation Number One," Shah complained that the outside reviewer did not select the QA cases to be reviewed, that he was placed on probation without a recommendation for such from the outside reviewer, that Karen Hart had selected and "stockpiled" the QA cases, and that the outside reviewer had not exercised his "oversight authority" over the case selection process. (R. 101-103). Shah had made these same complaints in his first contempt motion.

(2) In his "Violation Number Two," Shah complained the outside reviewer did not use any "recognized standards" in reviewing Shah's cases. He asserted this was a violation of the 2001 Consent Order, but this assertion is based upon a misleading and incomplete quote from that order, and a misreading of that order. Shah complained:

[Palmetto] failed and refused to comply with the Court's [2001 Consent] Order *that the* Quality Assurance review of Dr. Shah's cases should be "performed consistent with [Palmetto's] established quality assurance protocols and not in a discriminatory fashion."

(R. 103, *quoting* R. 2) (emphasis added). The quoted language from the 2001 Consent Order pertained to the case selection process, not the outside reviewer's QA review of Shah's cases: "The outside reviewer will insure that *the case selection process* is performed consistent with [Palmetto's] established quality assurance protocols and not in a discriminatory fashion." (R. 2) (emphasis added). Judge Keesley never imposed any particular standard upon the outside reviewer's QA review of Shah's cases. (See "Settlement Orders," *passim*).

Shah's complaint vacillates between national standards, community standards, and standards used within Palmetto's Department of Radiology, but he appears to focus on the Department standards. (R. 103-106). Those standards, however, could not be applied to Shah's cases, because those standards were the product of vetting within the Department amongst the other radiologists, and the entire purpose of the Settlement Orders was to remove the review of Shah's cases from these other radiologists. (See R. 104-105).

Shah also argued that "standards of review" were imposed upon the outside reviewer in the 2003 Supplemental Order.<sup>4</sup> To support this argument, he quotes but again misreads that order:

... every effort should be made to make the review as similar *as possible* to the customary and prevailing procedures followed for any other person on the Medical Staff ... [R. 105, *quoting* R. 17-18 (emphasis added)]

The outside reviewer shall also be given the *opportunity, at his option*, to witness a Quality Assurance meeting in the Department and shall be given the *opportunity (if he so desires)* to meet with radiologists (on the Hospital's Medical Staff), the Chief of the Department and Hospital employees involved in the QA Process to assist him in gaining an

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<sup>4</sup> Shah also complained the MEC did not use "community standards." (R. 105). The Settlement Orders did not reach the MEC proceedings in any fashion, including but not limited to what standards were to be used by the MEC. (See "Settlement Orders," *passim*).

understanding of the manner in which Quality Assurance reviews are traditionally conducted with the Department. [R. 105-106, *quoting* R. 18 (emphasis added)]

It simply was not “possible” to achieve the earlier-noted vetting within the Department and any resulting Department standard, because Shah’s cases had been removed from that vetting process. The outside reviewer was given “opportunit[ies],” that were “at his option” and “if he so desire[d],” but nothing in the order required him to do so. Moreover, were it assumed that the “Settlement Orders” imposed any requirement for any particular standard in the QA review of Shah’s cases (and they clearly did not), that requirement was imposed upon the outside reviewer, not Palmetto, and any assumed violation of that requirement manifestly cannot be a basis for contempt against Palmetto.<sup>5</sup>

(3) In his “Violation Number Three,” Shah complained that a member of the Radiology Department (John Bayard) had reviewed his medical cases in violation of the 2001 Consent Order. (R. 106-107). Shah complains four of these cases were presented to the “Hearing Committee” in December 2005 and “presumably” was part of reason for termination of Shah’s privileges. (R. 107). Shah does not pursue this issue on appeal.

(4) In his “Violation Number Four,” Shah complained that the “Hearing Committee” considered the letter from Patient “X” at its December 2005 proceedings, and this was contempt because the case had not been reviewed by the outside reviewer. (R. 107). He also complained that the case was not referred to the outside reviewer until after the effective date of Shah’s suspension, and despite the outside reviewer’s recommendation for a “more thorough review of [Patient X’s] films,” the Patient X case was used as evidence at Shah’s hearings. (R. 108). And, he continued, this evidence was

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<sup>5</sup> One can only imagine what other contempt motions and grounds Shah would have asserted had Palmetto become involved with the issue of the standards to be applied by the outside reviewer.

mis-used because the Hearing Committee had been misled to believe that only Shah had read the CT Scan, *i.e.*, he complained the Board was not told that two other radiologists had read the CT Scan and agreed with him. (R. 108-109). As shown later, the MEC and FHC were completely justified in their actions regarding Patient X.

(5) In his "Violation Number Five," Shah complained that persons presenting or testifying at his hearings made prejudicial statements against him, which demonstrated that Palmetto had conducted a discriminatory QA Process. He concluded that the "Settlement Orders" were "meant to deter this type of treatment and ensure an unbiased Quality Assurance review" for him. (R. 109-110). As a matter of law, statements made by witnesses in a hearing cannot be the basis for contempt against Palmetto. In any event, Shah does not pursue this issue on appeal.

(6) In his "Violation Number Six," Shah complained that Palmetto violated the 2003 Supplemental Order's provisions regarding administrative matters, because the decision to terminate him was based in part on administrative violations by him, and those violations had not been first handled by the Chief of the Radiology Department. (R. 110). The only specific violation noted by Shah concerned "Q" time reports, which indicated that Shah had the second highest delay in releasing transcribed reports. (R. 111). Shah does not pursue this issue on appeal.

### **C. The 2006 Action**

The complaint in the 2006 Action included all of the complaints made in the three contempt motions in the 1996 Action. The 2006 complaint also added new allegations of violating the Settlement Orders. At a November 4, 2008, motions hearing, the parties announced they had agreed to dismiss the 2006 Action with prejudice and in lieu thereof

would proceed on the contempt motions in the 1996 Action. Judge Early signed a Consent Order to this effect, and the Chief Administrative Judge signed a Consent Order transferring the 1996 action and contempt motions to Judge Early. Shah argues the trial court erred in limiting the issues to those raised in the contempt motions in 1996 Action and not also reaching the issues raised in the 2006 Action that were not previously raised in the contempt motions. Stated differently, Shah complains that Judge Early misread his own order. As shown later, this argument is manifestly without merit.

**D. The Trial of the 1996 Action and Contempt Motions**

The trial of the contempt motions in the 1996 Action began on November 10 and ended November 13, 2008. The parties presented voluminous evidence. Notably, despite having the burden of proof and relevant personal knowledge on important issues, Shah did not testify, thereby avoiding the crucible of cross-examination and depriving the court of the opportunity to observe his demeanor and credibility.

**ARGUMENTS**

**I. The Settlement Orders are the law of this case.**

Judge Early ruled that the Settlement Orders are the law of this case, noting that Shah had not appealed the Supplemental Order or the Reconsideration Order. (R. 36, 39-40). Shah argues this was error, because “[t]hese Settlement Orders were *consent* orders, agreed to by both parties.” (Init. App. Br. 45). This is simply false.

The 2001 Consent Order was a consent order and, as Shah concedes on appeal, cannot be attacked on appeal. (Init. App. Br. 45-46). Absent grounds to set aside a consent order under Rule 60, SCRCP, or subsequent agreement of the parties approved by the court, it is axiomatic that a consent order is the law of the case. *Ramseur v. Moore*,

21 S.E. 81 (S.C. 1895); *accord Raby Constr. LLP v. Orr*, 594 S.E.2d 478, 482 n.3 (S.C. 2004). The 2003 Supplemental Order and 2003 Reconsideration Order were not consent orders. They were the result of a contested hearing held upon petition of Palmetto. Since they were not consent orders, they could have been appealed. Since they were not appealed, they are the law of this case. *Buckner v. Preferred Mut. Ins. Co.*, 177 S.E.2d 544, 544 (S.C. 1970).

**II. Judge Early correctly interpreted his 2008 Consent Order and the Settlement Orders by Judge Keesley to hold that: (1) the only matters before him were the issues raised in the pending contempt motions filed in the 1996 Action; and (2) the judicial intrusion into the Peer Review Process was limited to the first step in that process, i.e., the QA review of Shah's cases.**

**A. Introduction**

Shah argues that Judge Early misinterpreted his own 2008 Consent Order and the Settlement Orders by Judge Keesley. Shah makes these arguments without considering or applying firmly established law on the meaning of court orders.

A trial court's order is to be construed like any other written instrument. *Petition of White*, 385 S.E.2d 211, 215 (S.C. App. 1989); *Weil v. Weil*, 382 S.E.2d 471, 474 (S.C. App. 1989). The controlling inquiry is the intent of the authoring judge. *O'Banner v. Westinghouse Elec. Corp.*, 459 S.E.2d 324, 327 (S.C. App. 1995). That intent must first be gleaned from the order itself, read as a whole and giving effect to every word in the order, not just isolated parts. *Eddins v. Eddins*, 403 S.E.2d 164, 166 (S.C. App. 1991); *Management Recruiters, Inc. v. R.J.R. Mechanical, Inc.*, 404 S.E.2d 908, 909 (S.C. App. 1991). If the order is not ambiguous, there is no room for construction and the order must be enforced as written. *Petition of White*, 385 S.E.2d at 215; *Weil*, 382 S.E.2d at

474. If the order is ambiguous, then the court may go beyond the four corners of the order to determine the authoring judge's intent. *Id.*

The plain language of Judge Early's consent order, as well as that of Chief Administrative Judge Casey Manning's consent order assigning the 1996 Action to Judge Early, demonstrate that the only issues before Judge Early were those raised in the pending contempt motions in the 1996 Action. The plain language of the Judge Keesley's Settlement Orders in the 1996 Action demonstrates that the judicial intrusion into the Peer Review Process was limited to the first step in that process, *i.e.*, the QA review.

**B. The only matters before Judge Early were the issues raised in the three (3) pending motions for contempt in the 1996 action.**

**1. Introduction**

The 1996 Action had been designated a complex civil litigation and assigned to Judge Keesley. His 2001 Consent Order continued this designation and provided the parties could use a "Petition for a Rule to Show Cause" (contempt motion) if any dispute arose regarding the court-ordered changes to the QA review process. (R. 2, ¶ 3).

Prior to November 10, 2009, the only matter before Judge Early was the 2006 Action. Shah announced at a November 4 motions hearing that the parties had reached an agreement whereby Shah would dismiss the 2006 Action with prejudice and proceed upon the 1996 Action and pending contempt motions. R. 302-303).

Two consent orders were entered after the November 4 hearing. First, upon joint motion of the parties in the 1996 Action, Chief Administrative Judge Manning entered an order assigning the 1996 Action to Judge Early. (R. 26-27). The parties moved "to assign

this case [1996 Action], and the petitions for rule to show cause, filed against [Palmetto] and currently pending in this case, to [Judge Early].” (*Id.*) (emphasis added). The parties also moved for all defendants except Palmetto to be dismissed from the 1996 Action, “and for this matter [1996 Action] to proceed for a non-jury hearing on those pending petitions against [Palmetto] as the sole defendant.” (*Id.*) (emphasis added).<sup>6</sup> Judge Manning granted the joint motion and ordered: “The currently pending petitions for rule to show cause shall be heard by Judge Early[.]” (R. 27) (emphasis added).

Judge Early entered his “Consent Order of Dismissal” in the 2006 Action after Judge Manning’s order, dismissing the 2006 Action with prejudice and further providing:

2. The parties will jointly seek an order designating and assigning [Judge Early] to hear [the 1996 Action] and the petitions for rule show cause which are currently pending in that case. [This assignment order had already been entered when Judge Early entered his consent order].

3. A non-jury hearing on the pending motions in the 1996 action shall commence on November 10, 2008[.]

5. [Shah] will proceed in the 1996 action on the pending petitions for rule to show cause and memoranda in support. The parties may argue and rely on such information, documents and discovery from the 2006 action, and affidavits of Drs. Shah, Close and Waldren, as may be relevant and admissible therein.

(R. 23-24, ¶¶ 2, 3, and 5) (emphasis added). The plain meaning of the consent orders by Judge Manning and Judge Early dismissed the 2006 Action with prejudice, leaving only the pending contempt motions in the 1996 Action.

After the filing of the consent orders, and after the commencement of the hearing on the contempt motions, Shah filed a memorandum wherein he alleged grounds not set

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<sup>6</sup> This order also recognized that the 1996 Action had been commenced against Palmetto’s predecessor in interest and ordered that the caption be changed so that Palmetto Health was the only named defendant. (R. 26, n.1).



forth in any of the pending contempt motions.<sup>7</sup> Judge Early held that these new grounds for contempt were not properly before him and were therefore denied. (R. 41-44). Shah argues that Judge Early misread his own order, and that the new grounds raised in his memorandum were properly before Judge Early under the terms of Judge Early's order. Shah never mentions Judge Manning's order, which was the instrument whereby Judge Early had jurisdiction in this matter and limited that jurisdiction to the pending contempt motions in the 1996 Action.

Shah's basic contention is precluded by the plain language of Judge Early's order and, therefore, his attempts to go outside the order are impermissible. *Petition of White*, 385 S.E.2d at 215; *Weil*, 382 S.E.2d at 474. Assuming any ambiguity in the order that would permit such evidence, the controlling inquiry is the intent of the authoring judge. *Id.*; see also *O'Banner*, 459 S.E.2d at 327. The appealed order conclusively demonstrates Judge Early's intent and thereby precludes all of Shah's appellate arguments.

2. Shah's arguments are manifestly without merit and not properly before this Court for appellate review.

Shah first argues that Judge Early's ruling was "in direct contradiction of the agreement reached by the parties[.]" (Init. App. Br. 22). His only citation of supporting evidence is a general reference to pages 3-4 of the November 4, 2008 Hearing Transcript. (*Id.*; see R. 303-304). Shah also claims "[t]he parties consented to presenting at the hearing matters relevant to the 2006 action." (Init. App. Br. at 23). He cites nothing in support of this assertion. (*Id.*). Shah's argument is irrelevant, because the controlling inquiry is the intent of Judge Early as the authoring judge. In any event, nothing in the November 4 hearing shows any agreement to incorporate any new issues

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<sup>7</sup> The consent orders were entered on November 10, 2008. The merits hearing commenced that same day. Shah filed his memorandum with new grounds on November 12, 2008.

from the 2006 Action into the 1996 Action and the pending contempt motions. (R. 301-311, *passim*). No one made any such statement at the hearing. (Id.).

After Shah announced the parties' agreement at the November 4 hearing, Palmetto agreed that the already-scheduled trial date of November 10 for the 2006 Action would now be a hearing "on the Rules to Show Cause." (R. 302-303, ll. 1-9, 11-25; see also R. 307, ll. 21-25). The only reference made by anyone as to what was to be heard on November 10 was the pending "Rules to Show Cause." No one ever said the hearing would also include any issues raised in the 2006 Action but not raised in the pending contempt motions in the 1996 Action. (R. 301-311, *passim*).

Shah also argues that Judge Early's ruling was "in direct contradiction of the agreement reached by the parties and the unequivocal language of the 2008 Consent Order." (Init. App. Br. 22).<sup>8</sup> Shah artfully redacts paragraph five (5) of the order to argue:

This Order allowed Dr. Shah to submit a "*memorandum in support ... and argue and rely on such information, documents and discovery from the 2006 action, and affidavits of Drs. Shah, Close and Waldron.*"

(Init. App. Br. at 22) (quoting 2008 Consent Order) (emphasis in brief). That paragraph actually provides in full:

Plaintiffs [Shah] *will proceed in the 1996 action on the pending petitions for rule to show cause and memoranda in support.* The parties may argue and rely on such information, documents and discovery from the 2006 action, and affidavits of Drs. Shah, Close and Waldren, *as may be relevant and admissible therein.*

(R. 24, ¶ 5) (emphasis added). Shah's assertion that the order "allowed Dr. Shah to submit a 'memorandum in support'" is simply false. There is no such provision in the 2008 Consent Order. The reference to "memoranda in support" was a plain reference to

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<sup>8</sup> As shown earlier, nothing shows any such agreement by the parties.

the pending memoranda already filed in support of the pending rules to show cause (contempt motions); each pending petition was supported by an already pending memorandum in support. (See R. 59-113). Notably, the order uses the term “memoranda,” which is the plural of memorandum, and further demonstrates the 2008 Order was referring to the pending memoranda already filed in support of the pending motions for contempt. Shah’s redacted quotation of the order silently inserts “memorandum” for “memoranda,” and then strings two sentences together with an ellipsis.

Shah’s quotation of the order also redacts out the last phrase in paragraph 5 of the order to create the illusion that the unauthorized memorandumu could rely on discovery and information from the 2006 Action without limitation. This is also simply false. The redacted phrase limited the use of such information to those matters “as may be relevant and admissible *therein*.” (emphasis added). The “therein” plainly refers back to the 1996 Action and the pending motions and memoranda for contempt. Again, paragraph 5 of the order provided in full:

Plaintiffs [Shah] *will proceed in the 1996 action on the pending petitions* for rule to show cause *and memoranda* in support. The parties may argue and rely on such information, documents and discovery from the 2006 action, and affidavits of Drs. Shah, Close and Waldren, *as may be relevant and admissible therein*.

(R. 24, ¶ 5) (emphasis added). In short, Shah artfully redacts paragraph 5 of the order to completely alter the plain language and meaning of the order.

Shah also notes Judge Early’s statements at the November 4 hearing that he planned to let the parties make the record they wanted. (Init. App. Br. 22). Shah never explains or argues how these statements support his interpretation of the 2008 Consent

Order, and his one-sentence “argument” is too conclusory to present any issue for appellate review. *R & G Constr., Inc. v. Lowcountry Reg'l Transp. Auth.*, 540 S.E.2d 113, 120 (S.C. App. 2000) (an issue is abandoned if the appellant's brief treats it in a conclusory manner). Moreover, Shah takes this statement out of context.<sup>9</sup>

The statements relied upon by Shah arose during a discussion of motions pending in the 2006 Action. Judge Early inquired whether these motions were still ripe. Shah responded:

[I]f we're going forward with the Rule to Show Cause on the 1996 lawsuit, that's evidence that was gathered in the 1996 lawsuit. [Palmetto's] position was that nothing that happened prior to the [2001 Consent Order] should come in, but obviously we don't have that deadline to be concerned with, *because we're going forward with a Rule to Show Cause on a lawsuit that arose in 1996*[.]

(R. 304) (emphasis added). Judge Early responded:

[W]e *don't have any Rule 403 issues*, because I'm going to be hearing it [the 1996 Action contempt motions]. . . . And I'll just let y'all *make the record like you want to make it*, I guess, so long as it doesn't get too laborious. . . . [S]ince we *don't have a jury*, I'm going to probably be a little more liberal in *receiving all of the evidence so you'll be able to make a full and complete transcript* in the event you don't like my ruling, either one of you.

(R. 304) (emphasis added). In other words, since the hearing on the contempt motions was to be a bench trial, Judge Early intended to admit all proffered evidence and decide later what was relevant, admissible, and persuasive. This is standard practice for bench trials. See *Brown v. Allstate Ins. Co.*, 542 S.E.2d 723, 726 (S.C. 2001) (“A trial judge's

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<sup>9</sup> Shah also notes a statement by Judge Early at the November 4 hearing that the hearing on the contempt motions would be basically the same issues as raised in the complaint in the 2006 Action. (Init. App. Br. 22; R. 303-304). This one-sentence “argument” is too conclusory to present any issue for appellate review. *R & G Constr., Inc. v. Lowcountry Reg'l Transp. Auth.*, 540 S.E.2d 113, 120 (S.C. App. 2000) (an issue is abandoned if the appellant's brief treats it in a conclusory manner). Moreover, the issues were “basically” the same, because the complaint in the 2006 Action included all issues that had been raised in the contempt motions under the 1996 Action. This “basic” similarity did not permit Shah to bootstrap the new issues from the 2006 Action into the 1996 Action or the pending contempt motions, nor does it support Shah's artful redactions of the 2008 Consent Order.

role in a bench trial is to admit all evidence and then evaluate it in a non-jury setting.”), *rev’g* 523 S.E.2d 807 (S.C. App. 1999). Judge Early followed this practice from the very beginning of and throughout the trial. (E.g., R. 323, 378-380, 392, 540). More importantly, Shah never explains how this approach supports his challenge to Judge Early’s reading of his own 2008 Consent Order.

Shah argues the 2008 Consent Order “expressly reserved [Shah’s] right to raise issues and present evidence of *additional* contemptuous conduct that was revealed through discovery in the 2006 action.” (Init. App. Br. 23) (emphasis added). Shah does not cite any portion of the Consent Order to support this argument, and there is no such language in the Consent Order. That order permitted the use of discovery from the 2006 Action, but only to the extent it was relevant and admissible to the issues raised in the pending contempt motions and the pending memoranda in support of those motions.

Shah also argues that the new issues from the 2006 Action were tried by implied consent, because Palmetto did not object to the introduction of the evidence. (Init. App. Br. 23-24). Shah never argued “implied consent” to the trial court and, therefore, it is not properly before this Court for appellate review. (See R. 262-277, *passim*). *Pye v. Estate of Fox*, 633 S.E.2d 505, 510 (S.C. 2006) (issue cannot be raised for the first time on appeal). In any event, this argument is without merit.

Any objection to the evidence would have been a futile act not required by the law, because Judge Early had already ruled that he would accept all proffered evidence and later determine its relevancy, admissibility, and persuasiveness. *Staubes v. City of Folly Beach*, 529 S.E.2d 543, 547 (S.C. 2000) (law does not require futile acts of objecting when court has already made it clear how the court would rule). *Accord State v.*

*Rowe*, 115 S.E. 583, 586 (S.C. 1923); *State v. Bantan*, 692 S.E.2d 201, 205 (S.C. App. 2010). Moreover, at the end of the trial, Shah specifically agreed with this approach:

Your Honor has been very inclusive in what you've allowed us to present. . . . We believe the matters that have been presented by both sides are before you and *to the extent that any of it is something that you feel should not be considered, we trust you to make that choice* and that decision. So, we have no concerns about the matters that have been presented by the defendants because we're confident that the court would make a decision about what is appropriate.

(R. 673-674) (emphasis added).<sup>10</sup> The trial judge agreed and again stated his previously stated intent to allow all proffered evidence into the record, after which he would decide what was relevant: "I'm going to allow everything that has been offered even over objections into the record and I will consider what I think is relevant to the issues at hand and make my decision based on that." (R. 674). This further demonstrates that any objection would have been a futile act not required by law.<sup>11</sup>

Throughout his brief on other issues, Shah argues that Palmetto failed to object to evidence. As shown above, any objections would have been futile, because Judge Early repeatedly made it clear that he was going to admit all proffered evidence and then decide what was relevant, admissible, and persuasive.

Also throughout his brief, Shah complains that Judge Early ruled upon grounds not argued by Palmetto during the hearing. At the end of the trial, Judge Early recognized that this case presented numerous, complicated issues. To short cut the need for any further closing arguments, Judge Early requested both parties to present their positions in writing, noting that "you can do it in the form of a proposed order" and that

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<sup>10</sup> Shah made this same statement to Judge Early during the post-trial hearing and even cited and quoted *Brown, supra*, to argue: "A trial judge's role in a bench trial is to admit all evidence and then to evaluate it in a non-jury setting." (R. 692).

<sup>11</sup> To the extent Shah makes this same argument on objections to evidence elsewhere in his brief, Palmetto incorporates the foregoing argument.

both sides would be given the opportunity to respond in writing to the submission by the other party. (R. 678-679). The parties followed this procedure and, therefore, Shah's arguments regarding matters not specifically argued during the trial are manifestly without merit.

3. Summary and Conclusion.

Judge Early correctly read his own 2008 Consent Order as limiting the issues to those raised in the pending contempt motions. Any assumed error by Judge Early is harmless, because Judge Manning limited Judge Early's jurisdiction in the 1996 Action to the "currently pending petitions for rule to show cause."

C. **Judge Early correctly read the Settlement Orders by Judge Keesley as limiting the judicial intrusion into the Peer Review Process to the first step in that process, i.e., the QA review of Shah's cases.**

Judge Keesley issued all three "Settlement Orders." The 2001 Consent Order was the first and principal order. It specifically provided:

[Shah] is required to participate in the Quality Assurance program. Normally and traditionally that Quality Assurance Process is conducted within the Radiology Department by other Radiologists[.] Part of the settlement agreement in this case requires that the Quality Assurance review of Dr. Shah's medical cases will be removed from the responsibility of the Radiologists who are members of or employed by RRC. Beginning July 31, 2001, the parties have agreed that a Radiologist mutually selected by [Palmetto and Shah] will conduct the Quality Assurance reviews of Dr. Shah's cases. This outside reviewer will have oversight authority over the case selection process as well as the cases themselves. The outside reviewer will insure that the selection process is performed consistent with [Palmetto's] established Quality Assurance protocols and not in a discriminatory manner. The parties reserve the right to amend or revise this aspect of their settlement at some time in the future by mutual consent. Should a dispute arise regarding this aspect of the settlement, the parties agree that this matter may be brought before this Court in the form of a Petition for a Rule to Show Cause.

(R. 2-3, ¶ 3) (emphasis added). The plain language of this order (above-emphasized) conclusively demonstrates that the only part of the Peer Review Process affected by the 2001 Consent Order was the QA review of Shah's cases. There is no mention of the other four stages of Peer Review.

In 2003, Judge Keesley issued the Supplemental Order to resolve conflicts over the Quality Assurance provisions of the 2001 Consent Order, to-wit: identifying who would do the QA review and who would decide whether a matter is a QA review matter or an administrative matter. That order provided in pertinent part:

The QA Process approved, in the [2001] Consent Order, was intended to provide an independent and impartial QA review of Dr. Shah's cases that would not involve the other radiologists .... [R. 13 (emphasis added)]

[T]he parties have attempted . . . to implement the Court ordered QA review of Dr. Shah's cases, but . . . have disagreed on which matters involve QA Process and which matters involve alleged violations of Administrative Requirements. [Id. (emphasis added)]

This Court agrees that Administrative Requirements are not matters traditionally included in the QA Process (defined below) as envisioned by the [2001] Consent Order. [R. 14 (emphasis added)]

[The 2001] Consent Order only applies to allegations or complaints about Dr. Shah that allege a deviation from the standard of patient care or traditional QA matters (the "QA Process"), not Administrative Requirements. The stated goal of the [2001] Consent Order is to remove [other radiologists] from involvement in the QA Process to ensure fairness, impartiality, and to remove any claim of bias. [Id. (emphasis added)]

As to administrative matters, the Supplemental Order simply provided that such would be referred to the Chief for handling pursuant to the normal bylaws and policies, subject to the Chief's right to decline to handle any such matter. (R. 15, 20). The Chief would also be the final arbiter over whether a matter was administrative or QA "when that issue is unclear." (Id.). The bulk of the Supplemental Order outlined the process for selecting the



person to conduct the QA review of Shah's cases and the responsibilities of that person. (R. 15-19). If a corrective action was initiated for a QA matter before being reviewed by the outside reviewer, it was to be sent to him for a review and report. (R. 19). If a corrective action was initiated for an administrative matter, the Chief would handle the relevant bylaw requirements (rather than the Radiology Department) unless he declined to do so. (R. 20). Importantly, Judge Keesley closed the Supplemental Order:

Nothing in this Order or in the [2001] Consent Order precludes the initiation of any administrative action provided under the Bylaws or Policies, or limits the ability of the Board of Directors of the [Hospital] or Hospital management to take such administrative action as they deem necessary for the proper administration and management of the [Hospital] and to assure quality patient care is provided.

(R. 20) (emphasis added). This closing paragraph dramatically highlights Judge Keesley's intent to leave hospital operations to the hospital and its management, and it fully supports the conclusion by Judge Early that the judicial intrusion into the Peer Review Process was very limited. The same is true of a footnote in the Supplemental Order wherein Judge Keesley recognized that the line between administrative and QA matters is murky:

[T]here is the possibility that a physician's failure to comply with Administrative Requirements can lead to QA proceedings or corrective action under the Bylaws. In certain cases, a physician's failure to abide by Administrative Requirements can be so pervasive or found to constitute such a pattern of impermissible conduct that it rises above mere failure to comply with Administrative Requirements to the point where patient care or the Hospital's ability to conduct its business is potentially compromised. In either event, QA proceedings or corrective action under the Bylaws could be instituted.

(R. 15, n.1) (emphasis added).

In short, the Supplemental Order confirmed that the 2001 Consent Order related to the QA Process only. The Supplemental Order was likewise focused on the QA

Process with the minor exception of the Chief deciding which issues were QA (if unclear), and then handling the administrative matters in the ordinary course unless he declined to so. Importantly, nothing in the Supplemental Order altered any step in the Peer Review Process except for continuing the existing alteration of the first step, i.e., the QA Process outlined in the 2001 Supplemental Order.

Shah was unhappy with the Supplemental Order and moved to alter or amend it. Judge Keesley denied this motion in the third "Settlement Order," the 2003 Reconsideration Order. In so ruling, Judge Keesley made it clear that the existing orders and their limited intrusion into the Peer Review Process was as far as he would go:

As has been repeatedly stated, the court is not equipped to function as a doctor or a hospital administrator. The [Supplemental Order] may not be the best possible solution and the court fully recognizes its lack of knowledge about all the intricacies involved. However, at this point, the court believes the current Order is as good as it can do.

(R. 22) (emphasis added). Judge Keesley's recognition that the judiciary cannot manage a hospital or the Peer Review Process again highlights Judge Keesley's intent to intrude upon that process in a very limited and focused manner. This again supports Judge Early's decision that the Settlement Orders did not judicially regulate the other steps in the Peer Review Process.

Throughout his brief, Shah argues Palmetto violated the Settlement Orders by actions in the non-QA stages of the Peer Review Process. For example, Shah repeatedly notes that Palmetto took corrective action without any recommendation from the outside reviewer that there be any corrective action. The Supplemental Order, however, expressly stated that the MEC, upon receipt of the outside reviewer's report, "shall determine what action, if any, should be taken," including whether the matter "should be

referred for corrective action.” (R. 19). As shown later in the discussions of Shah’s individual arguments, nothing in the Settlement Orders precluded the actions taken by Palmetto, and Judge Early correctly held that Shah failed to prove any contemptuous violation by Palmetto.

**III. Judge Early correctly stated South Carolina’s law on contempt and correctly found that Shah had failed to prove the essential element of willfulness in all of his contempt claims.**

Judge Early set forth the law of contempt in his order. Shah does not challenge this law on appeal and, therefore, it is the law of this case. *Buckner v. Preferred Mut. Ins. Co.*, 177 S.E.2d 544, 544 (S.C. 1970). In any event, Judge Early correctly stated the law as follows:

Contempt is the ultimate judicial power. For that reason, it is not lightly asserted and only sparingly imposed. *State v. Harper*, 376 S.E.2d 272, 273 (S.C. 1989); *Miller v. Miller*, 652 S.E.2d 754, 759 (S.C. App. 2007). Also for that reason, the law imposes strict requirements that limit contempt to narrow situations.

First, the party seeking contempt has the burden of proving the necessary elements by clear and convincing evidence, the highest standard of proof known to the civil law. *Durlach v. Durlach*, 596 S.E.2d 908, 912 (S.C. 2004); *Miller*, 652 S.E.2d at 761. Second, the conduct proscribed or prescribed by the order must be set forth in “clear and certain” terms; it must be stated specifically and definitely rather than by implication. *Welchel v. Boyter*, 196 S.E.2d 496, 498 (S.C. 1973). The proscribed or prescribed conduct must be ascertainable from the express terms of the order itself and not by reference to other materials, including any materials referenced in or incorporated into the order. *Phillips v. Phillips*, 341 S.E.2d 132, 133

(S.C. 1986); *American Fed. Bank, FSB v. Kateman (In re: First Union Nat'l Bank)*, 516 S.E.2d 1, 2-3 (S.C. App. 1999). . . . Third, the contemptuous conduct must be a “willful disobedience” of the order, *i.e.*, contempt does not lie for a violation resulting from mistake, misunderstanding, confusion, or negligence. *Henderson v. Henderson*, 379 S.E.2d 125, 129 (S.C. 1989) (emphasis added). To be “willful,” the disobedience must be done “voluntarily and intentionally with the specific intent to do something” forbidden by the order (the proscribed conduct) or “with the specific intent to fail to do something” required by the order (the prescribed conduct). *State v. Sowell*, 635 S.E.2d 81, 83 (S.C. 2006), *quoting Spartanburg County DSS v. Padgett*, 370 S.E.2d 872, 874 (S.C. 1988). . . .

(R. 32-33).<sup>12</sup> Judge Early then expressly found: “Were it assumed [Shah] has shown any violations of any proscribed or prescribed conduct in the Settlement Orders, there is no clear and convincing evidence they were willful as required by law. Thus, the motions are denied.” (R. 33).

As noted earlier, the issue of contempt resides solely in the discretion of the trial court and will not be reversed unless there is no evidence to support the court’s factual findings. *Ex parte Cannon*, 685 S.E.2d at 823. Here, Judge Early found that, as to all allegations of contempt, including the grounds not alleged in the contempt motions, Shah had failed to present clear and convincing evidence that Hospital acted willfully. Judge Early further found that Palmetto made a good faith effort to comply with the Settlement

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<sup>12</sup> Against this backdrop, Judge Early applied the following analytical framework: “The only issue before me is whether [Hospital] has violated the express terms of the Settlement Orders so as to give rise to a finding of contempt. Analysis of this issue requires a four-part inquiry. First, what are the parameters and requirements for contempt under South Carolina law? Second, what conduct is proscribed or prescribed by the Settlement Orders, such that deviation therefrom would support a claim for contempt? Third, do the grounds asserted in the three contempt motions allege a violation of any proscribed or prescribed conduct? Fourth, if so, has Plaintiff proven those violations as required by South Carolina law?” (R. 32). Shah does not challenge this framework, so it is the law of this case. *Buckner v. Preferred Mut. Ins. Co.*, 177 S.E.2d 544, 544 (S.C. 1970).

Orders. (R. 33, 53). It is Shah's appellate burden to prove this finding has no evidentiary support. *Ex parte Cannon*, 685 S.E.2d at 823. He has completely failed to do so. Shah has not pointed to any evidence that is so overwhelming, and so clear and convincing, that it proves as a matter of law that Hospital "voluntarily and intentionally with the specific intent to do something" forbidden by the order (the proscribed conduct) or "with the specific intent to fail to do something" required by the order (the prescribed conduct). *State v. Sowell*, 635 S.E.2d 81, 83 (S.C. 2006), quoting *Spartanburg County DSS v. Padgett*, 370 S.E.2d 872, 874 (S.C. 1988). The evidence before Judge Early, most of which was competing testimony from different witnesses set forth in affidavits or testimony in Peer Review hearings, manifestly created a question of fact on the issue of Hospital's specific intent. Thus, Shah has not carried his appellate burden and, therefore, this Court should affirm on all issues.

Moreover, there is ample evidence supporting Judge Early's finding that any assumed deviation from the Settlement Orders by Palmetto was not a willful violation as required by South Carolina law. Fred Crawford and Howard West were in charge of developing the procedures for compliance with the Settlement Orders. (R. 1624). Crawford testified that Palmetto used its best efforts to comply with the orders. (Id.). Karen Hart was the person responsible for getting case files to the Outside Reviewer. She testified that she used the same process for Shah's QA selection that she used for all other physicians as required by the Settlement Orders. (R. 2442-2460). Dr. Greta Harper was the Chief of Staff. She testified that Palmetto followed the Settlement Orders. (R. 2294-2384, 1860). The record is replete with other examples of supporting evidence and testimony. Thus, there is

some evidence supporting Judge Early's finding, which requires affirmance of the entire appealed order under the controlling standard of review.

**IV. Judge Early correctly held that state and federal law precluded Shah's requested relief, even if one assumed Shah had proven his claims.**

Judge Early ruled that Shah's requests for relief was limited to the requests made in the pending contempt motions and supporting memoranda, and that these requests were barred by state and federal law:

In addition, all motions are denied because the relief sought by Plaintiff is not available as a matter of law. Plaintiff's September 2005 motion and memoranda request an award of costs and attorney's fees as the only relief in addition to a finding of contempt. The December 2005 motion and memorandum request only a finding of contempt. Plaintiff's April 2006 motion and memorandum requests a finding of contempt, restoration of his privileges at Defendant's hospital, and damages (which under South Carolina's contempt law, may include attorney's fees). It is axiomatic that a court cannot grant relief not requested and, therefore, the foregoing requests are the only ones properly before me. An award of damages is not available to Plaintiff due to the immunity from damages provided by the Health Care Quality Improvement Act ("HCQIA"), which is a federal law that pre-empts any state law claim that would allow such damages. [Footnote 2]. Restoration of privileges is not available to Plaintiff under South Carolina's doctrine of non-review, which essentially deprives the courts of jurisdiction to grant this relief. [Footnote 3]. In any event, assuming any relief were available, the motions are denied for the other reasons set forth in this order.

[Footnote 2]: Congress passed HCQIA to address serious, national problems with the quality of healthcare. HCQIA provides immunity from liability for damages for participants in a professional peer review proceeding that meets the standards set forth in the Act. 42 U.S.C. § 11111. Those standards are presumed met unless rebutted by the practitioner, which has not occurred here. The record also contains abundant evidence that the professional review proceedings concerning Plaintiff satisfied the standards in the Act, 42 U.S.C. § 11112.

[Footnote 3]: In *Wood v. Hilton Head Hospital, Inc.*, 356 S.E. 841 (S.C. 1987), our Supreme Court affirmed the trial court's holding that it lacked jurisdiction to reinstate a physician to the medical staff of a private hospital (like Defendant here) and declined to adopt the minority view that such decisions are subject to judicial review.

(R. 31). Shah does not challenge Judge Early's ruling on what remedies were claimed by and available to him. Thus, it is the law of this case. *Buckner v. Preferred Mut. Ins. Co.*, 177 S.E.2d 544, 544 (S.C. 1970). Moreover, a review of the contempt motions and supporting memoranda demonstrates the accuracy of Judge Early's ruling. (See R. 59-113).

Shah mentions but never challenges Judge Early's ruling that HCQIA pre-empted any State law claim for damages. Thus, it is the law of this case. *Buckner, supra*.

As to the doctrine of non-review precluding the relief of reinstatement, Shah argues only that Palmetto waived this subject matter jurisdiction defense by agreement in the 2001 Consent Order. (Init. App. Br. 30). It is axiomatic, however, that "subject matter jurisdiction cannot be waived or conferred by agreement of the parties to an action." *In re November 4, 2008 Bluffton Town Council Election*, 686 S.E.2d 683, 688 (S.C. 2009). As to HCQIA, Shah argues he proved contempt and, therefore, the requirements of HCQIA have not been met. As found by Judge Early, Shah did not prove contempt and, therefore, Shah's argument fails of its own weight.

As to HCQIA and the doctrine of non-review, Shah argues Judge Early should not have reached these issues, because the issues of liability and remedies had been bifurcated. Shah overstates the bifurcation. Judge Early stated that if he found contempt, then Shah could present his "evidence on damages." (R. 554-555). Nothing in this statement precluded Judge Early from considering defenses to damages, particularly when those defenses precluded any relief regardless of the "evidence on damages."

**V. Judge Early correctly held that South Carolina law precluded Shah's contempt claims based on alleged violations of Hospital's Bylaws.**

Shah made numerous contempt claims based on alleged violations of hospital Bylaws, contending the references to the Bylaws in the 2003 Supplemental Order brought the contempt power to bear on such violations. Judge Early rejected this argument:

The proscribed or prescribed conduct must be ascertainable from the express terms of the order itself and not by reference to other materials, including any materials referenced in or incorporated into the order. *Phillips v. Phillips*, 341 S.E.2d 132, 133 (S.C. 1986); *American Fed. Bank, FSB v. Kateman (In re: First Union Nat'l Bank)*, 516 S.E.2d 1, 2-3 (S.C. App. 1999). To the extent Plaintiff relies upon alleged violations of any Bylaws or other matters referenced in the Settlement Orders as a ground for contempt, the motions are denied.

(R. 33). On appeal, Shah continues to argue that contempt is available to remedy the alleged Bylaw violations, but he never addresses or challenges Judge Early's reliance on *Phillips* or *American Federal*, both *supra*. Thus, Judge Early's ruling is the law of this case and requires affirmance. *Buckner v. Preferred Mut. Ins. Co.*, 177 S.E.2d 544, 544 (S.C. 1970). In any event, Judge Early ruled correctly. Nothing in the Settlement Orders or the evidence indicates Judge Keesley intended that the ultimate judicial power of contempt was to be used for alleged Bylaw violations. To the contrary, the Settlement Orders demonstrate Judge Keesley had no such intent.

The Settlement Orders do not specifically order Palmetto to abide by all Bylaws with regards to Shah. Rather, the Settlement Orders set forth two limited exceptions to the Bylaws and required Palmetto to comply with these exceptions, to-wit: (1) that the QA of Shah's cases be removed from the radiology department and be performed by an outside reviewer; and (2) that the Chief determine whether a matter is administrative or



QA.<sup>13</sup> Shah failed to prove a violation of these court-ordered exceptions and, therefore, there can be no contempt. Assuming Shah proved a violation of any Bylaw provision, his remedy (if any) is available only by an independent lawsuit such as the 2006 Action that he dismissed with prejudice. In seeking contempt, his remedy is limited to specific and willful violations of specific provisions of the Settlement Orders, which he has failed to do. Accordingly, Judge Early correctly ruled that any claims for alleged violations of Bylaws were not remediable through contempt.

As noted earlier, Judge Keesley's Settlement Orders establish an intent to make a very limited judicial intrusion into Palmetto's Peer Review Process and procedures. As a matter of law, any claim for contempt is available only to remedy a violation of this limited intrusion. As found by Judge Early, there was no such violation, and nothing in the Settlement Orders evidences any intent by Judge Keesley to involve the court or its contempt power in the full-fledged enforcement of the Bylaws argued by Shah. No one asked Judge Keesley to do so. It is inconceivable that he intended to do so, particularly in light of the limiting language used in all of his Settlement Orders.

## **VI. Judge Early correctly rejected Shah's contempt claims.**

### **A. The Case Selection Process**

Throughout his brief, Shah argues Palmetto violated the Settlement Orders, because the Outside Reviewer did not select the cases for QA review, and because the selected cases had been "stockpiled." This argument is manifestly without merit, because the Settlement Orders did not require the Outside Reviewer to select the cases and the evidence showed that cases were selected in the accordance with the Settlement Orders.

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<sup>13</sup> Judge Early undertook an extensive analysis of the 2003 Supplemental Order to reach this conclusion. (R. 37-41). Shah never specifically challenges this analysis and, therefore, it is the law of this case. *Buckner v. Preferred Mut. Ins. Co.*, 177 S.E.2d 544, 544 (S.C. 1970).

As Judge Early correctly found, the 2001 Consent Order set forth the case selection process, and it did not require the Outside Reviewer to select the cases. Rather, it gave the Outside Reviewer “oversight authority” to ensure that “the selection process is performed consistent with [Palmetto’s] established Quality Assurance protocols and not in a discriminatory fashion.” (R. 2). Karen Hart was the Director of Quality Assurance. She testified that Shah’s QA cases were selected in accordance with Palmetto’s established protocols, including the so-called “stockpiling” of cases. (R. 2442-2460). The Outside Reviewer agreed that the process used by Palmetto was the most common process for selecting QA cases. (R. 2440-2441). Judge Early accepted this testimony, and this precludes Shah’s appellate arguments under the controlling standard of review. (R. 44-47).

Shah also argues that subsequent changes to the case selection process prove the prior process was a violation of the Settlement Orders. (Init. App. Br. 36-37). This argument is manifestly without merit. The evidence showed that the first cases selected for review were selected in full compliance with Palmetto’s protocols, which is the only thing required by the Settlement Orders. The Outside Reviewer subsequently sought cases selected on a different basis, which was his authority under the Settlement Orders, and it is undisputed that Palmetto complied with that request.

Shah also complains that Palmetto should have used a community standard to compare Shah to his peers. (Init. App. Br. 37). This is nonsensical. Only the Outside Reviewer was conducting QA of Shah’s cases, and the Settlement Orders did not impose any particular standard on that review. Judge Early so ruled. (R. 48). Shah has not challenged this ruling and, therefore, it is the law of this case. *Buckner v. Preferred Mut.*

*Ins. Co.*, 177 S.E.2d 544, 544 (S.C. 1970). Moreover, Judge Early also ruled that were it assumed the Settlement Orders imposed any particular standard, it was imposed on the Outside Reviewer, not Palmetto. (R. 48). Judge Early also ruled that this issue was raised to and rejected by Judge Keesley in the 2003 Reconsideration Order, which Shah did not appeal, thereby making it the law of this case. (Id.) Shah's only challenge to this ruling is his erroneous assertion that the Reconsideration Order was a consent order that was not subject to appeal. Thus, Judge Early's ruling is also the law of this case. Finally, Judge Early ruled:

[Shah's] real complaint is that his review was not being done under the same standard produced by the QA vetting in the hospital's Radiology Department. Assuming this QA vetting would have produced a different result, and there is no clear and convincing evidence that it would, [Shah] voluntarily removed himself from it under the 2001 Consent Order. His decision to do so cannot and does not result in contempt by [Palmetto], particularly in the absence of any specific "community standard" requirement in the Settlement Orders, and particularly when [Palmetto] was not conducting the QA review of [Shah's] work.

(R. 48-49). Shah does not this ruling and, therefore, it is the law of this case. *Buckner v. Preferred Mut. Ins. Co.*, 177 S.E.2d 544, 544 (S.C. 1970). Moreover, it is manifestly correct under the plain language of the Settlement Orders.

Shah also complains that he was the only radiologist subjected to QA review. The evidence, however, is to the contrary. (R. 2442-2444, 2481-2514). Moreover, were it true that there was no QA in the radiology department, nothing in the Settlement Orders required such, so any assumed failure to do so cannot be a basis for contempt.

#### **B. The "Administrative" Issues Arguments**

The 2003 Supplemental Order made the Chief the final arbiter of what matters were administrative rather than QA. The Chief (Dr. Bayard) approved the cases sent to

the Outside Reviewer. (R. 2407-2409, 2411-2413). Judge Early accepted this evidence, and this precludes Shah's appellate arguments under the controlling standard of review. (R. 46-47). Moreover, as also found by Judge Early (*id.*), the Outside Reviewer's first report reflected significant concern over Shah's failure to adhere to administrative requirements and suggested an ongoing review of Shah's compliance with those regulations. (R. 855). Shah cannot complain that Palmetto adhered to the Outside Reviewer's recommendation, and such adherence manifestly cannot be contempt.

### **C. The "Breast Biopsy" Cases**

Judge Early rejected this contempt claim on several different grounds, noted by bracketed numbers below:

[Shah] claims that many of the cases sent to the Outside Reviewer involved breast biopsies, and he had already relinquished his privileges for these procedures for a year and a half. [1] This "violation" is not asserted in any of the "pending motions[," so it is not properly before as a contempt claim]." Moreover, it is manifestly without merit. [2] There is no clear and convincing evidence of this purported "relinquishment." [3] Assuming it were true that Plaintiff had stopped doing these procedures, that does not address the privilege question. It was not until after the MEC accepted the Outside Reviewer's recommendations on this subject that Plaintiff formally relinquished this privilege rather than satisfy the other conditions imposed for keeping this privilege.

(R. 41). As shown earlier, Judge Early properly rejected all claims not made in the pending contempt motions based on his 2008 Consent Order and Judge Manning's Order transferring the case to Judge Early.

Shah complains the breast biopsy cases evidence an improper case selection process. (Init. App. Br. at 24). As shown earlier, the evidence demonstrates that all cases sent to the Outside Reviewer were selected in compliance with the 2001 Consent Order's requirement that Palmetto's established protocols be followed. Contrary to Shah's

argument, Judge Early did not find that Shah continued to perform breast biopsies after his relinquishment of that privilege. Rather, Judge Early correctly found that Shah did not relinquish these privileges until after the Outside Reviewer's recommendations on this subject. The Outside Reviewer recommended suspension of breast biopsy procedures in his July 15, 2003 Report. (R. 855). Shah formally relinquished his breast biopsy privileges in a September 2003 letter. (R. 875). Thus, conclusive evidence supports Judge Early's actual ruling.

#### **D. The 35 Emergency Room Cases**

Judge Early rejected this contempt claim on several different grounds, noted by bracketed numbers below:

[Shah] contends [Palmetto] considered 35 emergency room cases without first having them reviewed by the Outside Reviewer. This "violation" is not asserted in any of the "pending motions." Moreover, it is manifestly without merit. [2] This was done in response to Plaintiff's repeated demands at the Medical Executive Committee (MEC) and Fair Hearing Committee (FHC) stages that he should be compared to other radiologists. He cannot now complain that Defendant heeded his requests. [3] This was done at the MEC and FHC stage of the PPR process, not the QA stage, to which the Settlement Orders clearly limited the imposition of any prescribed or proscribed conduct. This was done not as QA but as part of the MEC's investigation into whether Plaintiff had satisfied the conditions of his earlier imposed probation. The Settlement Orders did not attempt to limit the power or right of the MEC or the FHC to make any such investigation.

(R. 41-42). As shown earlier, Judge Early properly rejected all claims not made in the pending contempt motions based on his 2008 Consent Order and Judge Manning's Order transferring the case to Judge Early. As also shown earlier, Judge Early properly rejected all claims based on allegations occurring beyond the QA stage of the Peer Review process. Judge Early also found that the review of these cases was in response to Shah's requests for comparative studies, and Shah does not dispute this on appeal. (Init. App. Br.

at 25). Thus, it is the law of this case and requires affirmance. *Buckner, supra*. Moreover, and contrary to Shah's appellate arguments, the evidence shows that these reports were the result of the MEC's directive that a study be conducted for all radiologists (not just Shah) regarding X-ray readings by radiologists that differed from those of an ER physician. (R. 2027-2029, 1784). Indeed, on appeal, Shah complains later about the lack of comparison to other radiologists (Init. App. Br. 37) while simultaneously challenging here the use of such comparisons.

#### **E. Administrative Issues at the MEC Level**

Judge Early rejected Shah's claims that administrative issues were raised for the first time at the FHC level on two earlier noted grounds: (1) the violation was not asserted in any of the pending contempt motions and therefore not properly before him; and (2) this alleged violation occurred at the FHC level, and the Settlement Orders did not regulate any conduct at that level. (R. 42, ¶ 3). Shah summarily challenges this ruling without any specific argument except to note that Palmetto responded to these allegations. (Init. App. Br. at 26, § 3).<sup>14</sup>

#### **F. The Psychological Evaluation Requirement**

It is undisputed that Shah refused to comply with this condition of his probation. His privileges were revoked for this refusal.

The psychological evaluation requirement was imposed to assist Shah in improving his communication and interaction skills with patients and staff, and to improve his general attitude towards compliance with hospital regulations. As the Outside Reviewer noted in his first report:

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<sup>14</sup> This "argument" appears to be another "trial by implied consent" argument, though it is unclear. Assuming it is such an argument, it fails for the reasons noted earlier in this brief.

Dr. Shah did not show a willingness to proactively address concerns regarding compliance with the Rules and Regulations of the hospital. Instead he will often carry on extended debates about the appropriateness or necessity of a given policy. Although some of his arguments may be reasonable and the sentiment even shared by other physicians, they are irrelevant when there is a clear direction from medical staff bylaws, JCAHO requirements, or hospital rules and regulations. This pattern of behavior is disruptive at best and can cause greater problems at worst. I see two issues here: (a.) failure or delay in complying and b.) the general attitude that he can decide what rules are worthy of compliance. This attitude was more widespread among physicians in the past and has represented a difficult adjustment for many, however, it can no longer be tolerated in the modern framework of healthcare delivery. Note that this is not necessarily a finding of substandard care, but there must be a change or it could lead to that.

(R. 855) (emphasis added). As the Outside Reviewer found in his third report regarding Shah's treatment of a patient he required to urinate into a towel:

For physicians to be functioning members of any medical staff, their ability to show respect and compassion for their patients is at least as important as their medical knowledge. This case represents a serious breach. . . . [Alternatives were available and either] of these would have been simple to accomplish and the fact that they were not indicates a serious lack of "listening" to the patient. . . . The fact that none of these options was pursued, in the face of clear communication from both the patient and nursing staff, is unacceptable.

It is up to the Medical Staff to decide the appropriate response to this case. I will reiterate that I consider this to be equal if not more important than most medical issues as patient communication is always paramount in medical care. It does represent a deviation from the standard of care that I would expect at any hospital. . . . It is up to the Medical Staff to make a final determination of any action(s) that is to be taken.

(R. 886-887) (emphasis added).<sup>15</sup> In addition, the patient records were replete with other examples of Shah's inappropriate responses to patient and staff complaints and inquiries. (E.g., R. 631-638).

On appeal, Shah argues that imposition of the evaluation requirement violated the notice provisions of the Bylaws, and that the underlying issues were administrative issues

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<sup>15</sup> This is a heavily redacted excerpt of the Report, which is reproduced in its entirety at R. 886-887.

rather than QA issues. The Outside Reviewer's reports demonstrate that these so-called "administrative issues" had risen to the level of patient care (QA) issues, and Judge Keesley expressly held in the unappealed (law of the case) 2003 Supplemental Order that administrative issues could become QA issues. (R. 15, n.1). Judge Keesley also expressly held in this unappealed order that nothing in the Settlement Orders precluded Palmetto from taking necessary steps to ensure and protect proper management of the hospital and proper patient care. (R. 20). The evaluation requirement met these exceptions in the unappealed (law of the case) Supplemental Order. Moreover, as noted earlier, Judge Early properly rejected Shah's appellate arguments because: (1) these issues were not raised in contempt motions; (2) these issues related to alleged Bylaw violations, which were not enforceable by the contempt power; and (3) these issues concerned matters that occurred at later (post-QA) stages of the Peer Review Process, and the Settlement Orders did not proscribe or prescribe anything beyond the QA stage. (R. 42-43, 49).

**G. Patient X (a/k/a Patient 36)**

The Outside Reviewer recommended that Shah undergo further training on reading CT scans due to numerous misreads in the reviewed records. (R. 855). This CT training was imposed as a condition of probation. Shah completed the required training and his CT privileges were reinstated. Only four months later, Shah completely misread the CT scan of Patient X.

Shah's privileges were also revoked on the independent ground of his treatment of Patient X. This issue arose under the following facts:

1. Patient X was being treated for diverticulitis. Her physician began to suspect something more serious and scheduled a CT scan of her abdomen.



The radiologist's report on the CT scan revealed "a very large ovarian mass." Patient X was sent to Palmetto for a biopsy.

2. Patient X delivered the CT scans and the radiological report. The CT scans comprised seven large sheets containing 16 images each, and Patient X's name was on each of these images, *i.e.*, her name appeared 16 times on each of 7 CT sheets, a total of 102 times.
3. Patient X was placed on a gurney and given an IV that included sedation. Shah arrived and said: "Why are you here? ... I can't biopsy something that doesn't exist. I don't know why people expect me to biopsy something that doesn't exist. All you have is an enlarged uterus. ... I have confirmed with my other two colleagues and all three agree that you have an enlarged uterus. Get dressed and go home."
4. Patient X requested that Shah confer with the radiologist that had issued the first report. He left the room, and returned to say he could not reach the radiologist. At Patient X's request, Shah called her primary physician, and told him the same thing he had told Patient X: "There is nothing here to biopsy. I can't biopsy something that doesn't exist. It is an enlarged uterus. I am going to send the patient home."
5. Patient X, elated with the good news, had a celebration dinner with her family that night. Her treating physician called, advising that he had called the first radiologist, who was not available, but his partner had read the CT scan and confirmed the existence of the large ovarian mass. The treating physician advised it was essential that she be seen by an oncologist as soon as possible.
6. A neighbor of Patient X was a partner with the oncology group recommended by her treating physician. She immediately walked to his house with her CT scans. He was sitting at his desk, held the CT sheets up to his desk lamp, and confirmed the existence of the very large mass. Patient X underwent surgery to remove the cancerous mass and subsequent treatments to further combat the cancer.

(R. 542-552). After her surgery, Patient X wrote a letter to Palmetto advising of her experience with Shah; she included the radiology and surgical reports with this letter, and she later gave Palmetto a copy of the CT scans. (R. 547-549, 550-551).

Palmetto received Patient X's letter only three days before an October 31 MEC meeting to consider Shah's satisfaction of the conditions of his probation. The Chief of

Staff received the letter and delivered it to the MEC at this meeting. The MEC, in compliance with Judge Keesley's Supplemental Order, immediately referred the matter to the Outside Reviewer for review, and delivered the CT films to him on November 2. Based on Shah's failure to satisfy all conditions of probation, the MEC recommended suspension and revocation of Shah's privileges.

The Outside Reviewer issued a preliminary report on December 2. He noted the only excuse for the mis-read would be that Shah had seen the wrong films and recommended further review directly with Shah:

This case does represent a mis-interpretation with potential impact on patient care (although none occurred for other reasons [*i.e.*, the intervention of Patient X's treating physicians]). As mentioned on the [attached] form, the findings on the scan are evident so I have to wonder if the correct films were reviewed or if there is some other piece of information of which I am unaware. If other films were reviewed, this would still represent a problem, albeit of a different nature (not identifying the patient correctly). These films should be reviewed with Dr. Shah to see what explanation he might have. . . . I did speak with Dr. Shah by telephone, but I feel full review in person with Dr. Shah is indicated. This will serve as a preliminary review pending that discussion.

Comments: The CT scan shows an obvious pelvic mass with probable second mass as well as multiple deposits at other sites through [sic] abdomen. The pattern is most consistent with ovarian carcinoma with metastases. The initial reading was confirmed at surgery. It is difficult to understand how a review of the films at the time of [sic] scheduled biopsy could have lead to an interpretation of no mass as this is not a subtle case. It is possible that a different set of films were reviewed. This would be the most obvious alternative explanation. In this case, there would be an obvious error of misidentifying the patient. In either case this would be a deviation from [sic] standard of care that could have an impact on outcome [though not here due intervention by the primary physician].

I did speak with [Shah] by telephone and he indicated he thought there was an enlarged uterus that did not need biopsy. He said he did show the images to other radiologists who agreed with his opinion. . . . I told him the next step would be to review the films together to see if this was in fact the set of films he saw. It would probably be difficult to draw any further

conclusions about what happened at the time of [sic] scheduled biopsy without reviewing this in person with [Shah].

(R. 1015-1017) (emphasis added). The possibility of having read the wrong films was first suggested by Shah to the Outside Reviewer. During their telephone conversation, prior to the report:

[Shah] asked that we go over the films together because maybe I [Outside Reviewer] had a different set than he had. I told him I would be willing to do this and would not issue a final report until that time. For that reason, I have attached a preliminary review.

(R. 1018) (emphasis added). Shah never scheduled the meeting after procuring a delay of the final report.

Shah never met with the Outside Reviewer, despite requests from Palmetto that he do so (R. 1075), and despite the clear requirement of Judge Keesley's Supplemental Order that he (Shah) was responsible for arranging any meetings with the Outside Reviewer. (R. 18). Shah has never identified the "two radiologists" that he told Patient X and the Outside Reviewer agreed with his reading of the CT scan. He has never presented any evidence from them. He did not testify at trial. He has never presented any evidence that he read the wrong CT films.

On appeal, Shah first argues that Judge Early's finding that "[Shah] never contacted or met with the Outside Reviewer" is clearly incorrect, because the Outside Reviewer's report referenced a prior phone call with Shah. (Init. App. Br. 42). This is yet another example of artful redaction by Shah. Judge Early actually found:

Prior to this report, the Outside Reviewer had spoken with [Shah], and he confirmed he had told Patient [X] that she had an enlarged uterus rather than a mass, and that he had consulted with two other radiologists who agreed with his reading. The Outside Reviewer advised Plaintiff that they should meet and review the CT scan together to determine what had happened, and that he would not issue a final report until that time. On December 6, 2005,

[Palmetto] again advised [Shah] that the Outside Reviewer was available to discuss the Patient [X] matter with him, and gave him the Outside Reviewer's cell phone number. Plaintiff never contacted or met with the Outside Reviewer.

(R. 51) (emphasis added). Judge Early's actual ruling expressly noted the prior phone conversation and correctly held Shah never contacted the Outside Reviewer after the request by the Outside Reviewer and after Palmetto reminded him of the need to meet with the Outside Reviewer.

Shah next argues Palmetto ignored the Outside Reviewer's recommendation for an in-person interview. (Init. App. Br. 42-43). This is simply false. As found by Judge Early and not challenged by Shah on appeal, Palmetto gave Shah the contact information for the Outside Reviewer and encouraged him to contact the Outside Reviewer. (R. 1075). Again, it must be remembered that Judge Keesley's Supplemental Order made it Shah's responsibility to arrange meetings with the Outside Reviewer. He simply failed and refused to meet with the Outside Reviewer on Patient X.

Shah next mischaracterizes the Outside Reviewer's report and erroneously contends the Patient X matter involved x-rays:

In his Preliminary Report, Dr. Selby explained his *cursory review* of this case revealed Dr. Shah *was most likely presented with the wrong x-rays* by Hospital personnel. Having by then reviewed *hundreds of Dr. Shah's accurate x-ray readings*, Dr. Selby had a basis to make this statement.

(Init. App. Br. 43) (emphasis added). The mis-read of Patient X was of a CT scan, not an x-ray. The Outside Reviewer had not reviewed hundreds of accurate CT reads by Shah. To the contrary, the Outside Reviewer had previously identified numerous CT mis-reads and had recommended further CT training. Nothing in the Outside Reviewer's report indicates it was based on a "cursory review" of the Patient X case. To the contrary, the

length and depth of the report demonstrate it was not cursory. (R. 1015-1017). Moreover, the Outside Reviewer never said “Dr. Shah *was most likely presented with the wrong x-rays* by Hospital personnel.” Rather, he “wonder[ed]” if this was what happened and suggested this was the “most obvious alternative” to an obvious mis-read. (R. 1015-1016). In other words, the Outside Reviewer found that the only conceivable explanation for the mis-read would be a reading of the wrong films. He needed to discuss this with Shah to make any further determination of what happened, but Shah never met with him (as was his obligation under Judge Keesley’s Supplemental Order).<sup>16</sup>

Shah next argues Palmetto disregarded the procedures set forth in Judge Keesley’s Supplemental Order and ignored the Outside Reviewer’s request to meet with Shah. (Init. App. Br. 44). This is simply false. Upon receiving the letter from Patient X, the matter was immediately referred to the Outside Reviewer as required by Judge Keesley’s Supplemental Order. Palmetto did not ignore the request for the meeting with the Outside Reviewer. Rather, Palmetto encouraged Shah to have this meeting. (R. 1075). And, again, Judge Keesley imposed the duty of arranging such meetings upon Shah, not Palmetto. His failure to arrange the requested meeting cannot be contempt by Palmetto, nor can his failure to do so obligate Palmetto to ignore the serious matters involved in the case of Patient X until Shah saw fit to arrange a meeting (which he never did). And, again, the possibility of reading the wrong films was an excuse first suggested

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<sup>16</sup> Shah also argues later that the Outside Reviewer’s “only opinion . . . was, essentially, no medical conclusion could be drawn until after further review of the case.” (Init. App. Br. 45). This is simply wrong. The Outside Reviewer clearly concluded that, absent a showing that Shah had read the wrong CT film, which was a possibility first suggested but never proven by Shah himself, the only possible medical conclusion was that Shah had completely mis-read the film. (R. 1015-1017, *passim*). Shah never presented any evidence that he had read the wrong film.

by Shah, not the Outside Reviewer. Shah's failure to follow up on and prove this excuse did not and could not prevent Palmetto from moving forward on this matter.

### CONCLUSION

Contempt is the ultimate judicial power and sparingly used. It requires clear and convincing evidence of a specific intent to violate the express and specific terms of the underlying court order. As shown above, Judge Keesley wisely limited his Settlement Orders to very narrow and specific matters. As also shown above, Judge Early correctly held that Shah had failed to prove any contemptuous violation of those narrow and specific matters. For all of the foregoing reasons, the appealed order should be affirmed.

Respectfully Submitted,



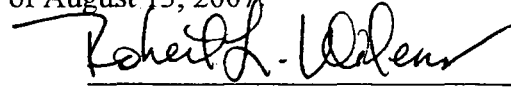
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The undersigned certifies that this Final Respondent's Brief complies with Rule 211(b) SCACR and the Supreme Court Order of August 13, 2007.

A handwritten signature in black ink, appearing to read "Robert L. Widener", is written over a horizontal line.

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THE STATE OF SOUTH CAROLINA  
In the Court of Appeals

APPEAL FROM RICHLAND COUNTY  
Court of Common Pleas  
Doyet A. Early, III, Circuit Court Judge

Case No. 1996-CP-40-0271

**RECEIVED**

MAR 29 2011

**SC Court of Appeals**

Paresh Shah, M.D. and Paresh Shah, M.D.,

P.A. ....Appellants,

v.

Palmetto Health .....Respondent.

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## LAW/ANALYSIS

### **I. The Hospital Has Misconstrued the Relationship Between the 2006 Action and the Rule to Show Cause Hearing And Used its Proposed Order to Misrepresent the Issues Before the Court.**

The Hospital devotes a substantial portion of its Brief to bolster the findings of the Circuit Court's Order that certain important issues were not properly before it. (Resp. Brief p. 17-30). By repeatedly making this argument, the Hospital has misrepresented the connection between Shah's Petitions for Rule to Show Cause and his 2006 lawsuit. During the hearing, the parties and the court operated with the understanding that all issues raised in the 2006 Action would be presented to the court in a non-jury rule to show cause hearing.

The procedural history is important. After Shah filed his Petitions for Rule to Show Cause, the Circuit Court failed to schedule any hearing on these Petitions in 2005 or 2006, despite repeated requests. Shah was, therefore, forced to file the 2006 Action. After his medical staff privileges were terminated and during the time the Petitions and Shah's 2006 Action were pending, additional evidence was discovered which supported Shah's allegations of violations of the underlying Court Orders by the Hospital. Further, Shah could not have presented all the evidence related to many of these particular instances of contempt in the previously filed Rule to Show Cause Petitions as petitions were being filed *while* the Hospital was subjecting Shah to the administrative hearings and the corrective action process. In the 2006 Action the parties conducted substantial discovery for two years on various allegations of contempt. All of this evidence was presented at the hearing on the pending Petitions for Rule to Show Cause.

The 2006 Action was slated for a date certain trial on November 10, 2009. The parties appeared before Judge Early on several pre-trial motions on November 4, 2009. Prior

to appearing on the record, Judge Early commented that since the 2006 Action principally involved breaches of a court order which specifically provided a rule to show cause hearing as the mechanism for alleged violations, a jury trial was unnecessary. {R. 686-689} After the parties discussed how to proceed off the record, the determination was made to proceed in the fashion of a non-jury rule to show cause hearing on all issues. (Id.). Shah was allowed to proceed on issues raised in the 2006 Action, as well as these issues raised in the earlier petitions, at a rule to show cause hearing.

As the record reflected, “all matters [of the 2006 Action] w[ould] be taken care of in the Rule to Show Cause.” {R. 302-303} As Judge Early stated and the parties recognized, *a rule to show cause hearing “would be the same issues basically raised in the [2006 Action].”* {R. 3030} Judge Early said he was going to be “more liberal in receiving all the evidence so [Shah would] be able to make a full and complete transcript.” {R. 305} As it related to “evidence gather[ed]...after [the 2006 Action] was brought in the discovery phase,” Judge Early stated, “we don’t have any Rule 403 issues because I’m going to be hearing it” and “I’ll just let y’all make the record like you want to make it.” {R. 304}

Throughout the three-day hearing, the Hospital *never once* raised an objection that any evidence or any issues presented by Shah to the Court were outside of scope of the petitions and therefore not properly before the Court. This objection had to be made specifically. State v. Stahlnecker, 386 S.C. 609, 617, 690 S.E.2d 565, 570 (2010) (“An objection must be made on a specific ground.”). The Hospital did not object at the hearing to evidence of the underlying facts giving rise to the initial 1996 lawsuit, such as Chief of Staff Kester Freeman’s unrefuted statement that he would “starve Shah out in legal fees.” {R. 324; 328}

The record clearly reflects that evidence obtained in the 2006 action was relied upon throughout the hearing to prove violations of the Court Orders. {R. 423, ll. 21 - 424, ll. 22; 516, ll. 21- 517, ll. 15; 523 ll. 10 – 525, ll. 19} In fact, as Hospital's counsel stated, the Hospital relied upon "the action that was filed in 2006 and the two years of discovery." {R. 573, l. 12 - 574, l. 24} Importantly, Judge Early **never stated** that evidence of contempt was not properly before him. He made no remark even suggesting such a reservation. He repeatedly indicated he would admit and consider all evidence of contempt: "I am going to make a full record." {R. 673, ll. 7-8}; "I'm going to allow everything that has been offered." {R. 674, ll.8-9}

The Consent Order of Dismissal allowing the parties to proceed through a rule to show cause hearing, explicitly stated, "the parties may argue and rely on such information, documents, and discovery from the 2006 action, the affidavits of Drs. Shah, Close and Waldren, as may be relevant and admissible therein." {R. 24} This also allowed for the parties to submit "memoranda in support" based on this evidence. Both parties submitted memoranda during the hearing. {R. 501} The Hospital filed its memorandum on November 10, 2008. Shah's consolidated memorandum was filed the next hearing day and responded to "some additional averments [and] arguments" set forth in the Hospital's memorandum. {R. 501, ll. 5-16} The Hospital never objected at the hearing that Shah memorandum raised issues not previously set forth in the petitions.

Further, the Hospital presents no law to support the proposition that all allegations of contempt must be specifically enumerated in a filed petition for rule to show cause. The well settled law is contrary to the Hospital's position. In Upchurch v. Upchurch, 367 S.C. 16, 27, 624 S.E.2d 643, 649 (2006) the Supreme Court recognized: "When issues not raised by the

pleadings are tried by express or implied consent of the parties, they shall be treated in all respects as if they had been raised in the pleadings. If a party does not object to the evidence when presented at trial, the issue is considered tried by consent.” Not only did the Hospital never object to the evidence on the ground it was outside the scope of the petitions, the Hospital presented evidence in opposition to these allegations.

On appeal, the Hospital avers “Shah never argued ‘implied consent’ to the trial court and, therefore, it is not properly before this Court.” However, in Shah’s Motion to Reconsider, the first two grounds raised were that the Court failed to rule on evidence before the it and that it failed to address issues the parties consented to be heard. {R. 262-263} Stahlnecker, supra, (“A party need not use the exact name of a legal doctrine in order for the issue to be preserved, but it must be clear the argument has been presented on that ground.”) Thus, as the record reflects, the parties tried these issues by express consent as evidenced by the record. At the very least, these issues were before the Circuit Court as a result of the Hospital never objecting on this ground.

So the question remains, how did Judge Early’s Order suddenly carve out and disregard the clear—mostly unrefuted— evidence of instances where the Hospital failed to comply with the Court Orders? This occurred when the Hospital slid this position into its proposed order which Judge Early signed without any revision or edit. By doing this, the Hospital was able to excuse Judge Early from fully addressing on the merits the several clearly documented instances of contemptible violations of the Court Orders. This approach runs afoul of the Court’s imperative to see to it that parties follow the commands of the court. See Miller v. Miller, 375 S.C. 443, 453-54, 652 S.E.2d 754, 759 (Ct. App. 2007) (holding

that without the power of find individuals in contempt, the administration of the law would be in continual danger of being thwarted by lawlessness).

The Hospital's attempt to misrepresent and distort the issues is further reflected in the provision of the Circuit Court's finding that even if contempt was found no relief could be awarded as a matter of law. {R. 30-31} Out of the blue, the Circuit Court also ruled that the Health Care Quality Improvement Act ("HCQIA") and the doctrine of non-review both applied and barred any relief sought. The hearing never addressed any issues of damages or other relief. These issues were not briefed by the parties. Likewise, neither the applicability of the HCQIA nor the doctrine of non-review was litigated. The Court stated "we are all working under the same objective which is to get whether or not there was a contempt matter...if I rule... [the Hospital is in contempt] then we would have a separate proceeding...we got to cross one bridge before we get to the next." {R. 554-555} It is an injustice for the Circuit Court to rule that evidence of contempt was not properly before him, while stunningly at the same time, making rulings on issues related to HCQIA and the doctrine of non-review when neither of those issues were litigated.

So the next question is how did the Circuit Court address issues of damages that were not before the Court? Again, the Hospital slid this finding in the proposed order. This time, it was financially motivated to do so. After this Order was entered, the Hospital promptly filed a motion for attorney's fees by claiming that a determination under HCQIA allows a statutory award of attorney's fees. See 42 U.S.C. § 11113. {R. 278-285} While this motion has not been heard, the Hospital seeks attorneys' fees well over 1.5 million dollars. **These attorneys' fees and costs relate primarily to defending the 2006 Action.** This further demonstrates the Hospital **knew** the issues of contempt raised in the 2006 Action were

incorporated by agreement into the rule to show cause hearing. Otherwise, it could not claim attorneys' fees in the Rule to Show Cause hearing incurred as a result of the 2006 Action. This further reveals the Hospital's litigation position on appeal is disingenuous and hypocritical.

For these reasons, the Hospital misrepresented the interconnection between the 2006 Action and the hearing before the Court in a further attempt to misrepresent the issues that were before the Circuit Court.

## **II. Evidence of Improperly Selected and Reviewed Medical Cases Was Before the Court.**

One of the fundamental requirements of the 2001 Consent Order of Settlement was to ensure fairness in Shah's QA process. This process required an outside reviewer for case selection. The Consent Order of Settlement clearly states, "This outside reviewer will have oversight authority over the case selection process as well as the cases themselves." {R. 2} The Hospital's conduct with regard to considering and relying upon stockpiled breast biopsy cases, and 35 separate Emergency Room cases, are clear violations of the Court Orders.

### **A. Violations of the Settlement Orders Regarding Stockpiled Breast Biopsies Cases**

All issues and arguments raised regarding breast biopsies constitute *prima facie* evidence the Hospital deliberately did not afford the Independent Outside Reviewer oversight authority with regard to the selection of Shah's cases for review. This demonstrates the Hospital wanted to find any reason to portray Shah as an incompetent doctor even on procedures, such as breast biopsies, which he had voluntarily discontinued performing years earlier. {R. 875} The Circuit Court's finding that the Hospital's review of old stockpiled cases not was before the Court strains reason, fairness and, more importantly, is refuted by



the record. In the absence of this objection, evidence related to the inappropriate review of collected breast biopsy cases was presented at length by Shah's testimony. {R. 356-358; 360-361; 364-365; 367-368; 374-375; 520-521} The Hospital also presented evidence and arguments on this issue. {R. 554-556; 609-611; 613-614; 627-628} Thus, this issue was tried by consent.

The evidence related to the Hospital improperly selecting breast biopsies further proves the Hospital tampered with the case selection process in order to achieve its desired result. No cases were stockpiled on any other physicians. After Shah complained that the selection of cases was a direct violation of the underlying Orders, an internal report of the Hospital's Probation Hearing Committee recognized this problem. It noted the old stockpiled medical cases sent to Dr. Selby for QA review were not a fair measurement of Dr. Shah's clinical skills. {975-980} Acknowledging the Court Orders were not followed, this Committee decided "a random audit of fifteen percent (15%) of all invasive procedures should be carried out ... *as required by Judge Keesley's Order, the selection shall be done under the direction of Dr. Bayne Selby.*" (*Id.*) This was an admission by the Hearing Committee that Dr. Shah's QA up to that point had not been a "fair measurement." This committee decision demonstrates the Order's instruction regarding case selection was not followed by the Hospital. Their own internal report admits as much and recognized the need for compliance.

The evidence related to the Hospital tampering with the case selection process is significant. After the issuance of this Hearing Committee Report, Dr. Selby performed a random audit of hundreds of medical cases performed by Shah. {R. 991; 994-999; 1007}.<sup>1</sup>

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<sup>1</sup> Once the Hospital finally allowed Dr. Selby to control the case selection process, no deviation from the medical standard of care was found, despite the fact hundreds of patient cases were reviewed.

Dr. Selby found no deviation from the standard of care. In the face of these glowing reviews, the Hospital took deliberate action to disregard these highly favorable reports. In fact, the Hospital concealed these favorable reports by Dr. Selby from hearing committee members.<sup>2</sup> Before the Circuit Court, the Hospital presented no evidence that it considered the “fairer measurement” reports or that it did not conceal these findings from decision-makers at the Hospital.

Thus, the Circuit Court erred in failing to determine that the Hospital’s tampering with the case selection process was not in violation of the Court Orders.

**B. Violations of the Settlement Orders Related to 35 Emergency Room Cases Never Reviewed by the Independent Outside Reviewer**

The Hospital’s brief largely ignores the 35 emergency department cases submitted by the head of that department. One of the most self-evident and egregious violations of the Court Orders is proven by the Hospital’s reliance on the totally unauthorized review conducted by Hospital employee, Dr. John Stewart, of 35 emergency room cases. Dr. Stewart’s report on these cases was one of the justifications for terminating Shah’s privileges. None of these ER cases was reviewed by Dr. Selby. These cases were not selected in a process overseen by Dr. Selby. These facts are unrefuted. As clearly and unequivocally stated in the Consent Order of Settlement, “the Quality Assurance review of Dr. Shah’s medical cases will be removed from the responsibility of the Radiologists . . . [and] a Radiologist mutually selected by Palmetto Richland Memorial and Dr. Shah will conduct the Quality Assurance reviews of Dr. Shah’s cases.” {R. 2} All reviews of Dr. Shah’s medical

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<sup>2</sup> As more fully discussed in pages 12-14 of Shahs’ initial brief, even after Dr. Selby had conducted reports based on the “fairer measurement,” Hospital administration refused to present these favorable reports to hearing members and falsely represented the reviews of “stockpiled” cases were Dr. Selby’s only reports. {R. 741-800}

cases were to be performed by the outside reviewer, not internally by other physicians at the hospital. The Hospital knew and understood this provision of the Order.

The fact that the Hospital's physician, Dr. Stewart, reviewed these 35 Emergency Room cases was first revealed in discovery in the 2006 Action. This documentation was submitted as additional *evidence* of contempt on the part of the Hospital with regard to the case selection process. The Hospital's argument that this constituted a new *issue* not previously raised by Dr. Shah in his petitions misses the mark. The broad, over-reaching violations by the Hospital by this improper case selection and review were not addressed in the Circuit Court's Order.

More importantly, the finding that this evidence was not properly before the Court is clear error. This issue was presented to the Court without objection. {R. 704-722; 510-515; 227-228, 253-254} The Hospital cannot argue— with any candor to this tribunal— the issue of the wrongful review of 35 Emergency Room cases was not before the Court. The Hospital's own memorandum submitted to the Circuit Court contained a section captioned: **“V. THE FAIR HEARING COMMITTEE PROPERLY CONSIDERED DR. SHAH'S CASES FROM THE EMERGENCY ROOM DEPARTMENT.”** In the Hospital's memorandum to the Circuit Court, the Hospital presented evidence and argued it “had a legitimate concern in reviewing Dr. Shah's ER cases,” despite the clear directives of the Court Orders. {R. 227-228}

At the hearing, the Hospital did not argue this alleged violation was not properly before the Court. In fact, the Hospital's position on appeal related to these ER cases illustrates just how disingenuous it is to argue this matter was not before the Court. The question is: How did the Hospital know to argue in it November 10, 2008 memorandum that

the 35 Emergency Room cases was not a violation of the Court Order if this was not set forth in the original petitions?<sup>3</sup> The only explanation is the Hospital **knew** Shah could present evidence of this contemptuous conduct revealed through discovery in 2006 Action. Otherwise, the Hospital would have never advanced this argument. The Hospital should be estopped from arguing otherwise. See Quinn v. The Sharon Corporation, 343 S.C. 411, 416, 540 S.E.2d 474, 476 (Ct. App. 2000) (Anderson, J., concurring) (“A court must be able to rely on the statements made by the parties because truth is the bedrock of justice. Therefore, a litigant cannot ‘blow both hot and cold.’ Under the doctrine of judicial estoppel, a party that has assumed a particular position in a judicial proceeding, via its pleadings, statements, or contentions made under oath, is prohibited from adopting an inconsistent posture in subsequent proceedings.”) (citations omitted).

If the Circuit Court had addressed the issue of this unauthorized review and reliance upon 35 Emergency Room cases as a reason for terminating Shah, the evidence is overwhelming the Court would have to find this act constituted an intentional and willful violation of the Court Orders. The Hospital indubitably knew all reviews of Dr. Shah’s medical cases were to be handled **only** by the independent outside reviewer. {R. 2} The Court Orders did not leave room for any exceptions.

The evidence is undisputed that Dr. Selby neither selected nor reviewed these cases. {R. 1019; 937; 939} The Hospital selected and considered these 35 cases and determined Dr. Shah violated a standard of care. The Hospital admitted these cases were sent to the Medical Executive Committee. It stated, “...the MEC determined that review of the ER cases was critical in evaluating Dr. Shah’s competence.” {R. 228}

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<sup>3</sup> As stated earlier, the answer cannot be because Shah presented this argument in his memorandum. Shah’s memorandum was filed on November 12, 2008, two days after the Hospital filed its memorandum.

Utilizing these cases against Dr. Shah in the QA process was a deliberate and patent violation of the letter and spirit of the Court Orders. The removal of Shah's QA reviews from physicians at the Hospital was the major purpose of the Settlement Orders. The Hospital's use of these 35 cases as a basis for Shah's termination of privileges is a demonstration of the Hospital's conscious disregard for the clear requirements of the Court Orders.

Accordingly, the Circuit Court erred when it failed to properly address unrefuted evidence the Hospital violated the Court Orders by internally reviewing 35 emergency room cases and used them to justify its decision to terminate him.

### **III. The Imposition of a Psychological Evaluation Should Have Been Addressed by the Circuit Court.**

For the Hospital and the Circuit Court to sidestep the issue concerning the Hospital's requirement for a psychological evaluation of Dr. Shah is erroneous. The Court erred in finding, "this issue is not properly before me as it was not raised until after the 2008 Dismissal Order" and "not asserted in any of the 'pending motions'" {R. 42-43}. These findings are clearly refuted by the record.

This issue was actually first addressed in a Petition for Rule to Show Cause submitted by Shah on December 19, 2005 {R. 89-94}. Respondent's brief specifically points out, in the section entitled "Shah's Second Contempt Motion," subsection (2), that this issue was raised by Shah in his petitions. (Res. Brief p. 12). Throughout the hearing, without objection, both parties presented evidence on the merits of the imposition of a psychological evaluation. The parties presented case law advocating their respective positions. {R. 453-459; 497-498; 502-504; 532-534; 615-616; 625-629}. Shah relied on Huellmantel v. Greenville Hosp. Sys., 402 S.E.2d 489 (Ct. App. 1991) as instructive. Id. The Hospital cited to In re Vora, 354 S.C.

590, 595, 582 S.E.2d 413, 416 (2003). {R. 649-652} In a filing submitted by the Hospital entitled, "Presentation of Palmetto Health," the Hospital specifically addressed the psychological evaluation issue under the heading: **"8. THE DECISION TO REQUIRE DR. SHAH TO UNDERGO AN EVALUATION WAS NOT A VIOLATION OF ANY ORDER."** {2385} Thus, this issue was a clearly framed before the Circuit Court. See Upchurch v. Upchurch, 367 S.C. 16, 27, 624 S.E.2d 643, 649 (2006) ("When issues not raised by the pleadings are tried by express or implied consent of the parties, they shall be treated in all respects as if they had been raised in the pleadings. If a party does not object to the evidence when presented at trial, the issue is considered tried by consent.").

At the conclusion of the hearing, Judge Early was particularly interested in each party submitting a proposed order that specifically addressed "the requirement of the psychiatric [sic] review" with emphasis on "the Greenville case."<sup>4</sup> He never once stated, nor did the Hospital once argue, this issue was not properly before the Court.

If the merits regarding this issue had been properly examined, the Court would have found a violation of the Court Order. The Court Orders required the Hospital to follow the Bylaws. Specifically, the 2003 Supplemental Order provides, "the Hospital advises that its [Bylaws]....are generally applicable to members of the Department...all physicians on the Hospital's Medical Staff must follow these Bylaws" [and] "Administrative Requirements should be addressed through the procedures set forth in the Bylaws and Policies." {R. 13-14} The Supplemental Order also required all administrative issues be handled by the chief of the department stating, "The Court, therefore, directs that matters involving Administrative Requirements be referred to the Chief [of the Radiology Department] for handling in accordance with the Bylaws and Policies." {R. 15}

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<sup>4</sup> The Court was referring to Huellmantel v. Greenville Hosp. Sys., 402 S.E.2d 489 (Ct. App. 1991).

The Hospital's counsel conceded these points during the hearing, stating "If I'm reading the Supplemental Order correctly...the Hospital is required to handle administrative requirements **in accordance with the Bylaws.**" {R. 561-563} Quinn, supra, "truth is the bedrock of justice ... therefore, a litigant cannot 'blow both hot and cold.'" In the Hospital's brief, it represents no argument to contradict or explain this clear admission by its counsel.

As the record demonstrates, the Bylaws expressly provide a detailed procedure for handling any matters warranting psychological evaluation.<sup>5</sup> The Bylaws specifically required the Hospital to place Shah on notice of any behavioral issues which would be addressed at the hearing by the committee. {R. 928} Admittedly, the Hospital did not comply with the Bylaw's notice requirement. {R. 1023-1024} Then, the Hospital argued Dr. Shah was a "disruptive" physician and should have known this was an issue. {R. 625-627} However, this argument must fail because the Bylaws contain a specific policy ("Disruptive Conduct Policy") to address allegedly disruptive conduct {R. 932-936} This policy sets forth a specific procedure to be followed regarding alleged disruptive behavior by a physician, including written notification and a meeting with the Chief of the physician's department. (Id.) This policy was never followed. The Hospital's failure to prove these requirements were met, constitutes the Hospital's concession it did not follow this policy.

The notice provisions required in the Bylaws are designed to provide physicians with basic due process and fairness. Once the Hospital ordered Shah to undergo a psychological evaluation by it's own self-selected psychologist, he was unable to defend himself. Shah was allowed an internal "appellate review" of this decision, and the other terms of his probation,

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<sup>5</sup> Requiring a physician to submit to a psychological evaluation is particularly damning and harsh. It has the effect of permanently stigmatizing a physician and discrediting his professional practice. Other physicians at the Hospital testified they found this requirement offensive, intrusive, stigmatizing, and unwarranted. {R. 981-990} This is why the Bylaws require a physician to have notice to defend against such an allegation. {R. 932-936}

but he was constrained to the record which had been submitted to the hearing committee. As such, he was specifically not afforded the right to present witnesses, testimony, or evidence to dispute the Hospital's contention he was disruptive. {R. 453-459; 1000-1004; 1005} If Shah had been properly given his due process rights, including notice, as required in the Bylaws, he would have had the opportunity to challenge the claim he needed a psychological evaluation. He could have confronted his accuser and called fact or expert witnesses. Since the Bylaws were not complied with, as required in the Court Orders, Shah was denied all due process rights. Due process requires that physicians be afforded timely notice of allegations in a hospital's internal administrative proceeding. See Huellmantel v. Greenville Hospital System, 303 S.C. 549, 402 S.E.2d 489 (Ct. App. 1991) (holding hospital failed to provide physician with due process to challenge the imposition of a psychiatric evaluation by failing to advise of claim warranting psychological care.). While Huellmantel dealt with an implied due process required by law for a public hospital, the facts here are more compelling because the Hospital's Bylaws specifically require proper notice. Courts have deemed hospitals to be contractually bound to follow their bylaws. See generally Strauss v. Peninsula Regional Medical Center, 916 F. Supp. 528 (D. Md. 1996); Bass v. Ambrosius, 520 N.W. 2d 625 (Wis. 1994); 40A Am. Jur. 2d Hospitals and Asylums § 17 (2006).

Evidence in the record supports a finding of contempt for failure to provide notice of psychological evaluation. Throughout the administrative process, Dr. Shah complained to the Hospital this psychological evaluation requirement was wrongfully imposed. Despite this notice, the Hospital continued to press forward and to terminate Shah for failure to submit to this evaluation. Dr. Stewart, the same doctor that wrongfully selected and reviewed the 35 Emergency Room cases told Shah, "you wanted...to snub your nose at the Medical



Staff...And so what you're doing is paying the price for it." {R. 2033, ll. 20-23} The Hospital's obvious desire for Shah to "pay the price" did not allow it to disregard the Court Orders.

Thus, the Circuit Court erred when it failed to even consider this evidence and then ruled it was not a ground for a finding of contempt.

**IV. The Circuit Court Misapplied the Evidence Concerning the Hospital's Failure to Follow the Court Orders With Regard to Patient X.**

The Hospital's response to Patient X fails to address why it did not follow the Court Orders when it determined Shah breached a standard of care. It is clear the Hospital never obtained a "Decision" from Dr. Selby, the independent, outside reviewer. The Supplemental Order states, "If a corrective action is initiated against Dr. Shah pursuant to Addendum 1 to the Bylaws that involves a QA matter not previously evaluated by the outside reviewer, the MEC shall send the matter to the outside reviewer . . . and his Decision will be deemed to satisfy the obligations of the Chief and/or the Department under sections 1.2, 1.3 and 1.4 of the Bylaws." {R. 19-20} By the underlying Order of the Court, the Hospital was required to obtain a "Decision" from the outside reviewer in order to be in compliance with the Order and the provisions of the Hospital Bylaws, specifically Addendum I, governing the procedures for the institution of a corrective action. Prior to any review or final "Decision" by Dr. Selby, the Hospital precipitously found in the report of the Termination Hearing Committee, "Dr. Shah's failure to note an obvious pelvis mass of 12 cm in and of itself establishes deficiencies in his clinical skills." {R. 1019-1021}

Prior to the issuance of the Report of the Termination Hearing Committee, the only "Decision" rendered by Dr. Selby regarding Patient X was, essentially, no medical conclusions could be drawn until after further review of the case in person with Shah. {R.

1015-1017} (Dr. Selby wrote “the best next step would be to review the films together to see if this was in fact the set of films he saw. It would probably be difficult to draw any further conclusion about what happened at the time of scheduled biopsy without reviewing this in person with the radiologist.”).

Although Dr. Selby explicitly requested “[a] full review in person with Dr. Shah,” the same day Dr. Selby sent his report to attorneys for the Hospital, (December 13, 2005) the Termination Hearing Committee began their proceedings and concluded that Shah had deviated from the standard of care in that case. Despite Dr. Selby’s request to review the case with Dr. Shah, the Hospital circumvented the role of the independent outside reviewer, circumvented the requirements of the Supplemental Order, circumvented the requirements of the Bylaws for the institution of a corrective action proceeding and reached its own conclusion. The Hospital supplanted its own determination about Patient X for that of Dr. Selby. This is a clear violation of the Court Orders.

The evidence in the record supports why Dr. Selby felt he needed to meet with Shah in order to issue a final report. Dr. Selby questioned whether Shah was given the correct films to review. {R. 1015-1017} Having reviewed hundreds of films and studies properly read by Shah, Dr. Selby was well familiar with Shah’s ability to read films and to see a baseball-sized mass. It was possible a Hospital employee mistakenly gave Shah the wrong films and/or misidentified the patient. Additionally, Dr. Selby could have met with the other two radiologists who also agreed with Shah’s finding on Patient X. There are many possible explanations regarding the case of Patient X, other than the Hospital’s bold assertion that Shah deviated from the standard of care.

The Hospital also attempts to disregard the legitimacy of Selby's concerns for an in-person meeting. The Hospital now claims Shah never identified at trial the two radiologists that agreed with his reading of the CT scan and never presented any evidence that he read the wrong CT films (Res. Brief p. 47).<sup>6</sup> If the Hospital would have allowed Dr. Selby to perform what the Court Orders required, those two radiologists could have been revealed and no one would be left to speculate now if Shah was given the wrong films. Dr. Selby could have reached a proper decision, but Hospital did not allow this to happen.

On appeal, the Hospital also attempts to place blame on Shah for not meeting with Dr. Selby prior to the Termination Hearing proceedings. Dr. Selby completed and transmitted his "preliminary review" on Patient X to the Hospital on December 13, 2005 at 3:36 pm. {R. 1018} The Hospital commenced its termination hearing less than (2) hours later at 5:28 pm. {R. 1785} It could not be practical nor possible for Shah to meet in-person with Dr. Selby (from Summerville) prior to the hearing.

Additionally, counsel for the Hospital knew this face-to-face meeting had not occurred and requested that Dr. Selby advise when such meeting was scheduled. {R. 1018} At the close of the termination hearing proceedings on December 15, 2005, the Hospital commenced its deliberations. {R. 1019-1021} The Hospital then found Shah deviated from the standard of care when he did not find the 12 cm mass. The Hospital concluded this warranted revocation of his privileges. This finding was made with complete disregard for the Court Orders. The Hospital completely misrepresents the facts when it claims "Shah

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<sup>6</sup> In making this argument, the Hospital states "[Shah] did not testify at trial." This is incorrect. Dr. Shah presented two sworn affidavits. See Miller v. Miller, 375 S.C. 443, 652 S.E.2d 754 (Ct. App. 2007) (holding rule to show cause for contempt that occurs outside the courtroom must be supported by an affidavit.) Moreover, Shah was present during the entire three-day hearing. If the Hospital had reason to believe his sworn affidavit lacked truthfulness or veracity, they could have cross-examined him.

never scheduled the meeting” or that he “never met with the Outside Reviewer” because, by this time, he had already been terminated. {R. 714-715, ¶¶29-30; 1022}

Further, the Hospital misrepresents— in a conclusory fashion— that “the clear requirement of Judge Keesley’s Supplemental Order [states Shah] was responsible for arranging any meeting with the Outside Review.” The Supplement Order states: “the outside reviewer and Dr. Shah shall work, in good faith to select a mutually agreeable time and manner to discuss the assigned cases and complaint. If they cannot agree on a time, Dr. Shah shall be given three (3) proposed appointment times and the proposed method of communication between the reviewer and Dr. Shah. {R. 18} There is no evidence Dr. Selby and Shah were not working together to select this date. Rather, the evidence demonstrates the Hospital took actions to find Dr. Shah had deviated from the standard of care without allowing Shah sufficient time or opportunity to meet with Dr. Selby, and prior to obtaining a “Decision” from Dr. Selby regarding Patient X. Thus, the evidence of the Hospital’s handling of Patient X constitutes a clear violation of the Court Orders.

**V. The Hospital Presented No Evidence and Improperly Claimed the Court Orders Only Pertained to One Specific Portion of the QA Process.**

The Hospital failed to direct the Court to evidence that substantiates the finding that the Court Orders “only [apply to] the first stage of this five stage [QA] process.”

The record is void of any evidence or any argument by the Hospital at the hearing to support this assertion. The finding the Court Orders “only [apply to] the first stage of this five stage [QA] process” is pure fiction. The fact the QA process can be delineated into five stages is nowhere in the record or in the Court Orders. This is another contrived attempt by the Hospital in drafting the order to misrepresent the record before the court.

During the hearing, the Hospital never advanced the position the Court Orders only applied to one “stage” of the QA process, but not other “stages.” For the Circuit Court to conclude the corrective action stage was exempt from the parameters of the Court Orders ignores the evidence. The record shows the Hospital and Shah contemplated and intended the Court Orders to govern throughout the QA process and any proceeding flowing from this process. After corrective action was commenced, the MEC Meeting Minutes reflect the MEC discussed the Court Orders and the “role of the MEC as outlined by the Court.” {R. 920-921} On May 19, 2004, Charles Beaman, President of Palmetto Health, sent a letter to Shah advising him that the MEC had voted to place Shah on probation. In that letter Beaman wrote:

“As you know, **the Order imposed on the MEC the duty and responsibility of determining ‘what action, if any should be taken, pursuant to Section 10.2.2(b) of the Bylaws, including but not limited to, whether or not the matter should be referred for corrective action in accordance with Addendum 1 of the Bylaws.’**”

{R. 925-927} (emphasis added)

After the corrective action had commenced, the Hospital continued to seek a review and decision from Dr. Selby of new cases “**as required by Judge Keesley’s Order.**” {R. 975-980} The Hospital obtained three additional reports from Dr. Selby. {R. 991; 994-999; 1007} In addition, the Hospital sent the case of Patient X to Dr. Selby. {R. 1013-1014} Dr. Selby was directed to render a decision pursuant to the Court Orders.

At no time did the parties contemplate or stipulate the Court Orders were inapplicable to certain “stages” of the QA process on Dr. Shah. All the evidence and the course of dealing between the parties are to the contrary. {R. 913-915; 916-917; 920-921; 925-927; 975-980;

1000-1004} To conclude otherwise, would render any enforcement of the Court Orders functionally meaningless.

The Circuit Court's narrow and restrictive finding that the Court Orders only pertained to one early and specific portion of the entire QA process led to the illogical and unfair refusal to consider substantial evidence of contempt. This finding disregarded clear evidence that: (a) 35 emergency room cases were not reviewed by Dr. Selby; (b) the Hospital failed to obtain a final report and decision from Dr. Selby on the case of Patient X; and (c) the imposition of a psychological evaluation requirement was in violation of the Bylaws.

**VI. The Elements of Contempt are Supported by the Record.**

After the Circuit Court's Order went to considerable lengths to narrowly limit the issues before it, in *dicta* like fashion, the Circuit Court found "were it *assumed* [Shah] has shown any violations...there is no clear and convincing evidence they were willful" {R. 33} "A determination of contempt...is subject to reversal where based on a finding that is without evidentiary support or where there has been an abuse of discretion. Pratt v. S.C. Dep't of Social Svcs., 283 S.C. 550, 324 S.E.2d 97 (Ct. App. 1984). Both of these grounds for reversal are demonstrated by the record in this case.

In its brief, the Hospital argues "Shah has failed to present clear and convincing evidence that Hospital acted willfully." (Res. Brief p. 32). The Hospital's position attempts to set an unattainably high bar to prove contempt. It insists that "willfulness" was not proven.

In the context of contempt, our supreme court defined a willful act "as one 'done voluntarily and intentionally with the specific intent to do something the law forbids, or with the specific intent to fail to do something the law requires to be done....'" State v. Sowell,

370 S.C. 330, 336, 635 S.E.2d 81, 83 (2006); Spartanburg County Dep't of Soc. Servs. v. Padgett, 296 S.C. 79, 82-83, 370 S.E.2d 872, 874 (1988). The Court of Appeals recently recognized that South Carolina relies on the Black's Law Dictionary's definition of "willful" in this context. State v. Garrard, Op. No. 4743, 2010 WL 3745158 (Sept. 22, 2010). The court recognized that Padgett relied upon the fifth edition of Black's Law Dictionary which defines "willful" as "[p]roceeding from a conscious motion of the will; voluntary. Intending the result which actually comes to pass; designed; intentional; not accidental or involuntary" but compared this definition with the current ninth edition of Black's Law Dictionary which defines "willful" as "[v]oluntary and intentional, *but not necessarily malicious*" and "willfulness" as "[t]he voluntary, intentional violation or disregard of a known legal duty." Id. \*2. (emphasis added). Clearly, with all of its resources and with the history of its relationship with Shah, the Hospital acted voluntarily and intentionally. Thus, because voluntary and intentional acts constitute willfulness, contempt was proven.

The Hospital also attempts to elevate the "clear and convincing" standard by arguing that Shah failed to present evidence "that is so overwhelming, and so clear and convincing." (Res. Brief p. 32). The Supreme Court has defined the term: "Clear and convincing evidence is that degree of proof which will produce in the mind of the trier of facts a firm belief as to the allegations sought to be established. Such measure of proof is intermediate, more than a mere preponderance *but less than is required for proof beyond a reasonable doubt; it does not mean clear and unequivocal.*" Peeler v. Spartan Radiocasting, Inc., 324 S.C. 261, 265, 478 S.E.2d 282, 284 n. 4 (1996)

The record is replete with evidence the Hospital deliberately proceeded in violation of the Court Orders. The "willful" standard does not require proof of malice. For contempt, the

willful standard only means the Hospital disregarded a known legal duty. The legal duties were *known* by the Hospital because they were parties to and bound by the Court Orders. They were served with repeated Petitions for Rule to Show Cause why they should not be found in contempt. If the Hospital violated the legal duties set forth in the Court Orders, contempt should be found. Shah presented more than a mere preponderance. The Hospital knowingly violated the Court Orders. The clear evidence of contempt can be succinctly summarized as follows:

- (a) The Hospital presented to the hearing committee 35 emergency room cases reviewed by Dr. John Stewart. Based on this review, the Hospital concluded that Shah had deviated from the standard of care in his handling of these cases and used this determination as a basis for terminating his medical staff privileges. These cases were neither selected by nor reviewed by Dr. Selby as specifically required by the Court Orders.
- (b) The Hospital determined Shah deviated from the standard of care in his reading of films taken by another radiologist of Patient X and terminated his privileges without allowing Dr. Selby to meet with Shah in person and without a Decision from Dr. Selby on this case as specifically required by the Court Orders.
- (c) The Hospital ordered Shah to undergo a psychological evaluation and failed to afford him required notice as mandated by the Bylaws, which the Court Orders specifically required be adhered to. The Hospital ruled his failure to have this evaluation warranted termination of his privileges.
- (d) The Hospital failed to allow the Dr. Selby to exercise oversight authority in the initial selection of medical cases for review and controlled the case selection process in a discriminatory fashion by submitting a stockpile of old cases in an attempt prevent an objective review of Shah's medical competence.

The Circuit Court should have found at least one of these constituted a violation of the Court Orders, i.e. the disregard of a known legal duty. In addition to the language of the Court Orders, Shah placed the Hospital on notice of these violations. {R. 801-820; 920-921; 993} In its Brief, the Hospital cannot point to any testimony or other evidence to dispute



Shah's affidavits and the requirements of the Court Order related to the above enumerated violations. Because it cannot, it simply sidesteps those violations and expects this Honorable Court to do the same. The evidence is overwhelming that the Hospital disregarded its legal duties required in the Court Orders. To affirm the Circuit Court's order is to affirm a ruling which lacks evidentiary support and constitutes an abuse of discretion.

Finally, the Circuit Court's Order and the Hospital's argument that contempt cannot be found because the Hospital made its "best efforts to comply with the orders" is unavailing. The Hospital claims it gave its "best efforts to comply." {R. 33; 53; Res. Brief p. 33} As the old adage goes, "close only counts in horseshoes and hand grenades. [It] doesn't count here when you have to abide by an order of the court." Kipperman v. Onex Corp., 260 F.R.D. 682, 691 (N.D. Ga. 2009). "Close enough" is simply not good enough. To allow this standard to prevail would scuttle the administration of justice. If the court does not enforce the letter and spirit of the Court Orders, Shah's career will be finished, litigants will give less regard to court orders and the rule of law will suffer.

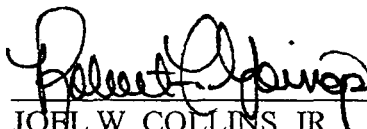
For these reasons, the Circuit Court erred in determined that contempt was not proven as a matter of law when it ruled contempt was not proven in this case.

### **CONCLUSION**

Based on these compelling reasons, this Honorable Court should conclude the Circuit Court erred in issuing an order which was not supported by the evidence or based on errors of law. As such, Shah respectfully requests this Court reverse the Order of the Circuit Court and, as it did in Ex parte Bland, 230 S.C. 1, 337 S.E.2d 540 (2008), enter an order of contempt. In the alternative, this Honorable Court should reverse the Circuit Court and remand the case for further proceedings.

Respectfully submitted,

COLLINS & LACY, P.C.

A handwritten signature in black ink, appearing to read "Robert F. Goings", is written over a horizontal line.

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APPELLANTS' REPLY BRIEF

Columbia, South Carolina

March 29, 2011

THE STATE OF SOUTH CAROLINA  
In the Court of Appeals

---

APPEAL FROM RICHLAND COUNTY  
Court of Common Pleas  
Doyet A. Early, III, Circuit Court Judge

---

Case No. 1996-CP-40-0271

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Paresh Shah, M.D. and Paresh Shah, M.D.,  
P.A.....Appellants,

v.

Palmetto Health.....Respondent.

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**PROOF OF SERVICE**

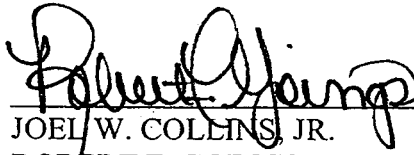
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I certify that I have served the Appellants' Reply Brief on Respondent by mailing a copy of same, via United States Mail, on March 29, 2011 to the following:

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THE STATE OF SOUTH CAROLINA  
In the Court of Appeals

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APPEAL FROM RICHLAND COUNTY  
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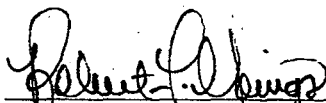
Palmetto Health.....Respondent.

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**CERTIFICATE OF COUNSEL**

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The undersigned certifies that Appellants' Reply Brief compiles with Rule 211(b) SCACR and the Supreme Court Order of August 13, 2007.



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March 29, 2011

**THIS OPINION HAS NO PRECEDENTIAL VALUE. IT SHOULD NOT BE  
CITED OR RELIED ON AS PRECEDENT IN ANY PROCEEDING  
EXCEPT AS PROVIDED BY RULE 268(d)(2), SCACR.**

**THE STATE OF SOUTH CAROLINA  
In The Court of Appeals**

Paresh Shah, M.D. and Paresh Shah, M.D., P.A.,  
Appellants,

v.

Palmetto Health Alliance, f/k/a Richland Memorial  
Hospital, Respondent.

Appellate Case No. 2009-122786

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Appeal From Richland County  
Doyet A. Early, III, Circuit Court Judge

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Unpublished Opinion No. 2012-UP-475  
Heard March 15, 2012 – Filed August 1, 2012

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**AFFIRMED**

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Jones, all of McNair Law Firm, PA, of Columbia; I.S.  
Leevy Johnson and William T. Toal, both of Johnson  
Toal & Battiste, PA, of Columbia; Frederick A.  
Crawford, of Richardson Plowden & Robinson, PA, of  
Columbia, for Respondent.

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**PIEPER, J.:** Appellants Paresh Shah, M.D. and his professional association appeal from an order of the circuit court denying three petitions for rule to show cause (collectively "the Petitions"). All three petitions alleged Respondent Palmetto Health Alliance f/k/a Richland Memorial Hospital (the Hospital) was in contempt of a 2001 confidential consent order of settlement (the Consent Order) and a 2003 supplemental order (the Supplemental Order) (collectively "the Settlement Orders"). Dr. Shah argues the trial court erred by finding the Hospital did not willfully violate the terms of the Settlement Orders. We affirm.<sup>1</sup>

## **FACTS**

Dr. Shah is a board certified vascular and interventional radiologist who formerly worked at the Hospital. In December 1995, the Hospital claimed Dr. Shah had mishandled the diagnosis of six patients. After a hearing, the allegations against Dr. Shah were found to be untrue. The following month, the Hospital excluded Dr. Shah from the duty rotation schedule. Dr. Shah then commenced an action against the Hospital by filing a complaint on January 19, 1996, alleging the Hospital had engaged in a malicious and conspiratorial peer review and denied him his right to practice (the 1996 Action). On the day of trial, the parties reached a settlement agreement and the trial court subsequently entered the 2001 Consent Order, which memorialized the parties' confidential settlement agreement.

The Consent Order (1) provided a monetary award to Dr. Shah; (2) required that future Quality Assurance (QA) reviews of Dr. Shah's medical cases would be removed from the responsibility of radiologists who were associated with the Hospital; (3) enabled either party to bring a dispute regarding the QA review or the duty rotation aspects of the settlement before the court "in the form of a Petition for a Rule to Show Cause"; and (4) dismissed the 1996 Action with prejudice. In essence, the Consent Order removed Dr. Shah from the "normal and traditional" QA process conducted by other radiologists within the Hospital's Radiology Department and established a process whereby an outside, board-certified radiologist would review Dr. Shah's medical cases instead. Upon the selection of an outside reviewer, the reviewer was to have oversight of the selection process and review of Dr. Shah's cases. The Consent Order only addressed the

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<sup>1</sup> The Hospital filed a motion to supplement the record two days before oral arguments were scheduled. At oral arguments, without objection, the motion was granted.

intradepartmental QA process and it expressly provided that Dr. Shah would continue to be bound by the Hospital's Bylaws.

Following the issuance of the Consent Order, the parties were unable to mutually agree upon an outside reviewer. Consequently, the Hospital filed a petition for rule to show cause asking the court to clarify matters addressed in the Consent Order, specify those matters covered by Dr. Shah's QA review process, and clarify the procedures for addressing issues not related to Dr. Shah's extra-departmental QA review process.<sup>2</sup> After a hearing on the petition, the trial court issued the Supplemental Order, which provided more explicit instructions regarding the selection and role of the outside reviewer.

The Supplemental Order first indicated that the purpose of the unique QA process approved for Dr. Shah's cases was "to provide an independent and impartial QA review of Dr. Shah's cases that would not involve the other radiologists within the Hospital's Department of Radiology who have been litigants in this case." The Supplemental Order then noted that "[t]he stated goal of the Consent Order is to remove the [Radiology] Department and the Chief of the Department from involvement in the QA process to ensure fairness, impartiality, and to remove any claim of bias." After recognizing that the 2001 Consent Order did not address alleged violations of Administrative Requirements, the Supplemental Order noted that "[d]uring the hearing, Dr. Shah [had] stated his willingness to have alleged violations of noncompliance with Administrative Requirements handled by the Chief [of the Radiology Department]." Therefore, the Supplemental Order provided that the Chief of the Radiology Department would be responsible for handling issues related to Dr. Shah's compliance with Administrative Requirements, i.e., those matters outside the scope of departmental QA addressed by the Consent Order. The Supplemental Order granted the Chief of the Radiology Department discretion to refer matters to the Chief of Medical Staff or the Medical Executive Committee (MEC).

The Supplemental Order also addressed the process for handling Dr. Shah's "QA process or a complaint against Dr. Shah [that] involves an allegation that Dr. Shah

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<sup>2</sup> The court referred to these other matters cumulatively as "Administrative Requirements," although these matters encompassed much more, including: state and federal regulations; the Hospital's Directives, Bylaws, and Policies; and licensing criteria. All of these items govern every physician affiliated with the Hospital.



deviated from the standard of care in treating a patient . . . ." The court specified that "every effort should be made to make the review as similar as possible to the customary and prevailing procedure followed for any other person on the Medical Staff." As a matter of course, the outside reviewer was to review Dr. Shah's cases and issue a "decision" regarding his work. The outside reviewer was to then notify the MEC, the Hospital's chief of staff, and Dr. Shah of his or her decision within thirty days. The Supplemental Order provided that "[u]pon receipt of the Decision, the MEC shall determine what action, if any, should be taken . . . ." The trial court concluded the Supplemental Order by stating:

Nothing in this Order or in the original Consent Order precludes the initiation of any administrative action provided under the Bylaws or Policies, or limits the Board of Directors of the Palmetto Health Alliance or Hospital management to take such administrative action as they deem necessary for the proper administration and management of the Palmetto Health Alliance and/or Hospital and to assure quality patient care is provided.

Dr. Shah filed a motion to alter or amend the Supplemental Order, but the trial court denied the motion, stating: "The solution of this dispute has to be made to fit within an overlay of federal, state, and local laws and regulations; requirements to meet medical and hospital standards; recognition of patient rights and the public interest; and, strict rules of confidentiality." Ultimately, the Hospital and Dr. Shah mutually agreed upon Dr. Bayne Selby, a radiologist with the Medical University of South Carolina, to serve as the outside reviewer. Throughout the following year, Dr. Selby reviewed Dr. Shah's cases and rendered reports as required by the Settlement Orders.

Shortly after receiving Dr. Selby's fourth report, the MEC initiated a "corrective action" against Dr. Shah. On April 5, 2004, the MEC decided to place Dr. Shah on a ninety-day probation, which the MEC subsequently extended to six months. Dr. Shah appealed. After a lengthy hearing, the Hospital's Fair Hearing Committee (FHC) issued a report of its findings and recommendations to the MEC. In this report, the FHC expressed its opinion that a random audit of invasive procedures performed by Dr. Shah from that point forward would provide a better measurement of Dr. Shah's competence than would a retrospective review of past cases. Therefore, the FHC recommended the MEC place Dr. Shah on probation until September 5, 2005, to allow the Hospital to conduct such an audit. The FHC

also recommended that the MEC require Dr. Shah to successfully complete several requirements as conditions of his probation. Dr. Shah appealed to the Hospital's Board of Directors, but the Board upheld the decision.

In compliance with the FHC report, Dr. Selby began reviewing a number of Dr. Shah's recent cases involving invasive procedures. During this time, Dr. Shah filed a petition for rule to show cause and a memorandum in support of the petition, alleging the Hospital was in contempt of the Settlement Orders. However, the court never held a hearing or ruled on Dr. Shah's petition. Dr. Selby's review resulted in three more reports. On October 31, 2005, the MEC met to discuss Dr. Selby's reports and whether Dr. Shah had satisfied all of the terms of his probation. The MEC ultimately determined Dr. Shah had not satisfactorily met the requirements as outlined in his probation. Therefore, the members of the MEC concluded the meeting by unanimously voting to suspend Dr. Shah's hospital privileges and to recommend the Hospital revoke such privileges.

On December 13, 2005, the FHC commenced a termination hearing. The purpose of the hearing was to hear Dr. Shah's challenge to the MEC's decision to suspend his hospital privileges and its recommendation that the Hospital permanently revoke such privileges. The hearing lasted three days, during which Dr. Shah called eighteen witnesses to testify on his behalf. After the hearing concluded, but prior to the FHC rendering its decision, Dr. Shah filed an amended petition for rule to show cause and a memorandum in support of the amended petition, alleging the Hospital's failure to comply with the terms of the Settlement Orders and Bylaws. Shortly thereafter, on December 30, 2005, the FHC issued its report upholding the MEC's decision to terminate Dr. Shah. The FHC based its decision on its findings that Dr. Shah (1) failed to satisfy the terms of his probation; (2) continued to suffer deficiencies in his clinical competence; and (3) failed to adhere to the Hospital's administrative policies and procedures.

On March 14, 2006, Dr. Shah appeared before the Hospital's Board of Directors to appeal his termination. However, the Board sent Dr. Shah a letter the following month stating its decision to affirm his termination. Shortly thereafter, on April 13, 2006, Dr. Shah filed a third petition for rule to show cause and memorandum in support, again alleging the Hospital's repeated failure to comply with the Settlement Orders. As with the prior petitions, for some unknown reason the trial court never scheduled a hearing on the matter. Therefore, Dr. Shah commenced a new lawsuit against the Hospital by filing a complaint on July 12, 2006, asserting

causes of action for civil compensatory contempt, breach of the Settlement Orders, and breach of the Hospital's Bylaws (the 2006 Action).

After the parties had commenced discovery in preparation for the 2006 Action, the trial court issued an order granting the parties' request to assign the 2006 Action and the pending petitions for rule to show cause to the Honorable Doyet A. Early, III. At a subsequent motions hearing, the parties announced to the trial court that they had reached an agreement to proceed on the Petitions and dismiss the 2006 Action with prejudice. On November 10, 2008, the trial court entered a consent order of dismissal (the Order of Dismissal) signed by all parties. The Order of Dismissal encompassed the parties' agreement that Dr. Shah would dismiss the 2006 Action with prejudice and proceed on the Petitions. The Order of Dismissal also provided "The parties may argue and rely on such information, documents, and discovery from the 2006 Action, and affidavits of Drs. Shah, Close and Waldren, as may be relevant and admissible therein."

Two days after the trial court issued the Order of Dismissal, Dr. Shah filed a "memo in support of consolidated petitions for rule to show cause." After a hearing, the trial court issued an order on February 26, 2009, denying the Petitions. In its order, the trial court found the only permissible grounds and the only permissible relief for contempt were those set forth in the three Petitions and supporting memoranda pending at the time of the Order of Dismissal. Therefore, the trial court declined to consider any grounds for contempt not asserted in the Petitions and the three supporting memoranda, including five alleged violations of the Settlement Orders set forth in Dr. Shah's "memo in support of the consolidated petitions." As to the grounds for contempt set forth in the Petitions, the trial court found, "[Dr. Shah's] allegations, even if assumed true, do not come within the narrowly drawn ambit of the Settlement Orders' proscribed and prescribed conduct. Moreover, the evidence convinces me that [the Hospital] never intended to violate the Settlement Orders, assuming it did in some way." The trial court also ruled, "In addition, all motions are denied because the relief sought by [Dr. Shah was] not available as a matter of law." Pursuant to Rule 59, SCRCP, Dr. Shah filed a motion to alter or amend the judgment. However, the trial court issued an order on April 2, 2009, denying Dr. Shah's motion. This appeal followed.

## **STANDARD OF REVIEW**

A decision on contempt rests within the sound discretion of the trial court, and an appellate court will not disturb such decision unless the trial court has abused its

discretion. *DiMarco v. DiMarco*, 393 S.C. 604, 607, 713 S.E.2d 631, 633 (2011). As an equitable matter, we review the exercise of that discretion de novo. See *Chisholm v. Chisholm*, 396 S.C. 507, 510, 722 S.E.2d 222, 223 (2012) (reviewing the family court's discretion in awarding attorney's fees under a de novo standard of review). Consequently, we will affirm the decision of the trial court unless the appellant satisfies this court that the preponderance of the evidence is against the findings of the trial court. *Id.*

## ANALYSIS

Dr. Shah first challenges the trial court's ruling that the only grounds for contempt properly before it were those asserted in the three Petitions. Dr. Shah argues (1) such finding was a direct contradiction of the parties' agreement and the unequivocal language in the Order of Dismissal, and (2) new issues of contempt arising from the 2006 Action were tried by implied consent of the parties. We disagree.

"As a general rule, judgments are to be construed like other written instruments." *Hailey v. Hailey*, 357 S.C. 18, 25, 590 S.E.2d 495, 498 (Ct. App. 2003) (internal quotation marks omitted). "The determinative factor is the intent of the parties or the court, as gathered, not from an isolated part of the contract or judgment but from all its parts." *Petition of White*, 299 S.C. 406, 412, 385 S.E.2d 211, 215 (Ct. App. 1989). Hence, a judgment or contract should be examined and considered in its entirety. *Id.* "[I]f the language employed is plain and unambiguous, there is no room for construction or interpretation and the effect thereof must be declared in the light of the literal meaning of the language used." *Id.*

We find the Order of Dismissal unequivocally limited the grounds for contempt to those asserted in the Petitions. The first paragraph provides, "The Plaintiffs agree to and hereby dismiss [the 2006] action against all Defendants *with prejudice*." The order subsequently provides, "Plaintiffs will proceed in the 1996 action on the pending petitions for rule to show cause and memoranda in support." Read together, we find these provisions unambiguously express the parties' agreement for Dr. Shah to dismiss all of his claims against the Hospital from the 2006 Action and proceed solely on the three petitions for rule to show cause that were pending at the time the court issued the Order of Dismissal. Dr. Shah interprets the language permitting "[t]he parties [to] argue and rely on such information, documents and discovery from the 2006 action, and affidavits of Drs. Shah, Close and Waldren, as may be relevant and admissible therein," as expressly allowing

him to assert grounds for contempt other than those in the Petitions. However, looking at the Order of Dismissal as a whole, this language can only reasonably be interpreted as an expression of the court's intent to permit the parties to supplement or support their existing arguments already set forth in the pending Petitions and supporting memoranda with information subsequently discovered in preparation for the 2006 Action. Therefore, grounds for contempt other than those asserted within the Petitions and the three supporting memoranda were not properly before the trial court.

As to Dr. Shah's implied consent argument, we find the issue is not preserved for our review. Dr. Shah argues the Hospital's failure to object to the introduction of evidence relating to issues from the 2006 Action constituted the Hospital's implied consent to litigate grounds for contempt not asserted in the Petitions. However, Dr. Shah did not make this argument in his motion to alter or amend the judgment. Therefore, the issue was never ruled upon by the trial court. *See Herron v. Century BMW*, 395 S.C. 461, 465, 719 S.E.2d 640, 642 (2011) ("[A]n issue cannot be raised for the first time on appeal." (internal quotation marks omitted)). Furthermore, even if the issue of implied consent was properly preserved, Dr. Shah's argument lacks merit because any objection made by the Hospital to the introduction of evidence would have been futile due to the trial court's ruling that it would allow all evidence offered, despite any objections, and it would then determine the relevancy, admissibility, and persuasiveness of the evidence. *See Staubes v. City of Folly Beach*, 339 S.C. 406, 415, 529 S.E.2d 543, 547 (2000) (providing our courts do not require parties to engage in futile actions in order to protect their interests on appellate review). For these reasons, we find the trial court acted within its discretion by only considering evidence that related to the grounds for contempt asserted in the Petitions and the three supporting memoranda.

Next, Dr. Shah challenges the trial court's determination that the Hospital was not in contempt of the Settlement Orders. Dr. Shah argues the trial court erred by finding the Settlement Orders only applied to the initial QA review, and therefore, allegations that the Hospital violated its Bylaws did not provide grounds for holding the Hospital in contempt. Dr. Shah also argues that the evidence supports finding the Hospital in contempt. We disagree.

"All courts have the inherent power to punish for contempt . . . ." *Ex parte Cannon*, 385 S.C. 643, 660, 685 S.E.2d 814, 824 (Ct. App. 2009) (citation omitted). "[C]ontempt results from the willful disobedience of a court order."

*Knight v. Austin*, 396 S.C. 518, 522, 722 S.E.2d 802, 804 (2012) (citation omitted). "A willful act is one which is done voluntarily and intentionally with the specific intent to do something the law forbids, or with the specific intent to fail to do something the law requires to be done; that is to say, with bad purpose either to disobey or disregard the law." *Miller v. Miller*, 375 S.C. 443, 454, 652 S.E.2d 754, 759-60 (Ct. App. 2007) (internal quotation marks omitted). "Where a contemnor is unable, without fault on his part, to obey an order of the court, he is not to be held in contempt." *Smith-Cooper v. Cooper*, 344 S.C. 289, 301, 543 S.E.2d 271, 277 (Ct. App. 2001) (citation omitted). "In a proceeding for contempt for violation of a court order, the moving party must show the existence of a court order and the facts establishing the respondent's noncompliance with the order." *Hawkins v. Mullins*, 359 S.C. 497, 501, 597 S.E.2d 897, 899 (Ct. App. 2004) (citation omitted). "Before a court may find a person in contempt, the record must clearly and specifically reflect the contemptuous conduct." *Miller*, 375 S.C. at 454, 652 S.E.2d at 760 (internal quotation marks omitted). "Once the moving party has made out a prima facie case, the burden then shifts to the respondent to establish his or her defense and inability to comply with the order." *Id.* (internal quotation marks omitted).

We find the Settlement Orders only govern the QA review process; these orders do not purport to govern every aspect of continued interaction between Dr. Shah and the Hospital. Both the 2001 Consent Order and the 2003 Supplemental Order expressly set forth limited requirements regarding Dr. Shah's QA reviews. The purpose of the Consent Order was to establish an extra-departmental process for conducting Dr. Shah's QA reviews to ensure that Dr. Shah received fair and unbiased reviews of his cases. The Consent Order does not reference any other stage of the peer review process, much less set forth any requirements as to how the Hospital was to conduct its review of matters outside the QA process.

The court issued the Supplemental Order to set forth additional procedures and guidelines regarding the QA review process and to "clarify the procedure for handling issues related to non-QA Administrative Requirements." In this order, the court first recognized that "Administrative Requirements are not matters traditionally included in the QA Process as envisioned by the prior Consent Order," and therefore, "should be addressed through the procedures set forth in the Bylaws and Policies." This language acknowledges that the court only intended to specify how the Hospital conducted QA reviews of Dr. Shah's cases. Accordingly, the Supplemental Order directs the Chief of the Hospital's Radiology Department to handle any allegation that Dr. Shah violated the Administrative Requirements in

accordance with the Hospital's Bylaws and Policies. The fact that the court directs a person affiliated with the Hospital to handle these administrative matters internally and in accordance with the Hospital's rules and regulations expresses the court's intent to narrowly limit its intrusion on the Hospital's self-governance to directing how the Hospital conducted QA reviews of Dr. Shah's cases. The Supplemental Order concludes by reiterating this intent, expressly indicating that the court does not intend to preclude the Hospital from taking *any action* authorized under the Bylaws or limit the Hospital's managers and directors from taking such action that they deem necessary.

Although the Supplemental Order addresses matters outside the QA review process, such as Administrative Requirements, the court did not direct the Hospital to handle these matters in any particular manner. Rather, the court permitted the Hospital to address these matters in accordance with its own rules and regulations. Because the Settlement Orders only set forth requirements governing how the Hospital conducts QA reviews of Dr. Shah's cases, our review in this case is limited to determining whether the Hospital complied with those requirements. Therefore, we decline to address the asserted grounds for contempt that are unrelated to the QA review process. *See* Rule 220(b)(2), SCACR (providing an appellate court need not address points unnecessary to the decision of the appeal).

As to the merits of the case, we find Dr. Shah failed to present clear and convincing evidence that the Hospital willfully violated the Settlement Orders. Dr. Shah contends the Hospital failed to comply with requirements governing the QA review by not providing Dr. Selby, the outside reviewer, with oversight authority in the case selection process. To support his position, Dr. Shah points to evidence that Dr. Selby did not personally select the medical cases used in his review. However, Dr. Shah's argument misinterprets the Settlement Orders. The Consent Order provides a mutually selected outside reviewer will conduct the QA reviews of Dr. Shah's cases and "[t]his outside reviewer will have oversight authority over the case selection process as well as the cases themselves. The outside reviewer will insure that the selection process is performed consistent with [the Hospital's] established protocols and not in a discriminatory fashion." The Supplemental Order subsequently reiterates this latter provision, indicating "every effort should be made to make the review as similar as possible to the customary and prevailing procedure followed for any other person on the Medical Staff." This language unambiguously required the Hospital to provide the outside reviewer with the authority to *oversee* the QA review for the purpose of ensuring Dr. Shah's reviews

were conducted in accordance with the existing procedures and protocols, and not in a discriminatory manner.

While this authority would certainly permit the outside reviewer to personally select the cases used in Dr. Shah's QA review if he or she so chose, the Settlement Orders did not specifically require the outside reviewer to do so. Moreover, the Settlement Orders do not prohibit the Hospital from submitting cases to Dr. Selby for his review. Although the Hospital selected the first group of cases that Dr. Selby used in his review, the Hospital fully complied with Dr. Selby's subsequent request for additional cases selected on a different basis. The evidence shows Dr. Selby was then free to choose which cases he would use in his review of Dr. Shah. The record herein does not clearly support a finding that the Hospital willfully impaired or prohibited Dr. Selby's authority to oversee the QA review and process. For these reasons, we find the trial court acted within its discretion by declining to hold the Hospital in contempt.

Again, we emphasize that the merits of the decision to terminate Dr. Shah's hospital privileges is not before us. Rather, our review of this case is narrowly limited to determining whether the Hospital willfully violated the terms of the Settlement Orders. In addition, while we recognize the procedures adopted by the parties and the trial court were unusual, we also recognize the court's broad discretion in choosing to implement equitable remedies or sanctions, including contempt. Even if the evidence is conflicting as to willful conduct, the fact finder's decision on contempt may be affirmed absent an abuse of the broad discretion granted to the court.<sup>3</sup>

## **CONCLUSION**

For the foregoing reasons, the decision of the trial court is hereby

**AFFIRMED.**

**GEATHERS, J., concurs.**

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<sup>3</sup> In light of our disposition herein, we decline to address Dr. Shah's remaining arguments. *See Futch v. McAllister Towing of Georgetown, Inc.*, 335 S.C. 598, 613, 518 S.E.2d 591, 598 (1999) (providing an appellate court need not address all issues on appeal when the disposition of one issue is dispositive).



**SHORT, J., dissenting:**

I respectfully dissent. The appellant, Dr. Shah, had full privileges at the Hospital for more than twenty-nine years, and he maintained a large and profitable independent radiology practice there until the Hospital terminated his privileges on March 14, 2006. In 1995, the Hospital awarded an exclusive contract to a radiology group to render all radiological services for the Hospital, and that is when this dispute began. Ultimately, the parties reached a settlement agreement; however, they could not agree on an outside reviewer and the scope of the review process. Therefore, Judge Keesley issued a supplemental order addressing the issues and providing for a method to be used by the parties to select an outside reviewer.

Dr. Shah alleged the Hospital willfully violated the settlement orders by failing to comply with requirements governing the review process by not providing Dr. Selby, the outside reviewer, with oversight authority in the case selection process. However, the trial court found the settlement orders only applied to the QA review process; thus, Dr. Shah's allegations failed to provide grounds for holding the Hospital in contempt.<sup>4</sup> When read in totality, I find the clear intent of the 2001 consent order and 2003 supplemental order was to provide for an outside review of Dr. Shah's cases to determine whether he deviated from the standard of care in treating patients. I also find the orders do not limit the outside review to the QA review process because the supplemental order states:

When a matter involves the traditional QA Process *or a complaint against Dr. Shah involves an allegation that Dr. Shah deviated from the standard of care in treating a patient*, those matters shall be referred to an outside

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<sup>4</sup> "Contempt results from the willful disobedience of a court order, and before a court may find a person in contempt, the record must clearly and specifically reflect the contemptuous conduct." *Widman v. Widman*, 348 S.C. 97, 119, 557 S.E.2d 693, 705 (Ct. App. 2001). A party can act willfully by voluntarily and intentionally doing something the law forbids or failing to do something the law requires to be done. *Ex parte Kent*, 379 S.C. 633, 637, 666 S.E.2d 921, 923 (Ct. App. 2008).

reviewer pursuant to the Consent Order and the procedures set forth herein. (Emphasis added).

On December 30, 2005, the Hospital's Fair Hearing Committee issued its report upholding the decision to terminate Dr. Shah's privileges. According to the report, Dr. Shah's termination was justified in part by the Hospital's internal review of thirty-five emergency room cases, which had not been reviewed by Dr. Selby as required by the 2003 supplemental order. These cases were not selected in a process overseen by Dr. Selby, and he did not review them. In addition, these cases contained allegations that Dr. Shah deviated from the standard of care in treating patients; therefore, they should have been reviewed by Dr. Selby per the settlement order. These facts are undisputed.

The circuit court refused to consider this evidence because it found Dr. Shah did not assert it in any of his pending petitions for contempt, and the Hospital's internal review of thirty-five emergency room cases was done at the MEC and FHC stage of the PPR Process and not the QA stage. However, I find the circuit court erred in refusing to consider this evidence concerning the issue of contempt. This evidence was revealed through discovery in the 2006 action, and the parties agreed this evidence could be considered by the court. Dr. Shah's principal grounds in his petitions for contempt were that the Hospital did not allow Dr. Selby to have oversight regarding the case selection process, and this evidence clearly demonstrated the Hospital's conscious disregard for the 2003 supplemental order, which provided for an outside review of Dr. Shah's cases to determine whether he deviated from the standard of care in treating patients. I find the refusal to allow Dr. Selby to review the thirty-five emergency room cases is evidence of the Hospital's continual refusal to comply with the 2003 supplemental order. Further, the issue concerning the thirty-five emergency room cases was presented to the court without objection, and the Hospital presented evidence of the emergency room cases in its memorandum to the court.

I further find the unauthorized review of the thirty-five emergency room cases by the Hospital's employee, Dr. John Stewart, and the Hospital's reliance thereon as justification for terminating Dr. Shah's privileges constitutes overwhelming evidence that the Hospital intentionally and willfully violated the 2003 supplemental order. There is no question the Hospital knew all reviews of Dr. Shah's cases were to be handled by an independent outside reviewer only. As a result, I find the Hospital willfully failed to comply with 2001 consent order and the 2003 supplemental order by conducting an internal review of the thirty-five

emergency cases and determining Dr. Shah violated the standard of care. The Hospital should not have considered these cases in its decision to revoke Dr. Shah's hospital privileges. Therefore, I would remand this case to the trial court to determine the appropriate remedy to be imposed.

THE STATE OF SOUTH CAROLINA  
In the Court of Appeals

APPEAL FROM RICHLAND COUNTY  
Court of Common Pleas

Doyet A. Early, III, Circuit Court Judge

Case No. 1996-CP-40-0271

**RECEIVED**  
OCT 05 2012  
SC Court of Appeals

Paresh Shah, M.D. and  
Paresh Shah, M.D., P.A.....Appellants,

v.

Palmetto Health Alliance, f/k/a  
Richland Memorial Hospital.....Respondent,

**APPELLANTS' PETITION FOR REHEARING AND REHEARING *EN BANC***

**TO: THE HONORABLE JUDGES OF THE SOUTH CAROLINA COURT OF APPEALS:**

Pursuant to Rules 221 and 240 of the South Carolina Appellate Court Rules, Appellants Paresh Shah, M.D. and Paresh Shah, M.D., P.A (collectively "Dr. Shah") seek an order granting rehearing and rehearing *en banc* of this Court's unpublished, 2-1 opinion affirming the decision of the circuit court.

Dr. Shah respectfully avers this Honorable Court overlooked or misapprehended the following points, which support reversal of the circuit court's order declining to find Respondent Palmetto Health Alliance ("Hospital") in contempt of court as a result of its willful violation of two prior circuit court settlement orders ("Settlement Orders").

## LAW/ANALYSIS

### **I. The Court Misapprehended that the Order of Dismissal Limited the Grounds For Contempt to Those Asserted in the Petitions for Rule to Show Cause Filed Before Commencement of the 2006 Action.**

The majority opinion erroneously found the Consent Order of Dismissal unequivocally limited the grounds for contempt to the grounds raised in the prior petitions for rule to show cause ("Petitions"). The Consent Order of Dismissal was entered to allow the court to take up the merits of this dispute by way of the pending 1996 case instead of the separate action filed in 2006 ("2006 Action"). It must be understood that Dr. Shah filed his Petitions during the time that the Hospital was actively violating the Settlement Orders. He made multiple requests that the court schedule a hearing, but these Petitions were never heard. Eventually, after he was terminated and his Petitions had never been addressed, Dr. Shah was forced to file the 2006 Action, alleging that the Hospital had violated the Settlement Orders from the 1996 action.

The parties engaged in discovery for over two years. Additional grounds and more supporting evidence of contempt were revealed during this time. A week before the scheduled jury trial of the 2006 Action, the parties instead agreed to proceed with a Rule to Show Cause hearing before Judge Early. Judge Early believed that judicial economy and proper procedure required the issues of contempt to be heard in the 1996 action. As Judge Early stated, **"all matters [of the 2006 Action] w[ould] be taken care of in the Rule to Show Cause."** (R. 302-03). Judge Early stated and the parties recognized, the rule to show cause hearing **"would be the same issues basically raised in the [2006 Action]."** (R. 303). Judge Early said he was going to be "more liberal in receiving all the evidence so [Dr. Shah would] be able to make a full and complete transcript." (R. 305). As it related to "evidence gather[ed]...after [the 2006 Action] was brought in the discovery phase," Judge Early stated, "we don't have any Rule 403 issues

because I'm going to be hearing it" and "I'll just let y'all make the record like you want to make it." – (R. 304). Accordingly, the Consent Order of Dismissal explicitly stated that the parties could file "**memoranda in support**" and "**argue and rely on such information, documents and discovery from the 2006 action**, and affidavits of Drs. Shah, Close and Waldron, as may be relevant and admissible therein" at the rule to show cause hearing. (R. 24). The Consent Order of Dismissal and Judge Early's comments make it clear that the grounds for and evidence of contempt revealed in the 2006 Action would be merged into the Rule to Show Cause hearing. Following this, both parties submitted extensive memoranda in support and presented additional evidence. (R. 198-261).

The previously filed Petitions were broad and encompassed all issues presented to the circuit court. Dr. Shah complained of the following general violations of the Settlement Orders in his Petitions: (a) lack of oversight by independent outside reviewer in the case selection process; (b) intense scrutiny of Dr. Shah's practice while no QA review of any kind was conducted on any of the other radiologists for over a year and a half (R. 61-73); (c) non-compliance regarding the handling of Administrative Requirements (R. 89-94); (d) unfair and discriminatory selection of medical cases without any involvement of the outside reviewer (R. 97-113); (e) the handling of the case of Patient X and the discriminatory and unfair process related to the evidence presented to the MEC hearing committee (Id.); and (f) wrongfully imposing psychological evaluation. (R. 92-93). **All of these issues were presented in the previously filed Petitions.**

Furthermore, the Hospital never objected at the hearing that Dr. Shah's memorandum raised issues not previously set forth in his Petitions. The Hospital, likewise, never objected that any evidence presented at the hearing exceeded the scope of the issues properly before the court.

All of the evidence Dr. Shah presented was directly related to the Hospital's violations of the Settlement Orders, as set forth in the Petitions, and the additional evidence that Dr. Shah gathered in the 2006 Action was properly before the court. In the Petitions, Dr. Shah raised the issue of the discriminatory fashion in which cases were selected without the oversight authority of the outside reviewer. The discovery conducted in the 2006 Action revealed further evidence to prove this claim. For example, discovery revealed that 35 Emergency Room cases used to justify his termination were neither selected nor reviewed by the independent outside reviewer. Both parties presented significant evidence related to these 35 Emergency Room cases and argued the merits in memoranda to the court. (R. 227-228; 253-254). The Hospital never once objected to the admission and circuit court's consideration of this evidence or other evidence of contempt. The Court's decision misapprehends the Consent Order of Dismissal and, as a result, erroneously fails to consider the evidence of contempt arising from the 2006 Action.

Based on this conclusion, the Court erred in refusing to consider evidence of five (5) violations listed in Dr. Shah's memorandum, namely evidence related to: (1) improperly selected and stockpiled breast biopsies; (2) the 35 Emergency Room cases never selected or reviewed by the independent outside reviewer; (3) the improper handling of administrative issues; (4) the wrongful imposition of a psychological evaluation in violation of the Bylaws; and (5) the Hospital's discriminatory QA process against Shah. (R. 252-260; App. Brief pp. 24-28). Such evidence demonstrates the Hospital's deliberate pattern of non-compliance with and conscious disregard of the Settlement Orders.

**II. Dr. Shah's Argument that Issues From the 2006 Action Were Tried by Implied Consent is Preserved for Appeal and the Hospital's Objections Would Not Have Been Futile.**

The Court erroneously found Dr. Shah failed to preserve for appeal the argument that evidence and grounds of contempt revealed in the 2006 Action were tried by "implied consent." The majority opinion reasoned this issue was not preserved because "implied consent" was not mentioned in Dr. Shah's motion to alter or amend.

The South Carolina Supreme Court has held that "a party is not required to use the exact name of a legal doctrine in order to preserve the issue." Herron v. Century BMW, 395 S.C. 461, 466, 719 S.E.2d 640, 642 (2011) (citations omitted). Instead, "the issue must be sufficiently clear to bring into focus the precise nature of the alleged error so that it can be reasonably understood by the judge." Id. (multiple citations omitted). In Herron, the Supreme Court cautioned that appellate courts "need to approach issue preservation rules with a practical eye and not in a rigid, hyper-technical manner." Id. at 470, 719 S.E.2d at 644.

Although Dr. Shah did not use the exact phrase "implied consent" in his motion to alter or amend, the rules of issue preservation do not require such rigid compliance. Throughout his motion to alter or amend, Dr. Shah argued that evidence adduced during the 2006 Action was presented to the circuit court and the Hospital either did not object to, expressly briefed and addressed the issues, or offer any evidence to contradict this evidence. (R. 262-277 ¶ 4, 5, 10, 13, 15, 16). Even more, at the Motion to Reconsider hearing, Dr. Shah's counsel argued that "we presented it – a great deal of which I recall without objection." (R. 693 ll. 13-17). In Upchurch v. Upchurch, 367 S.C. 16, 27, 624 S.E.2d 643, 649 (2006), the Supreme Court recognized, "[w]hen issues not raised by the pleadings are tried by express or implied consent of



the parties, they shall be treated in all respects as if they had been raised in the pleadings. If a party does not object to the evidence when presented at trial, the issue is considered tried by consent.” (emphasis added). Since the Hospital did not object, and Dr. Shah expressly argued that the Hospital did not object and tried these issues, then the doctrine of implied consent was sufficiently raised to the circuit court.

The Court alternatively found that if Dr. Shah’s implied consent argument was properly preserved, it was without merit because the Hospital’s objection to the introduction of this evidence would have been “futile.” The Court’s ruling essentially found litigants are not required to object to preserve the record. Objecting is not a futile act. Upchurch holds that “if a party does not object to the evidence when presented at trial, the issue is considered tried by consent,” and long-standing precedent holds “the failure to make an objection at the time evidence is offered constitutes a waiver.” Cogdill v. Watson, 289 S.C. 531, 537, 347 S.E.2d 126, 130 (Ct. App. 1986). If the Hospital truly believed these issues were not properly before the court, it should have, at the *very least* noted this objection on the record to be later considered by the trial court and, if necessary, by the appellate court.

A review of the transcript illustrates that objecting was not futile because the Hospital had no reservations about objecting to other evidence it believed should not be considered. The Hospital objected to certain portions of Dr. Shah’s affidavit stating, “[f]or the record, we have objected and filed our objections to paragraph three through nine of Dr. Shah’s affidavit.” (R. 323, ll. 25-8). Judge Early indicated his willingness to take into consideration such objections by responding, “I will...take it subject to your objection and let [counsel for Shah] make a record, and I’ll give it whatever weight, if any, it deserves.” (R. 323, ll. 9-12). The Hospital also objected to Dr. Shah’s presentation of any documentation and evidence that predated 2001. The

Hospital's counsel was quick to tell Judge Early, "This is one of the exhibits that we objected to that predates the November 2001 order . . . we do object to all of those materials." (R. 328, ll. 16-19). The Court responded stating, "Why don't you just have a running objection *to everything that took place prior to November 28, 2001?*" (R. 329, ll. 20-22). The Hospital also objected to evidence related to the dispute giving rise to the Supplemental Order, to which Judge Early stated, "Thank you. I'll note that." (R. 339, ll. 8-15). Judge Early even would ask the Hospital if they had "an objection...for relevancy, hearsay, no foundation?" for certain witnesses and those objections were entertained, and then renewed throughout for which Judge Early would respond, "So noted." (R. 379-380; 391; 397; 402-403). All throughout, Judge Early would invite objections, stating "Any objection to that, Mrs. Jones?" or "Any objection by the Plaintiff." (R. 437, ll. 16-17; 551, ll. 18-22).

While the circuit court entertained and considered the Hospital's many other objections, at no time did the Hospital object to the submission of the evidence that this Court refused to consider. Therefore, objecting during the course of the hearing was not an exercise in futility. Judge Early took all evidence subject to any objections made and, considering these objections, later determined the admissibility and weight of the evidence.

In short, Dr. Shah's implied consent argument was raised in his Rule 59 motion and was therefore preserved for appellate review. In addition, it would not have been futile for the Hospital to object to evidence of contempt uncovered by the 2006 Action. Because such evidence was presented with the Hospital's implied consent as a matter of law, the circuit court and this Court should have considered it in deciding if the Hospital violated the terms of the Settlement Orders. This Court should not allow the Hospital to wreck the professional career of this doctor by approaching issue preservation rules in a rigid, hyper-technical manner.

**III. The Settlement Orders Set Forth Requirements for Addressing Administrative Issues and the Hospital's Violation of its Bylaws and Policies Provide Grounds for a Finding of Contempt.**

The Court misinterpreted the Settlement Orders by concluding they only govern the QA *review process* and, as a consequence of this ruling, disregarded significant evidence of contempt. The majority opinion recognizes the Settlement Orders “address matters outside the QA process, such as Administrative Requirements,” but wrongfully construes the Settlement Orders to find they “d[o] not direct the Hospital to handle these matters in any particular manner[;] rather, the [circuit] court permitted the Hospital to address these matters in accordance with its own rules and regulations.” In so holding, the majority reasoned, “the Settlement Orders only govern the QA review process; these orders do not purport to govern every aspect of continued interaction between Dr. Shah and the Hospital,” and “the court only intended to specify how the Hospital conducted QA reviews of Dr. Shah’s cases.” This reading of the Settlement Orders misconstrues and overlooks specific provisions related to the handling of Administrative Requirements.

The Supplemental Order defines Administrative Requirements as, “(a) medical record documentation; (b) behavioral guidelines; (c) staff interaction and utilization; (d) response to requests for information; (e) timely completion of reports; and (f) timely response to complaints.” (R. 14). As the Supplemental Order explains, after the Consent Order of Settlement was entered, the parties found that further clarification regarding Dr. Shah’s QA was necessary. Specifically, as Judge Keesley noted in the Supplemental Order, “the parties have had difficulty in selecting a mutually agreeable outside reviewer and have disagreed on which matters involve the QA Process and which matters involve alleged violations of Administrative Requirements.” (R. 13).

The parties sought guidance from the circuit court in determining how these issues should be handled, including issues related to Administrative Requirements. In the Supplemental Order, Judge Keesley made it clear that the procedure set forth in the Supplemental Order would determine how such issues should be dealt with by the Hospital:

Alleged violations of Administrative Requirements were not addressed in the Consent Order [of Settlement]. Since the parties have been unable to agree on the interpretation of the Order and have submitted this issue to the court, *this Supplemental Order will govern how alleged violations of Administrative Requirements by Dr. Shah will be handled.*"

(R. 14) (emphasis added). During the hearing prior to the entry of the Supplemental Order, the parties acknowledged and agreed that the Chief of the Radiology Department would handle administrative issues, in the same manner as he would for other physicians, i.e. in accordance with the Bylaws. (Id.)

This understanding between the parties is reflected in the Supplemental Order, which states "[d]uring the hearing, Dr. Shah stated his willingness to have alleged violations of and noncompliance with Administrative Requirements handled by the Chief [of the Radiology Department]. The Court, therefore, *directs that matters involving Administrative Requirements be referred to the Chief for handling in accordance with the Bylaws and Policies.*" (R. 15) (emphasis added). The inclusion of this directive in the Supplemental Order was not meant to be an indication that the Settlement Orders would not govern Administrative Requirements. It is just the opposite. This provision was included precisely *because* the Settlement Orders would govern such issues. The fact that Shah agreed for the Chief of the Radiology Department to handle administrative issues does not mean that Supplemental Order did not set forth a procedure to be followed in such matters. The Supplemental Order expressly required the Hospital to follow the Bylaws. The Hospital's counsel even acknowledged this during the Rule to Show

Cause hearing, stating “if I’m reading the Supplemental Order correctly . . . the Hospital is required to handle administrative requirements in accordance with the Bylaws.” (R. 562). These findings even contradict the order of Judge Early. (R. 37-38).

Accordingly, the Supplemental Order makes it abundantly clear that the Hospital was required to follow its Bylaws and policies with regard to any alleged violations of Administrative Requirements concerning Dr. Shah. The Hospital’s failure to follow its own Bylaws and policies therefore constitute grounds for a finding of contempt.

**IV. The Court Erred in Declining to Address Grounds for Contempt It Believed Were “Unrelated to the QA Process.”**

The Court erred in failing to address issues it believed did not relate to the QA process. In so holding, the majority incorrectly found the Settlement Orders applied only to the initial review process and not to the QA’s corrective action proceedings. By ruling that the Settlement Orders only applied to the “first stage” of QA, the Circuit Court disregarded evidence of the Hospital’s reliance on 35 emergency room cases not reviewed by Dr. Selby, the Hospital’s failure to obtain a final report and opinion from Dr. Selby on the case of Patient X, and the unfair imposition of a required psychological evaluation. As correctly noted in the dissenting opinion, the Supplemental Order governs any “complaint against Dr. Shah involv[ing] an allegation that Dr. Shah deviated from the standard of care in treating a patient.”

The QA process includes corrective action. Corrective action is the continuation of QA, as an adverse QA review can result in the institution of corrective action. The Settlement Orders do not state that case selection is the only process involved in QA. In fact, the Settlement Orders discuss procedures for the institution of a corrective action proceeding as a result of the review conducted by the independent outside reviewer. (R. 12-19).

The Hospital ostensibly took corrective action against Dr. Shah as a result of the QA reviews conducted by Dr. Selby. In a letter from the Hospital's President, Dr. Shah was informed that adverse "action was taken after the MEC [Medical Executive Committee] reviewed the findings and recommendations of J. Bayne Selby, the independent outside [reviewer]." (R. 925). The letter went on to state, "the Order imposed on the MEC the duty and responsibility of determining 'what action if any, should be taken pursuant to Section 10.2.2(b) of the Bylaws, including, but not limited to, whether or not the matter should be referred for corrective action in accordance with Addendum 1 to the Bylaws.'" (*Id.*) The Hospital also cited the Settlement Orders as its authority to take further action against Dr. Shah following Dr. Selby's review: "[T]he Medical Executive Committee ('MEC') . . . *pursuant to the Order* and Addendum I to the Medical/Dental Staff Bylaws, Rules and Regulations ('Medical Staff Bylaws') voted . . . to initiate corrective action against you." (R. 723-724). Therefore, the Hospital understood the Settlement Orders to govern their corrective action proceedings against Dr. Shah.

Additionally, the original probationary terms imposed by the Hospital referenced the Settlement Orders and Dr. Selby's review of Dr. Shah's cases. (R. 925-26). During the corrective action process, the Hospital never asserted that the Settlement Orders were inapplicable. In fact, the Hospital acted to the contrary. During the probation hearing, the Hospital called Dr. Selby to testify regarding his review of Dr. Shah's cases, as well as his overall impression of Dr. Shah's clinical skills. (R. 938). The Probation Hearing Committee report contains a specific provision related to the continued selection and review of Dr. Shah's cases in accordance with the Settlement Orders. (R. 977). Even during the probationary period, Dr. Selby was still reviewing Dr. Shah's cases. (R. 991; 994-99; 1007). Throughout its dealings

and correspondence with Dr. Shah, the Hospital continually referenced the Settlement Orders and the need for compliance with the Bylaws. The Hospital cited the Settlement Orders and Bylaws as authority for all actions it took related to Dr. Shah.

Then, at the hearing before Judge Early, the Hospital called Dr. Eva Jane Rawl to testify regarding Dr. Shah's QA. (R. 631-41). Dr. Rawl was the chairperson of the Fair Hearing Committee (the committee that voted to uphold the MEC's decision to terminate Dr. Shah's privileges). If QA only involved the case selection process, as this Court found, then there would have been no need for the Hospital to call Dr. Rawl as a witness, as she was never involved in the case selection process. The Hospital called Dr. Rawl to testify because it knew that subsequent corrective action is *part* of the QA process.

More than this, the record is replete with transcripts of hearings, reports of hearings, and documentation from the Hospital referencing the need for compliance with both the Bylaws and the Settlement Orders during corrective action. (R. 904-12; 916-17; 920-21; 923-24; 925-27; 975-80). The Hospital's CEO even boasted of the plan to "get rid of Dr. Shah . . . for QA." (R. 832). To hold that the Settlement Orders applied to the initial review of Dr. Shah's cases and not to the subsequent corrective action initiated against him by the Hospital completely disregards the evidence before the Court. During the hearing, the Hospital neither advanced the position nor presented any evidence supporting the proposition that the Settlement Orders only govern the "first stage" of QA. Moreover, the Hospital never asserted that QA and corrective action were separate and distinct procedures.

Thus, the Court overlooked and misapprehended the clear evidence that the Settlement Orders are not limited to the case selection process.

**V. The Court Overlooked Evidence of Violation of the Settlement Orders in the Hospital's Imposition of a Psychological Evaluation.**

The majority opinion erred in disregarding evidence that the Hospital violated the Settlement Orders in its handling of the later addition of another probationary requirement, namely that Dr. Shah submit to a psychological evaluation. As previously stated, the Supplemental Order provides that all issues of alleged violations of Administrative Requirements should be handled in accordance with the Hospital's Bylaws and its written policy on Disruptive Conduct. (R. 13-15). The Supplemental Order also acknowledges that while Administrative Requirements may not traditionally be part of the QA process, administrative issues negatively impact patient care. Footnote 1 of the Supplemental Order states,

Non-compliance with Administrative Requirements is not a matter typically included in the QA Process. However, as was pointed out during the hearing, there is the possibility that a physician's failure to comply with Administrative Requirements can lead to QA proceedings or corrective action under the Bylaws. In certain cases, a physician's failure to abide by Administrative Requirements can be so pervasive or found to constitute such a pattern of impermissible conduct that it rises above mere failure to comply with Administrative Requirements to the point where patient care or the Hospital's ability to conduct its business is potentially compromised.

(R. 15).

The Hospital claimed that Dr. Shah's conduct was significant enough to impact patient care, thus making this a QA issue and requiring corrective action. In deciding to terminate Dr. Shah's privileges, the Hospital's Hearing Committee stated in its report, "Dr. Shah's violation of Item #10 of the terms of probation [required psychological evaluation], *standing alone* merited the MEC's Decision [to revoke Dr. Shah's privileges]." (R. 1020) (emphasis added). The Hospital attached great importance to the psychological evaluation requirement as part of QA.



In fact, the Hospital relied on this language in Footnote 1 of the Supplemental Order at the hearing as justification for failing to comply with the Settlement Orders. (R. 554). At the hearing, counsel for the Hospital stated, “[a]nd what it [Supplemental Order, footnote 1], basically, says is while I have defined administrative matters up here, sometimes these things I have defined are not only administrative matters, they’re quality assurance matters, and when they’re quality – when they rise to the level of being quality assurance matters, they they’re handled in the quality assurance way.” (R. 558-59). Accordingly, the Hospital expressly acknowledged that that the administrative matters related to Dr. Shah were QA matters.

Furthermore, the evidence demonstrates the Hospital willfully violated the Bylaws and Disruptive Conduct Policy in the handling of the requirement that Dr. Shah undergo a psychological evaluation. It is undisputed that Dr. Shah was never afforded any notice that such evaluation would be required, as was his right under the Bylaws. (R. 928; 978; 980). Dr. Shah was not able to defend himself against these allegations and was denied the due process rights afforded to him pursuant to the Bylaws, Addendum I and the Constitution. See Huellmantel v. Greenville Hospital System, 303 S.C. 549, 402 S.E.2d 489 (Ct. App. 1991) (holding hospital failed to provide physician with due process to challenge the imposition of a required psychiatric evaluation by failing to advise of claim warranting psychological care.).

The Hospital also failed to comply with the Disruptive Conduct Policy, an internal written policy in the Bylaws. There is no other rules and regulations other than as included in the Bylaws. This policy sets forth specific procedures to be followed in the event a physician is believed to be engaging in conduct that is disruptive to the operation of the hospital and/or the care of patients. This policy requires that the physician be given, among other things, written notice of the questionable behavior and an opportunity to meet with Hospital personnel (i.e. the

Chief Medical Officer and/or the Chief of Staff). (R. 932-33). The Hospital's Chief of Staff acknowledged she never provided Shah with any written documentation evidencing issues requiring a psychological evaluation or notifying him that his mental stability would be an issue before any hearing panel. (R. 735-37; 1023-24). Nevertheless, the Hospital asserted that Dr. Shah should have understood he had been given notice because he was deemed to be a "disruptive" physician. (R. 625-27). However, this is not the notice expressly required by the Disruptive Conduct Policy of the Hospital's Bylaws.

The majority opinion erroneously found that evidence should not be considered relating to the Hospital's violation of its Bylaws and the Settlement Orders in the imposition of the probationary requirement of psychological evaluation.

**VI. The Court Overlooked Clear and Convincing Evidence of the Hospital's Willful Violation of the Settlement Orders.**

The majority opinion incorrectly concluded that Dr. Shah did not present clear and convincing evidence of the Hospital's willful violation of the Settlement Orders. As the dissent found, Dr. Shah did present clear and convincing evidence of the Hospital's contempt.

In the context of contempt, a willful act is defined "as one 'done voluntarily and intentionally with the specific intent to do something the law forbids, or with the specific intent to fail to do something the law requires to be done.'" State v. Sowell, 370 S.C. 330, 336, 635 S.E.2d 81, 83 (2006). In State v. Garrard, 390 S.C. 146, 700 S.E.2d 269 (Ct. App. 2010), this court defined "willful" as "[v]oluntary and intentional, *but not necessarily malicious*" and "willfulness" as "[t]he voluntary, intentional violation or disregard of a known legal duty." The Hospital knew what the Settlement Orders required, but voluntarily, repeatedly, and systematically violated the protections afforded to him. This was expressly found in the dissent.

The record is replete with numerous instances of the Hospital's disregarding a known legal duty:

- (a) The Hospital presented to the hearing committee 35 emergency room cases reviewed by Dr. John Stewart. Based on this review, the Hospital concluded Dr. Shah had deviated from the standard of care in his handling of these cases and used this determination as a basis for terminating his medical staff privileges. These cases were neither selected by nor reviewed by Dr. Selby as specifically required by the Settlement Orders.
- (b) The Hospital determined Dr. Shah deviated from the standard of care in his reading of films of Patient X taken by another radiologist. The Hospital then terminated his privileges without allowing Dr. Selby to meet with Dr. Shah in person and without a Decision from Dr. Selby on this case as specifically required by the Settlement Orders.
- (c) The Hospital ordered Dr. Shah to undergo a psychological evaluation and failed to afford him the requisite written notice as mandated by the Bylaws, as incorporated in the Settlement Orders. The Hospital found Dr. Shah's failure to submit to this evaluation warranted termination of his privileges.
- (d) The Hospital failed to allow Dr. Selby to exercise oversight authority in the initial selection of medical cases for review and controlled the case selection process in a discriminatory fashion by submitting a stockpile of old cases in an attempt prevent an objective, unbiased review of Dr. Shah's medical competence.
- (e) The Hospital never provided the Fair Hearing Committee with the "Fairer Measurement" Report of the 533 cases selected by Dr. Selby.

As the dissent found, "there is no question the Hospital knew all reviews of Dr. Shah's cases were to be handled by an independent outside reviewer only." Therefore, "the Hospital's reliance [on the unauthorized review of cases] . . . constitutes overwhelming evidence that the Hospital intentionally and willfully violated the 2003 supplemental order."

Dr. Shah complained to the Hospital that he was being treated unfairly and that his QA review was being conducted in a manner inconsistent with the Settlement Orders and in a discriminatory fashion. (R. 718-19; 801-20). Dr. Shah repeatedly pointed out, and the Hospital internally acknowledged, that other physicians in the radiology department were not subject to

any QA reviews whatsoever. (R. 914; 921; 1853). In response, the Hospital employee who wrongfully selected and reviewed the 35 Emergency Room cases, told Dr. Shah, “you wanted . . . to snub your nose at the Medical Staff . . . [a]nd so what you’re doing is paying the price for it.” (R. 2033, ll. 20-23).

Evidence of willfulness is further highlighted by the fact the Hospital concealed from the Hearing Committee favorable reports prepared by Dr. Selby pursuant to his QA review of Dr. Shah. These reports were part of the “Fairer Measurement” mandated by the Probation Hearing Committee in its report upon realizing the cases were not being selected in accordance with the proscribed procedure set forth in the Settlement Orders. (R. 976; 979). The binder of information prepared by the Hospital and given to the Fair Hearing Committee purposefully excluded these favorable reports from consideration. (R. 730-40; 742-46). The Hospital did everything it could to achieve its desired result, even willfully manipulating the evidence. No evidence was submitted to dispute this fact.

Based on these underlying facts and circumstances, as well as a myriad of others contained in the record and presented by Shah in his Appellants’ Brief, the deliberate actions taken by the Hospital and its failure to adhere to the provisions of the Settlement Orders demonstrate the willful nature of its actions. Given the totality of the record, the Court erred in misconstruing and overlooking clear and convincing evidence of willfulness in violating the Settlement Orders.

#### **VII. The Majority Opinion Overlooked Evidence of Violations Concerning the Review of Dr. Shah’s Medical Cases.**

There is ample evidence in the record demonstrating the Hospital’s willful and deliberate violations of the Settlement Orders related to the revocation of Dr. Shah’s privileges.

#### **A. Thirty-Five Emergency Room Cases**

The Supplemental Order states, “When a matter involves the traditional QA Process or a complaint that Dr. Shah deviated from the standard of care in treating a patient, those matters shall be referred to an outside reviewer.” (R. 15). Based on this provision, not only was the outside reviewer charged with conducting reviews of cases that fell within the ambit of traditional QA, but he was also to review any other cases where Dr. Shah was deemed to have violated the standard of care.

In contravention of the Settlement Orders, the Hospital selected and reviewed thirty-five cases from the emergency room in which Dr. Shah was accused of deviating from the standard of care in his reading of radiological films. The evidence and testimony clearly establishes Dr. Selby, the independent outside reviewer, never reviewed these thirty-five ER cases. (R. 2028-29; 2053). The entire “quality assurance” process conducted by the Hospital with regard to these cases was a review and determination solely by Dr. John Stewart, an emergency room physician, that Dr. Shah’s interpretation of these films was incorrect. Dr. Stewart’s review of these cases was a clear, intentional violation of the Settlement Orders. Further, the Hospital’s reliance on these cases as justification for Dr. Shah’s termination demonstrates its willful, contemptuous conduct. The Hearing Committee stated in its report, “the information from the Hospital’s Emergency Department of Dr. Shah’s misinterpretations during the probationary period further support the finding that Dr. Shah continued to suffer clinical deficiencies during the period of probation.” (R. 102).

Evidence relating to the 35 Emergency Room cases was before the Court and was incorrectly overlooked. The improper review conducted by Dr. Stewart was revealed during discovery in the 2006 Action. As discussed in detail above, per the terms of the Consent Order

of Dismissal, Shah was allowed to “argue and rely on . . . information, documents and discovery from the 2006 action.” (R. 24). At the hearing, the Hospital presented evidence in opposition to these allegations. The conclusion that the Hospital’s wrongful review of 35 Emergency Room cases was “not before the court” ignores that the Hospital’s own memorandum in opposition to the Rule to Show Cause hearing fully briefed this issue. The Hospital’s memorandum contains a defined section captioned **“V. THE FAIR HEARING COMMITTEE PROPERLY CONSIDERED DR. SHAH’S CASES FROM THE EMERGENCY ROOM DEPARTMENT.”** (R. 227). The Hospital presented evidence and argued it “had a legitimate concern in reviewing Dr. Shah’s ER cases.” (R. 227-228). Not once did the Hospital argue this alleged violation was not properly before the Court. In fact, evidence and arguments concerning the 35 Emergency Room cases were presented *ad nauseam* at the hearing, as reflected in the transcript. As the dissenting opinion found, “the issue concerning the thirty-five emergency room cases was presented to the court without objection, and the Hospital presented evidence of the emergency room cases in its memorandum to the court.” (Order. p. 12). Therefore, the majority opinion should have considered this evidence of contempt by the Hospital and determined it rose to the level of a willful violation of the Settlement Orders.

**B. Patient X**

The Supplemental Order also sets forth the procedure to be followed in the review of any case that is not selected through the traditional QA process, as was the case with Patient X (i.e. a patient complaint). The Supplemental Order states,

[I]f a corrective action is initiated against Dr. Shah pursuant to Addendum 1 to the Bylaws that involves a QA matter not previously evaluated by the outside reviewer, the MEC shall send the matter to the outside reviewer, pursuant to the QA Process outlined above, and his *Decision* will be deemed to satisfy the

obligations of the Chief and/or the Department under sections 1.2, 1.3 and 1.4 of the Bylaws.

(R. 19-20) (emphasis added).

Dr. Shah presented clear and undisputed evidence that the Hospital did not await a final Decision from the outside reviewer prior to using this case as grounds upon which to justify revocation of his clinical privileges. The only report submitted by Dr. Selby was entitled "Preliminary." (R. 1016). In the cover letter Dr. Selby submitted with this report, he indicated he needed additional time to review the case/films in person with Dr. Shah before he could render a final decision related to the treatment of Patient X, and that "this will serve as a preliminary review pending that discussion." (R. 1015). In the email Dr. Selby sent with his report, he again reiterated to the Hospital his desire to meet with Dr. Shah, stating that he "would not issue a final report until that time. For that reason I have attached a preliminary review." (R. 1018). Despite Dr. Selby's insistence that he meet with Dr. Shah, mere hours after Dr. Selby presented his preliminary report on the Patient X case, the Hospital proceeded to terminate Shah's privileges. (R. 1018-19). The Hospital concluded Dr. Shah's alleged failure to diagnose a baseball-sized mass in Patient X's abdomen "standing alone, support[ed] the MEC's Decision" even without a Decision from Dr. Selby. (R. 1020).

Given the explicit provisions contained in the Settlement Orders regarding the procedure to be utilized in the review of Dr. Shah's medical cases, the majority opinion overlooked the Hospital's blatant violations and contemptuous conduct in the handling of the review of Patient X's case.

#### **VIII. The Court Should have Addressed All Issues on Appeal.**

The Court held it did not need to address Dr. Shah's remaining arguments because the issue addressed was dispositive. This was in error because the only issue addressed by the Court

was that of the case selection process by the outside reviewer. As discussed above, case selection is just one of several matters addressed by the Settlement Orders, which set forth a specific procedure for the Hospital to follow concerning Dr. Shah. As more fully explained above, the Settlement Orders set forth the way in which administrative issues were to be handled (i.e. psychological evaluation), the process for the selection of cases for traditional QA review, the process to be used for cases in which Shah was deemed to have violated the standard of care (i.e. the 35 Emergency Room cases), and the procedure to be used for any case that was presented to the MEC that had not been previously reviewed by the outside reviewer (i.e. the case of Patient X). (R. 1-20).

The conclusion that the Hospital complied with the terms of the Settlement Orders with regard to the selection of Shah's cases for traditional QA review is not dispositive of all other issues related to the Hospital's willful lack of compliance with the other provisions of the Orders. The evidence aptly demonstrates the Hospital willfully failed to follow many of the directives and procedure set forth in the Settlement Orders. As such, the Court erred in determining that the issue of case selection was dispositive of all other issues.

**IX. The Court Overlooked that the Circuit Court Erred in Holding that the Relief Sought Was Not Available as a Matter of Law.**

The Court failed to address the circuit court's erroneous conclusion that "[a]n award of damages is not available to Plaintiff due to the immunity from damages provided by the Health Care Quality Improvement Act ("HCQIA")" and that "restoration of privileges is not available to Plaintiff under South Carolina's doctrine of non-review, which essentially deprives the courts of jurisdiction to grant this relief." (R. 30).

As an initial matter, the determination of any appropriate remedy, or any defenses based on HCQIA or the doctrine of non-review was *never* before the circuit court. The circuit court



bifurcated the finding of contempt from the issue of sanctions/damages. (R. 554-55). The circuit court should have never ruled on matter never before it.

Furthermore, HCQIA does not statutorily bar the court from fashioning an equitable remedy of damages based on a finding of contempt. Even if HCQIA applied, the statutory scheme provides rebuttable qualified immunity based on “reasonableness,” and certainly is it not reasonable to violate a court order. 42 U.S.C. §§ 11112(a). South Carolina law has held that relief for contemptuous conduct is designed to “return [the] aggrieved party to the status quo” which may include reinstatement, lost profits, loss of reputation, humiliation, and mental distress arising out of a contemnor’s violation, including recovery of litigating the court’s order, costs, and attorneys’ fees. Curlee v. Howle, 277 S.C. 377, 287 S.E.2d 915 (1982); Jarrell v. Petoseed Co., Inc., 331 S.C. 207, 500 S.E.2d 793 (Ct. App. 1998).

Likewise, the doctrine of non-review does not deprive the circuit court of jurisdiction to reinstate or restore privileges as part of the remedy if it finds a party in contempt of a court order. Under the doctrine of non-review, “it is improper for the courts to review the decisions of governing boards of private hospitals concerning the staff privileges of practitioners.” Wood v. Hilton Head Hosp., Inc., 292 S.C. 403, 405, 356 S.E.2d 841, 842 (1987). This doctrine is rooted in subject matter jurisdiction principles. Id. In this case, the doctrine of non-review is inapplicable because the Settlement Orders specifically state “[t]he parties agree that no jurisdictional defense will be raised with regard to any enforcement action brought before this Court on any aspect of this Consent Order.” (R. 2-3). The circuit court also misapplied the scope of the doctrine of non-review. This doctrine is not intended to undo court orders, such as these Settlement Orders, and there is no legal authority support its application in this case.

**X. The Court Should have Reversed the Circuit Court Ruling that it Improper for the Court to be Involved in the “Intricacies” of the Hospital.**

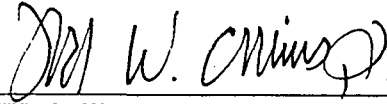
The Court should have reversed the circuit court’s conclusion that it “cannot, and will not become involved in the ‘intricacies’” of the Hospital. With this finding, the circuit court concluded that the directives set forth in the Settlement Orders were too general to support a contempt claim. (R. 37). The majority opinion “recognize[s] the procedures adopted by the parties and the trial court were unusual,” but should also have recognized that the circuit court was *required* to ensure that the parties abide by the terms of a court order. Instead, the majority opinion essentially held the court has “broad discretion” in choosing how to enforce orders through equitable remedies. Without the Court’s involvement and ability to enforce the terms of the Settlement Orders, a settlement such as this is rendered meaningless. Dr. Shah is simply asking for judicial enforcement of the terms of the Settlement Orders the Hospital voluntarily entered into. The Court should not give the Hospital “broad discretion” in violating these orders, but instead should enforce them strictly since they are contracts between the parties.

**CONCLUSION**

For the foregoing reasons, Dr. Shah hereby requests the Court issue an order granting rehearing and rehearing *en banc* and reversing the decision of the circuit court ruling the Hospital was not in contempt of the Settlement Orders.

Respectfully submitted,

By:



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October 5, 2012

THE STATE OF SOUTH CAROLINA  
In the Court of Appeals

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APPEAL FROM RICHLAND COUNTY  
Court of Common Pleas  
Doyet A. Early, III, Circuit Court Judge

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Case No. 1996-CP-40-0271  
Appellate Case No. 2009-122786

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**RECEIVED**  
OCT 05 2012  
SC Court of Appeals

Paresh Shah, M.D. and  
Paresh Shah, M.D., P.A.....Appellants,

v.

Palmetto Health Alliance, f/k/a  
Richland Memorial Hospital.....Respondent,

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**PROOF OF SERVICE**

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I certify that I have served Appellants' Petition for Rehearing and Rehearing *En Banc* upon Respondent by mailing a copy of same, via United States Mail, postage prepaid, on October 5, 2012 to the following counsel of record:

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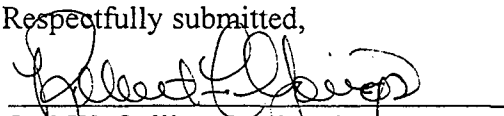
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October 5, 2012

**PROOF OF SERVICE— APPELLANTS’  
PETITION FOR REHEARING AND  
REHEARING *EN BANC***



## The South Carolina Court of Appeals

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January 18, 2013

Mr. Joel W. Collins, Jr.  
PO Box 12487  
Columbia SC 29211

Re: Shah, Paresh v. Palmetto Health  
Appellate Case No. 2009-122786

Dear Counsel:

Enclosed is a copy of an order of the panel denying your petition for rehearing. Your petition for rehearing en banc was distributed to the judges, but it has been rejected. *See* Rule 219, SCACR.

Very truly yours,

*V. Claire Allen, Deputy*

CLERK

cc: Jane W. Trinkley  
Celeste Tiller Jones  
William T. Toal  
Frederick A. Crawford  
Robert L. Widener

FILE NO. 629-108

JAN 21 2013

REC'D. JWGLHml CSJab  
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Robert Fredrick Goings  
Amy Lynn Neuschafer

# The South Carolina Court of Appeals

Paresh Shah, M.D. and Paresh Shah, M.D., P.A.,  
Appellants,

v.

Palmetto Health, Respondent.

Appellate Case No. 2009-122786

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## ORDER

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After careful consideration of the petition for rehearing, the Court is unable to discover that any material fact or principle of law has been either overlooked or disregarded, and hence, there is no basis for granting a rehearing. Accordingly, the petition for rehearing is denied.

Paul G. Efort, Jr. J.  
*Adhere To My Decent*

Daniel G. Pieper J.

Joe W. Stearns J.

Columbia, South Carolina



cc:

Jane W. Trinkley  
Celeste Tiller Jones  
William T. Toal  
Frederick A. Crawford  
Joel W. Collins, Jr.  
Robert L. Widener  
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Amy Lynn Neuschafer

**FILED**

January 18, 2013