

THE STATE OF SOUTH CAROLINA
In The Court of Appeals

APPEAL FROM HORRY COUNTY
Court of Common Pleas

J. Michael Baxley, Circuit Court Judge

Case Nos. 2008-CP-26-9047 and 2008-CP-26-9368

Sean D. Fay, as Personal Representative for the
Estate of Kelly L. Fay, Deceased, ... Respondent/Appellant,

v.

Grand Strand Regional Medical Center, LLC, d/b/a
South Strand Ambulatory Care Center, and Stephen
W. Law, D.O., Dr. Richard Young, M.D., and
Grand Strand Urology, LLP, ... Defendants,

Of whom Grand Strand Regional Medical Center,
LLC d/b/a South Strand Ambulatory Care Center is, ... Appellant/Respondent.

And Of Whom Stephen W. Law, D.O. is, ... Respondent/Appellant,

And Of Whom Dr. Richard Young, M.D., and
Grand Strand Urology, LLP, are, ... Respondents.

RECORD ON APPEAL - VOLUME III

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SC Court of Appeals

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**RECORD ON APPEAL
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Patient

FAY, KELLY L

16169

F000341684

Adm Date Service/Lon

01/26/02

SSACC EMERGENCY DEPT

Status

REG ER

Account #

F00100659455

PATIENT

Soc Sec No DOB Age Sex MS Race Religion
387-22-2325 02/25/76 25 F M CA NO RELIGION
Address: 3582 EVERGREEN WAY
MYRTLE BEACH, SC 29577
Home Ph: (843)839-0021 County: HORRY

GUARANTOR

FAY, KELLY L SS#: 387-22-2325
Address: 3582 EVERGREEN WAY
MYRTLE BEACH, SC 29577
Home Ph: (843)839-0021 County: HORRY
Relationship to Patient: PATIENT

OTHER GUARANTOR

FAY, SEAN SS#: 999 99 9999
Address: SP

Home Ph: County:
Relationship to Patient: HUSBAND

PERSON TO NOTIFY

FAY, SEAN
3582 EVERGREEN WAY
MYRTLE BEACH, SC 29577
Home Phone: (843)839-0021 Work Phone:
Relationship to Patient: HUSBAND

PATIENT EMPLOYER

THE HAMPTON INN OCEANFRONT
OCEAN BLVD
MYRTLE BEACH, SC 29577
Work Phone: (843)946-6400
Occupation: ASST GEN MGR

GUARANTOR EMPLOYER

THE HAMPTON INN OCEANFRONT
OCEAN BLVD
MYRTLE BEACH, SC 29577
Work Phone: (843)946-6400
Occupation: ASST GEN MGR

OTHER GUARANTOR EMPLOYER

LEGENDS GOLF
HWY 501
MYRTLE BEACH, SC 29579
Work Phone: 8432365168
Occupation: WEBMASTER

INSURANCE #1

445 CAROLINA CARE HMO
PO BOX 100234
COLUMBIA, SC 29202-3234
Phone (800)868-6734
PA CODE 41107

Policy # 387222325
Coverage #
Subscriber FAY, KELLY L
Rel to Pt PATIENT
Eff. to Rel Y Assign Y
Group

AUTHORIZATION

Treat/Precert
Ins Verif Not Required
Pro Review Not Required

INSURANCE #2

Phone
PA CODE

Policy #
Coverage #
Subscriber
Rel to Pt
Eff. to Rel Assign
Group

AUTHORIZATION

Treat/Precert
Ins Verif
Pro Review

INSURANCE #3

Phone
PA CODE

Policy #
Coverage #
Subscriber
Rel to Pt
Eff. to Rel Assign
Group

AUTHORIZATION

Treat/Precert
Ins Verif
Pro review

OCCURRENCES

Code Type
11 ONSET OF SYMPTOMS/ILLNESS

Date Time
01/26/02 0802

CONDITIONS

Code Type
80 WHITE-RACE

Special Program

Unit BarCode Number



Last Hospitalization

Admission Comment

Financial Class

07

Attending Physician

HCIS

Admitting Physician

HCIS

Emergency Room Physician

HCIS

Prim Care Physician

HCIS

Family Physician

HCIS

Other Physician

0337

ADMISSION/REGISTRATION

Date Time Source
01/26/02 0803 PHYSICIAN/SELF REFER

Rm/Bed
WI

Arrival Mode
PT STS POSSIBLE KIDNEY STONES

Chief Complaint/Reason for Visit
PT STS POSSIBLE KIDNEY STONES

Admitted By
FADM.KMB

REGISTRATION FORM

Grand Strand Regional Medical Center
809 82nd Parkway ** Myrtle Beach ** SC 29572
(843) 692-1000

Printed: 01/26/02 0804



GrandStrand 1/26/02
001

INSTRUCTIONS FOR << FAY KELLY >>

Our doctors and staff appreciate your choosing us for your emergency medical care needs. Read these aftercare instructions carefully. Please call us if you have any questions about your medical problem. We are here to serve you.

KIDNEY STONES:

Your exam shows you have had a kidney stone. Kidney stones usually form when there are high levels of calcium or uric acid in the urine; they may also result from repeated urinary infection. There is usually a great deal of pain when a stone passes from the kidney down the tube (ureter) to the bladder. Kidney stones that block the ureter completely can cause permanent damage to the kidney. Surgery or lithotripsy is necessary sometimes for larger stones.

Treatment of kidney stones usually requires pain medicine. It is also important that you drink 2-3 quarts of fluids daily to keep from getting dehydrated. Hospital care and IV fluids may be needed if you have:

- * Uncontrolled pain, an urinary infection, or severe blockage.
- * Nausea and vomiting which prevent you from drinking enough fluids.

About half the patients who pass one kidney stone have a second episode. In general, to prevent further kidney stones you should drink 10 glasses of fluid a day (at least 1/2 should be water). Avoid grapefruit juice, apple juice and limit animal protein to 10oz per day and salt to 2-3gms a day.

~~Other restrictions may be recommended depending on the composition of your~~ stone. Please use a urine filter to strain all your urine until your stone passes; then take it to your doctor so it can be analyzed. See your doctor for follow-up as advised. Call or go to the emergency room right away if you develop fever, more intense pain, or repeated vomiting.

PRESCRIPTIONS:

Fill all the prescriptions ordered by your doctor and take them as directed.

- * If you have been given an antibiotic, be sure to take all of it.
 - * Keep your drugs out of the reach of children, in a cool, dry, dark place.
 - * Don't give your medicine to other people or use it for other illnesses.
 - * Call us right away if you have problems with drug side-effects or allergy
- Bring your medicines with you any time you go to emergency for treatment.

NARCOTIC PAIN MEDICINE:

You have been prescribed a narcotic for pain relief. These drugs are usually combined with acetaminophen (Tylenol#3, Percocet, Darvocet, Anexsia, Vicodin or aspirin (Empirin#3, Percodan, Synalgos-DC) for increased effect. Narcotic act on the central nervous system to reduce pain; they also impair mental alertness and physical abilities. We advise you not to drink alcohol, drive car, or operate dangerous equipment when you are taking one of these drugs. Long term use of narcotic pain medications may be habit-forming.

You can lessen stomach irritation from your medicine by taking it with meals or a full glass of water. Common side effects of narcotics are: nausea and vomiting, heartburn, constipation, dizziness, sleepiness, and mood changes. If you have bothersome side effects or symptoms of an allergic reaction (itching, hives, rash), stop taking your medicine and call your doctor or the emergency room right away. Please keep your narcotic medicine well out

FOLLOW-UP CARE:

Your physician today has been DR. STEVE LAW

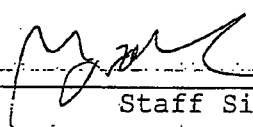
For follow-up care you have been referred to the following doctor or clinic:

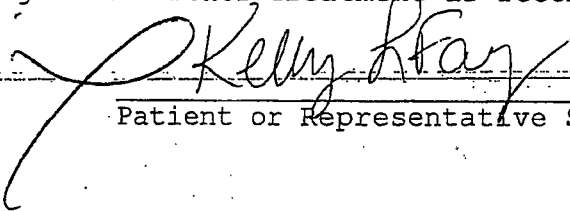
RICHARD YOUNG
822 82ND PARKWAY, UROLOGY

Phone: 449-5538

Please make an appointment for further treatment in _____ days. Be sure to tell your referral doctor or clinic that we have sent you, and bring your medicines and instructions to the office. If you had x-rays, an EKG, or lab tests today, they have been reviewed by your doctor. We will contact you at once if other important findings are noted after further review by our staff. If you do not continue to improve or if your condition worsens, please call your doctor or the emergency department right away so you can be examined.

I acknowledge receipt of these instructions. I understand that my condition may require more care and will arrange for further treatment as recommended.


Staff Signature


Patient or Representative Signature

RELEASE OF INFORMATION AUTHORIZATION

I authorize South Strand Ambulatory Care Center to release all medical records of << FAY KELLY >> for the purpose of continuation of care to:

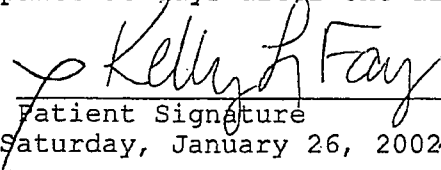
RICHARD YOUNG
822 82ND PARKWAY, UROLOGY

Phone: 449-5538

The authorization places no restrictions on any information to be released, including any treatment for alcohol, drug abuse, HIV testing, psychiatric, or Sickle Cell trait. If any restrictions are to be placed on information released, please state: _____

This authorization expires 90 days after the date of my signature unless otherwise specified.

 Date


Patient Signature


Staff Signature

Saturday, January 26, 2002 - 11:51 AM

GrandStrand 1/26/02
003

GRAND STRAND REGIONAL MEDICAL CENTER
SOUTH STRAND AMBULATORY CARE CENTER

ER REPORT

NAME: FAY, KELLY L
MED REC #: F000341684

PHYSICIAN: LAW, STEPHEN W
ROOM #:

PT: FAY, KELLY L
DOS: 01/26/2001
DICT PHY: STEPHEN W. LAW, DO

CC: Abdominal pain and back pain.

HPI: A 25-year-old female with sudden onset of right flank pain beginning approximately 1-1/2 hours prior to arrival. She describes the pain as sharp, 7-8 out of 10 on the pain scale, radiating around to her right periumbilical area. She denies any palliative or provocative factors. She states the pain is waxing and waning in character; however, it is progressive in a crescendo fashion. She does complain of some mild nausea, but no vomiting. She denies any fevers or chills, dysuria, hematuria or menstrual irregularities.

PMH: Significant for kidney stones and depression. The first day of her last menstrual period is currently on.

MEDS: Include Prozac and birth control pills.

ALL: None.

SH: Patient is a nondrinker and nonsmoker.

PE: VITAL SIGNS: Patient is afebrile; vital signs are stable. GENERAL: Pleasant, uncomfortable-appearing 25-year-old female. HEENT: Normocephalic and atraumatic. Conjunctivae are pink. Oropharynx is clear with moist mucous membranes. NECK: No JVD. CARDIAC: Regular rhythm without ectopy or murmur. LUNGS: Clear to auscultation bilaterally. ABDOMEN: Patient has moderate-to-severe flank tenderness noted on the right CVA. Her abdomen is soft, nontender and nondistended without rebound, rigidity or guarding. There are active bowel sounds. GU/RECTAL: Examinations deferred. EXTREMITIES: No clubbing, cyanosis or edema.

DIFF DX: Includes ureterolithiasis versus pyelonephritis versus cholecystitis.

LAB: Patient had a urinalysis and KUB performed. Her urinalysis on a cath'd specimen reveals no evidence of blood.

KUB reveals what appears to be a kidney stone noted at the right ureteropelvic junction measuring approximately 4-5 mm on the plain KUB. No evidence of other stones is noted.

Because the patient is in severe pain with the lack of blood in the urine, she did have a CT scan performed to rule out the possibility of hydronephrosis. According to the radiologist, there is a right UPJ stone with moderate-to-severe obstruction.

EDC: Patient had good pain relief with 30 mg of IV Toradol and 12.5 mg of Phenergan and 1 mg of IV Dilaudid. She states her pain is now approximately a 2 out of 10.

GrandStrand 1/26/02
004

ED REPORT

Page 1 of 2

ROA_0904

GRAND STRAND REGIONAL MEDICAL CENTER

ATT. PHY LAW, STEPHEN W

NAME: FAY, KELLY L
MED REC# F000341684

=====

CONS: Case was discussed with Dr. Richard Young, on-call urologist, who requests to see the patient on Monday since the patient's pain is under control. I did explain to the patient, however, that if her pain becomes out of control or if she has increasing nausea, vomiting, any fevers or chills, that she is to return to the emergency department immediately.

PROV DX:

1. Renal colic
2. Severe hydroureter.

cc: RICHARD YOUNG, MD

D 01/26/2002 11:38:20

T 01/26/2002 12:06:26/334

Job #: 797761/Doc #: 446094

LAW, STEPHEN W

Electronically Signed by STEPHEN W LAW on 02/18/02 at 2203

GrandStrand 1/26/02
005

ED REPORT

Page 2 of 2

ROA_0905

Date	Time of Arrival	Patient Name	D.O.B.	Age	Ht./Wt.	To Room #						
1-26-02	0800	FAY, Kelly	2-25-76	25		3						
ID Band	Yes ☒ No ☐	TB Screen: ☐ POS ☐ NEG ☒	Latex Screen ☐ Yes ☐ No ☒	Visual Acuity ☐ OS ☐ OD ☐	Mode of Arrival ☐ EMS ☐ Amb ☐ W/C ☐ Carried ☐							
Triage Nurse:	Jelland		Imm: ☐ UTD ☐ Not UTD	Tetanus: ☒ DTP ☐ MP: ☒ None								
Triage	Info. Obtained From _____ Triage Time 0800			☐ EMERGENCY ☒ URGENT ☐ NON-URGENT								
	C/C - Onset 40 (P) on pain 1/2 hr Agitated, anxious - 10 min Rho x 1			PMH: Depression, Kidney stones								
	PCP: ☒			Meds: Prozac, S.C.P.H.								
	Tx PTA _____											
Treatment at Triage _____			* Affix Allergy Band ☐ Yes ☒ NKA ☒									
ALLERGIES _____			Type of Reaction _____									
Nurse's Notes	Time _____ Time to Room: _____ Comments _____											
	0800 Crying, alert, pink, warm, no vital signs											
	0820 pt. is in X-ray. To (R) side of flank above pain 30 min.											
	0835 Central urine to lab - Gu											
Meds	Time	Temp.	BP	HR	RR	SpO2	Pain 0-10	G.C.S.	R.T.S.	Attachments ☐		
	0810	100/64	38	16	16	100	7	15	12			
Orders	IV FLUIDS / MEDICATIONS			SITE	TIME	INITIALS	IV FLUIDS / MEDICATIONS			SITE	TIME	INITIALS
	IVF C NS 1/2 liter 0830			Gu	10	Gu	IVF C NS 1/2 liter 0830			Gu	10	Gu
Physician	CBC			DIF	Comp Panel	Card Monitor	Glucose: S / C			CK/ISO/TROP	O2 via	pCXR / CXR
	PT / PTT			Amy	ABG	pCSP / CSP	Hepatic Panel			ETOH	Pulse Ox	KUB / Abd
	Basic Panel			BHCG	EKG / RS	Type/Screen	IV Accur			30m IV Tacard	12.5g IV Phenergan	Gu
	Time of Initial Exam 804			Notes _____			Consult Called _____			Consult Arrived _____ Name _____		
Discharge	Dictated By: ☐ EMP ☐ Consultant ☐ PCP			Physician(s) Signature _____			Provisional Dx: <u>Renal Colic, Severe, Hydronephrosis</u>			Condition on Disposition: ☐ Improved ☒ Stable ☐ Unstable ☐ Deceased		
	Mode of Disposition: ☒ Amb ☐ EMS ☐ W/C ☐ Carried ☐ Stretcher			Departure Time 1200			D/C ☒ EN ☐ EPIC ☐ Rx ☒ SE ☐			Admit ☐ Transfer ☐ OR ☐ AMA/ELOPE ☐		
	Discharge Instructions _____			Rx _____			Case Management: <u>working</u>			X-RAY ☐ Y ☒ LAB ☐ Y ☒ ACT ☐ Y ☒ P.T. ☐ Y ☒		
	Follow up ☐ _____			Discharged By: <u>M. J. Doolittle</u>			EKG ☐ Y ☒ WORK ☐ S ☐ L ☐ N			APPT ☐ Y ☒ N		

ED Core Encounter Record

WHITE - Chart CANARY & GREEN - Per Facility Protocol

PAGE A

T3113-C 11/00

ROA_0906

FAY KELLY
 AAF-00100659455 UHF-000341684
 387-22-2325 25 F DOS: 01/26/02
 LAM, STEPHEN W
 BO: 02/25/76
 REG ER

me	Temp.	BP	HR	RR	SpO ₂	O ₂ Delivery	Pain Scale 0-10	GCS	Rhythm	RTS	Nurse's Interventions/Evaluations	Initials
0800							5-6				Pain 4 to "5" now	Gr
0852											Specimen in Lab	Gr
											R side stone noted on KUB	Gr
0910							5-6				Dr. Law to speak to pt	Gr
0940							0				IVF infusion well	Gr
											Q/V	Gr
											Q pain now. PA	Gr
											Net	Gr
1020							0				Sponse at bed side	Gr
											Return from C.T. via stretcher	Gr
1200											He Hc CPT out	Gr
											Epic Med 5/c reviewed	Gr
											SCAT + ST/100	Gr
											given	Gr

Initials	Signature / Title
MR	

PATIENT IDENTIFICATION

FAY, KELLY L
 A#F00100659455 U#F000341684
 387-22-2325 25 F DOS: 01/26/02
 LAW, STEPHEN W REG ER
 BD: 02/25/76

GrandStrand 1/26/02
 007

ED Nursing Flow Sheet - Continued

SAMPLE EMERGENCY DEPARTMENT LEVEL OF CARE

Points Intervention **ADMISSION/TRANSPORT**

- ☐ ED visit for suture check/suture removal only.
*Do not assign any additional points
- 10 ☐ Transfer in - nsg home, other institution
- 20 ☐ Transfer out - nsg home, other institution
- 25 ☐ Hospital admission (Inpatient/Observation)
- 20 ☐ DOA /AMA/LWBS
- 40 ☐ Transfer with nurse to other facility

ASSISTING/MONITORING

- 5 ☐ Pulse oximetry (episodes of:)
- 10 ☐ Cardiac monitor (rhythm strip/nurse)
- 10 ☐ Traction assist
- 25 ☐ Monitoring-High level equipment
- 20 ☐ Monitoring-Simple-Initial Assessment
- 30 ☐ Monitoring-Intermediate
- 40 ☐ Monitoring-Complex-multi systems/conscious sedation

WOUND CARE

- 10 ☐ Wound cleansing/simple
- 15 ☐ Wound cleansing/complex
- 10 ☐ Dressings - small to moderate
- 15 ☐ Dressings - large to complex
- 20 ☐ Dressings - extensive

OB/GYN

- 20 ☐ Fetal heart tones
- 30 ☐ Precipitous delivery
- 30 ☐ Newborn care
- 20 ☐ Pelvic exam

SPECIAL NEEDS

- 10 ☐ Special teaching needs
- 10 ☐ Special emotional needs
- 10 ☐ Special service needs
- 10 ☐ Pediatric patient
- 10 ☐ Social services
- 10 ☐ Isolation
- 10 ☐ Combative patient
- 10 ☐ Coordination of care

TOTAL POINTS:

70

EMERGENCY DEPARTMENT VISIT LEVEL

Check Only One

Points	Description	Code
☐ N/A	Suture Recheck/Suture Removal	99281
☐ 0-25	Level 1	99281
☐ 26-55	Level 2	99282
☒ 56-85	Level 3	99283
☐ 86-125	Level 4	99284
☐ 126 +	Level 5	99285
☐ N/A	Critical Care	99291

EMERGENCY DEPARTMENT PROCEDURE CATEGORY

Check all that apply

Description

- ☐ Procedure Category 1 (number of:)
 - ☐ Procedure Category 2 (number of:)
 - ☐ Procedure Category 3 (number of:)
- (see reverse side for procedures)

ED Physician: LAW

ED Physician Assist:

Points Intervention **MEDICATIONS**

- 5 ☐ Medications - PO, suppository, topical (episodes of:)

ORDERS/PROCESSING

- 5 ☒ X-Ray; CT/MRI/Nuclear Medicine/US/Spec Proc (# of: 11)
- 5 ☒ Lab/Blood Bank/EKG/Respiratory Therapy requests (# of: 1)

INTERVENTIONS

- 10 ☒ Specimen collection (urine, stool, sputum, wound, blood) (# of: 11)
- 5 ☐ Visual acuity
- 20 ☐ MAST suit
- 10 ☐ Ear/eye irrigation
- 10 ☐ Ring removal
- 15 ☐ Decontamination
- 10 ☐ Hemocult/Glucostrix
- 10 ☐ Glucose scan/Urine dipstick
- 15 ☐ Enema administration (fleets)
- 45 ☐ Enema administration (soap suds)/Manual Disimpaction
- 20 ☐ GI Suction/Iavage
- 20 ☐ Tubes: Catheterization, NG, Urinary
- 10 ☐ Foley/G tube irrigation
- 10 ☐ Elastic wrap
- 15 ☐ Warming/cooling measures
- 10 ☐ Respiratory therapy treatment/VO2 (episodes of:)
- 30 ☐ Sexual Assault/Rape Exam

EDUCATION/DISCHARGE INSTRUCTIONS

- 5 ☐ Discharge instructions, routine
- 10 ☒ Discharge instructions, special/extensive
- 5 ☐ Crutch/Walker training

CRITICAL CARE

Check all that apply

TREATMENT OR PREVENTION OF CRITICAL ILLNESS/CRITICAL INJURY

Conditions such as one of the following:

- ☐ Central nervous system failure
- ☐ Circulatory failure
- ☐ Shock-like conditions
- ☐ Post Op complications
- ☐ Renal failure
- ☐ Hepatic failure
- ☐ Metabolic failure
- ☐ Respiratory failure
- ☐ Overwhelming infection

TIME IN: TIME OUT:

PT Name	<u>FAY, KELLY L</u>
Unit #	<u>A#F00100659455 U#F000341684</u>
Acct. #	<u>387-22-2325 25 F DOS: 01/26/02</u>
	<u>LAW, STEPHEN W REG ER</u>
DATE OF VISIT:	<u> </u>

Consulting:

Level Assigned By: Mg D...

Not Part of the Permanent Medical Record

GrandStrand 1/26/02
008

DIAGNOSTIC IMAGING

SOUTH STRAND AMBULATORY CARE - 5050 HWY 17 BYPASS - SURFSIDE BEACH, SC
PHONE #: 8438396066 FAX #: 8438391002

PATIENT TYPE: DEP ER LOC/RM: F.XED/F.XED DOB: 02/25/1976

PATIENT NAME: FAY, KELLY L SEX: F EXAM DATE: 01/26/2002

OD PHYSICIAN: LAW, STEPHEN W ADM: 01/26/2002 ORDERED: 01/26/2002

MED RECORD #: F000341684 AC#: F00100659455

REASON: FLANK PAIN RAD:

ADMISSION CLINICAL DATA: PT STS POSSIBLE KIDNEY STONES

EXAMS: 000402038 ABDOMEN 1 VIEW

Clinical data: Right flank pain.

Study: Abdomen.

A supine abdominal radiograph is obtained, and there is a 0.8 x 0.4 cm stone projecting in the expected region of the right ureteropelvic junction. A few calcific densities within the lower pelvis likely represent phleboliths. The bowel gas pattern appears normal.

~~Impression: Findings are most consistent with a moderate size stone in the region of the right ureteropelvic junction.~~

A

** Electronically Signed by JOHN J. CHOMYN MD on 01/27/2002 at 1158 **
Reported and Signed by: JOHN J. CHOMYN, MD

CC: STEPHEN W LAW

Dictated Date/Time: 01/26/2002 (1033)
Electronic Signature Date/Time: 01/27/2002 (1158)

PAGE 1 SS AMBULATORY CHART COPY

GrandStrand 1/26/02
009

GRAND STRAND REGIONAL MEDICAL CENTER
DEPARTMENT OF RADIOLOGY

SOUTH STRAND AMBULATORY CARE

FAY, KELLY L

UNIT NO: F000341684

DOB: 02/25/1976 AGE: 25

SEX: F

PHYS: LAW, STEPHEN W

ACCT: F00100659455

EXAM DATE: 01/26/2002 STATUS: DEP ER

LOC: F.XED

PT STS POSSIBLE KIDNEY STONES

EXAMS:

000402044 CT ABDOMEN WITHOUT CONTRAST

Clinical data: Pain

Study: CT abdomen.

Axial 5 mm sections are obtained from the level of the adrenal glands to the iliac crest, and the exam is performed without oral or intravenous contrast.

There is mild right hydronephrosis of a stone within the proximal ureter, the stone lies at or close to the level of the ureteropelvic junction, and the stone has a diameter of approximately 0.5 cm in an axial plane. There's minimal pyelosinus extravasation of urine and no stone lies within the left kidney. There is no left ureterectasis distal to the stone, and the ureter has a normal-caliber.

Impression:

Right ureteropelvic junction region stone and some pyelosinus extravasation of urine suggests that it is at least moderately obstructing.

Emergency room is aware.

** Electronically Signed by JOHN J. CHOMYN MD on 01/27/2002 at 1541 **
Reported and signed by: JOHN J. CHOMYN, MD

CC: STEPHEN W LAW

Dictated Date/Time: 01/27/2002 (1153)

Technologist: JAMIE P. LATWAITIS

Transcribed Date/Time: 01/27/2002 (1435)

Transcriptionist: FRAD.BLR

Printed Date/Time: 02/07/2002 (1029)

PAGE 1

GrandStrand 1/26/02
010

ROA_0910

GRAND STRAND REGIONAL MEDICAL CENTER
DEPARTMENT OF RADIOLOGY

SOUTH STRAND AMBULATORY CARE

FAY, KELLY L

UNIT NO: F000341684

DOB: 02/25/1976 AGE: 25

SEX: F

PHYS: LAW, STEPHEN W

ACCT: F00100659455

EXAM DATE: 01/26/2002 STATUS: DEP ER LOC: F.XED

PT STS POSSIBLE KIDNEY STONES

EXAMS:

000402045 CT PELVIS WITHOUT CONTRAST

Study: CT pelvis.

Clinical data: Rule out kidney stone.

Axial 7 mm sections are obtained from the top of the iliac crests to the level of the inferior pubic rami, and the examination is performed using both oral and intravenous contrast.

There is no pelvic ascites. Left ovary appears to be at the upper limits of normal in size and the urinary bladder is mostly collapsed.

Impression:

No evidence of urolithiasis or ureteral obstruction, but please refer to the CT abdomen report as the patient has an obstructing stone in the region of the right ureteropelvic junction.

** Electronically Signed by JOHN J. CHOMYN MD on 02/01/2002 at 1721 **
Reported and signed by: JOHN J. CHOMYN, MD

CC: STEPHEN W LAW

Dictated Date/Time: 01/27/2002 (1154)

Technologist: JAMIE P. LATWAITIS

Transcribed Date/Time: 02/01/2002 (1613)

Transcriptionist: FRAD.BLR

Printed Date/Time: 02/01/2002 (1727)

PAGE 1

SS AMBULATORY CHART COPY

GrandStrand 1/26/02
011

ROA_0911

RUN DATE: 01/27/02
RUN TIME: 0300

Columbia and Strand * LAB * (LWIF)
** COMMUNITY MED CENTER FINAL CUMULATIVE SUMMARY **

PAGE 1

Patient	Age/Sex	Location	Account#	Attending Physician
FAY, KELLY L	25/F	F.XED	F00100659455	LAW, STEPHEN W

***** URINALYSIS *****

Date Time	01/26/02 0835	Reference	Units
UA COLOR	YELLOW	(YELLOW)	
UA APPEARANCE	CLEAR	(CLEAR)	
UA GLUCOSE	NORM	(NORMAL)	
UA BILIRUBIN	NEG	(NEGATIVE)	
UA KETONES	NEG	(NEGATIVE)	
UA SPEC GRAVITY	1.020	(1.001-1.035)	
UA BLOOD	NEG	(NEGATIVE)	
UA PH	5.0	(5.0-8.5)	
UA PROTEIN	NEG	(NEGATIVE)	
UA UROBILINOGEN	NORM	(NORM-1mg/dL)	
UA NITRITE	NEG	(NEGATIVE)	
UA LK ESTERASE	NEG	(NEGATIVE)	

** END OF REPORT **

FAY, KELLY L

Age/Sex: 25/F

Acct#: F00100659455
Unit#: F000341684

Location: SSACC EMERGENCY DEPT

COMMUNITY MEDICAL CENTER MEDICAL RECORDS FINAL CUMULATIVE SUMMARY

GrandStrand 1/26/02
012

ROA_0912

Billing: 843 248-1369
Fax: 843 248-1339

Horry County Fire/Rescue

2560 North Main Street, Suite 1
Conway, South Carolina, 29526

CAD # 0201823
Grid # 353

print date: Monday, January 28, 2002

Call Summary

Call received	Jan 28, 2002	Outcome	Hospital ER
Nature	Other medical	Call completed by	Jackson, Melissa
Location	3582 EVERGREEN WAY MYRTLE BEACH, SC, USA 29577-	Level of care	Medical Emergency
Location type	Resident	Destination	3016 Grandstrand Hospital
Response mode	Emergency Changed to No Change	Reason	Closest available
Respond with	No other HCFR Resp.	Delay to hosp reason	No Delay
Assist at scene			
Response delay	No Delay		
Patient found	Prone		
Patient positioned	Supine		
Patient transported	Main Stretcher		
Patient returned			

Call Received	13:59 Jan 28, 2002	Scene	14:07	Destination	14:40
Dispatch	14:00	Patient Side	14:07	Clear	15:00
Enroute	14:01	Depart	14:10		

Patient Information

Name	FAYE, KELLY L	Home Phone	(843)839-0021	Doctor	
SSN	387-22-2325	Mailing Address	3582 EVERGREEN WAY MYRTLE BEACH, SC, USA 29577-	Pers. Effects	
DOB	Feb 25, 1976 (25 Y)				
SEX	F				

Employment:

Occupation
Employer
Phone
Address

Next of Kin:

Name
Relation
Address

Insurance:

Company Other
Address P.O. 100234
COLUMBIA, SC, USA
29202-3234

Phone

Company 445CAROLINA CA
State

Policy # 387222325

History

Chief Complaint: Unresponsive
MOI / Present Illness: Unconscious
Trauma:
Relevant Past History: Other - KIDNEY STONES
Medications: Other - OXYCODONE
Allergies: No Known Allergies

Prognosis

Primary Diagnosis: Other - Unconscious
Secondary Diagnosis: Other - Unconscious

GrandStrand 1/28/02
007

Billing: 843 248-1369
Fax: 843 248-1589

Horry County Fire/Rescue

2560 North Main Street, Suite 1
Conway, South Carolina, 29526

CAD # 0201823

Grid # 353

print date: Monday, January 28, 2002

Assessment

Time	Who	Body Area	Assessment
14:08	Jackson, Melissa	Lower Extremities, Left Foot	Other
		Lower Extremities, Right Foot	Discoloration
		Upper Extremities, Left Arm	Discoloration
			Other

Vital Signs

Time	BP	Pulse	SPO2	Cap Refill	GCS	Respiratory	Effort	Rate	Left	Right
14:08		166, Weak, Regular	74 %	Absent	E1 M1 V1 = 3	Shallow		30		
14:24		166, Weak, Regular	75 %	Absent	E1 M1 V1 = 3	Shallow		30		

Revised Trauma Score

Time	Score	Details
14:24	3	GCS = 3 (0); Resp. Rate = >29 (3); Systolic BP = 0 (0)

Interventions

Time	Treatment	Description	Further Details
14:07	Oxygen	LPM : 15 LPM, Device : BVM, Indication : low SAO2, By: Jensen, Michael	
14:07	Airway Maintained	By: Jensen, Michael	
14:07	Artificial Resp	Device : BVM, Indication : assist resp., By: Jensen, Michael	
14:08	Oral Airway Used	Type : nasal, Size : 30 french, By: Jensen, Michael	
14:08	EKG Monitored	Rhythm : SINUS TACHYCARDIA, By: Jackson, Melissa	
14:08	IV Administered	Site : left hand, Solution : normal saline, Rate : TKO, By: Jackson, Melissa	
14:11	Dextrose Stick for BGL	BGL Reading : 40-80, By: Jackson, Melissa	
14:13	Dextrose 50%	Indication : coma/seizure unknown origin, Result : No Marked Response, Dosage : 25gm, By: Jackson, Melissa	
14:18	Naloxone	Indication : unconscious unknown, Result : No Marked Response, Dosage : 2.0mg, By: Jackson, Melissa	

General Comments

U/A PT LAYING ON FLOOR, VERY HOT TO TOUCH, CYANOTIC WITH SHALLOW RAPID RESP. AND VOMIT IN MOUTH. PT ALSO HAS BEEN INCONTINENT OF URINE AND FECES. PT HUSBAND STATES SHE WAS RECENTLY TREATED FOR KIDNEY STONES BUT OTHERWISE HAS NO HX. HE STATES SHE WAS FEBRILE LAST NIGHT AT 101 DEGREES, AND THIS MORNING HE WENT TO WORK, THEN CAME HOME AND FOUND HER LIKE THIS. PT ROLLED ONTO HER BACK AND SUCTIONED, THEN VENTILATED WITH A BVM AND 30# NASAL AIRWAY. PT HAS INTACT GAG REFLEX. PT EXTREMELY HOT TO TOUCH SO SEVERAL COLD PACKS APPLIED. PT TREATMENT AS LISTED IN INTERVENTIONS SECTION OF THIS REPORT. PT AIRWAY MAINTAINED THROUGHOUT TX. PT TX TO GSRMC FOR EXAM. PT UNABLE TO SIGN DUE TO CONDITION.

Signatures

Time	Type	Disclaimer

GrandStrand 1/28/02
008

Billing: 843 248-1369
Fax: 843 248-1589

Horry County Fire/Rescue

2560 North Main Street, Suite 1
Conway, South Carolina, 29526

CAD # 0201823
Grid # 353

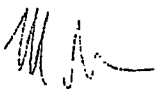
print date: Monday, January 28, 2002

Shift Information

DHEC Permit 03708

14 SMB Sta. 36

Start Date/Time: 10:45 Jan 28, 2002

Crew #	Name	Certification	Signature	Crew #	Name	Certification	Signature
170	Jackson, Melissa	82197		292	Jensen, Michael	84016	

Miscellaneous

Misc Hierarchy 1: Emergency, Non Ambulatory, Moved only by stretcher, Was Unconscious, Was in Shock, Required O2, Required IV, Required EKG, Possible Stroke or MI

Misc Hierarchy 2: A74

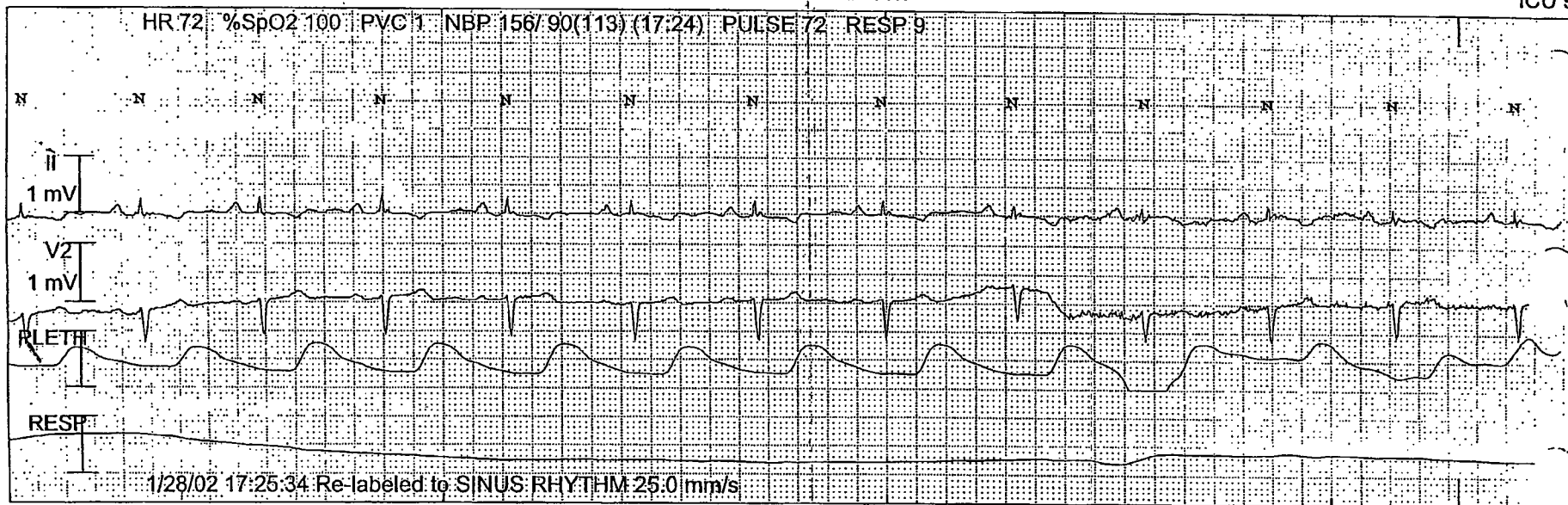
GrandStrand 1/28/02
009

ROA_0915

DEBRUHL, PETE

Medical Record Number:

ICU 9



ROA_0916

GrandStrand 1/28/02
010

Rocio Nardo - nurse
AKA

D 215

25415-

5A - Faye Kelly

Vent

T-100?
R

Resp arrest

#8 NS X 5 TLC

Dopa - 25 mcg

#20 L hand

154 Ws.

#20 Rt hand

Leva - 8 mcg

#20 Rt AC

foley - 100 out put 2 units Platelets

BP $\frac{66}{47}$

Rocher 2 gm IV

Vanc 500 mg IV

Gentam 200 mg IV

2 amp bicarb

Kelly Fay

Mon., November 23, 1998

S: Wife of Mr. Sean Fay who was a former security officer at Methodist College Police Dept.. She is here to establish herself. Primary problem has been with an intolerance of oral contraceptive pills. She has seen Mr. Ron Foster in the past. Initially she was on Desogen for almost four years. At that time she was changed to Ortho-Cept and then subsequently to Triphasil. She has had significant nausea, vomiting and weight gain with the medication though her periods have remained regular. She is not tolerating either one to any effective degree.

PAST MEDICAL HISTORY:

None.

PAST SURGICAL HISTORY:

Recent wisdom tooth extraction on the left side.

HEALTH MAINTENANCE:

LMP two weeks ago, last pap smear in 3/98.

MEDICATIONS:

Triphasil 1 q.a.m.

ALLERGIES:

None.

SOCIAL HISTORY:

She manages the Hampton Inn in Fayetteville, married and has no children.

HABITS:

None.

FAMILY HISTORY:

Grandfather with hypertension, both parents in good health. Has a younger brother in good health.

O: Wt. 174 lbs., blood pressure 120/80. CHEST: clear. CVS: RRR without murmur, gallop, rub or click.

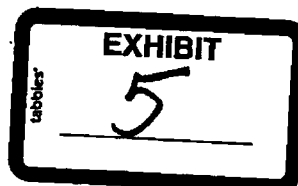
A: 1. Oral contraceptive advise.

P: 1. Patient to restart Desogen at her next cycle.

2. Samples give x 5 months.

3. F/U with any problems, otherwise we will see her in 3/98 for complete physical exam along with pap smear.

CK, MD/jw



PI 22

Kelly Fay
02/01/99

042688

S: Kelly is a 22-year-old white female patient of Dr. Kommu. She comes in today complaining of a 2-week history of a moderate headache which she describes as temporal in nature. Pain is throbbing with occasional stabbing as if someone has stuck a knife through her head. She denies any past medical history of migraines or any family history of migraines. She states that the headache is off and on. However, over the past two weeks headache has had an underlying dullness to it which occasionally flares at times of stress at work. She states she has been under a lot of stress at work secondary to her boss having left his job and therefore giving her more responsibility. Also, she is considering leaving her own job in the near future. She does not associate any visual disturbances or any nausea, vomiting with this. Denies any blurred vision, double vision, syncope, near syncope, chest pain, shortness of breath or any other symptomatology. Predominantly complains of temporal headache pain. She does not relate this with her menses. She is, in fact, due for her period but has had this ongoing headache for the past two weeks and has never had premenstrual headaches. She is otherwise generally in good health and is without any other complaints at this time.

O: Weight 173 lbs., blood pressure 130/88, pulse 88/min. GENERAL: She is alert and oriented, appears in no acute distress and is well-hydrated with good color. HEENT: TMJs and external auditory canals bilaterally are within normal limits. Eyes with EOMI and PERLA. There is no nystagmus. Oropharynx is clear without erythema or exudates. NECK: Supple without lymphadenopathy, thyromegaly, JVD or carotid bruits. LUNGS: Clear to auscultation bilaterally. CVS: Regular rate and rhythm. No audible murmurs, rubs, gallops or clicks.

A: Probable tension headaches.

- P:
1. Begin Naprosyn 500 mg at the onset of headache and may increase to b.i.d. with headaches.
 2. Patient is to return to clinic in 3-4 weeks for further evaluation and follow-up of headache. However, if in the interim headaches worsen or persist, she is to notify so we can prescribe other medications, or she may be seen. Otherwise, patient may return to clinic p.r.n.

RL, P.A.-C/sm

PI 23

Kelly Fay
Wed., March 31, 1999
42688

S: Twenty three year old who is here complaining of increased urinary frequency and dysuria. She also complains of occasional decreased urinary output secondary to the dysuria. Her p.o. intake remains normal. She has not had any fever, does not describe any N/V and no CVA tenderness. She has had recurrent urinary tract infections in the past but recovers from them without any difficulty.

O: Wt. 170 lbs., blood pressure 122/78, temperature 98.1, pulse 66. CHEST: clear. CVS: RRR, normal S1 and S2. ABDOMEN: soft, positive bowel sounds, no CVA tenderness noted.

LAB: 1. UA shows SG of 1.015, pH 5.0, trace protein, 1+ leukocytes, 15-20 WBC's, abundant bacteria.

A: 1. UTI.

P: 1. Will treat with Bactrim DS 1 b.i.d. x 5 days.
2. Encourage fluids.
3. RTC if no significant improvement.

CK, MD/jw

Kelly Hay
42688

Thur., May 20, 1999

S: 23 year old who is here for complete physical exam and pap smear. She has an insignificant past medical history, no complaints today with the exception of skin tags which she has had for almost 15-20 years across her neck and she would like them removed at some time.

O: Wt. 170 lbs., blood pressure 138/84, temperature 97.0, heart rate 80. HEENT: external auditory canals normal. TM's normal bilaterally. EYES: PERRLA, EOMI, fundi normal. Oropharynx is clear without erythema or exudates. NECK: supple without adenopathy. No thyromegaly or carotid bruits. CHEST: clear. CV: RRR with normal S1 and S2. NO murmurs, rubs or gallops. ABDOMEN: soft, positive bowel sounds, no hepatosplenomegaly or masses. PELVIC: normal female anatomy. Vagina is moist, no adnexal masses or tenderness. Uterus is non-tender. Pap smear done. BREASTS: without tenderness, retractions or dimpling noted. EXTREMITIES: without clubbing, cyanosis or edema. Reflexes 2+. NEURO: non-focal.

LAB: 1. UA shows SG of 1.010, pH 5.0, negative for protein, glucose, nitrites or leukocytes. CBC shows WBC of 7.7, Hgb 13.0, Hct 38.2, Pkt 266, MCV 86.3.

A: 1. Normal 23 year old exam.

P: 1. F/U results of pap smear and other lab work once available.
2. Patient to reschedule appointment to have skin tags removed at her convenience.
3. F/U as needed for routine health care.
4. Continue Desogen for oral contraception as needed.

CK, MD/jw

PI 25

Kelly Faye
42688

Thur., June 3, 1999

S: 23 year old who is here for skin tag removal. She has multiple hyperpigmented skin tags across her neck and upper shoulders which she would like removed today. They have not changed in size, have been present for a number of years. She reports no other problems.

O: Wt. 172 lbs., blood pressure 124/78, temperature 98.9, pulse 78. CHEST: clear. CVS: RRR, normal S1 and S2.

A: 1. Skin tags.

PROCEDURE:

Area cleansed with Betadine and then anesthetized with 1% Lidocaine with Epinephrine. Each skin tag was then removed with scalpel without difficulty and the base cauterized. Patient tolerated procedure well.

CK, MD/jw

PI 26

Kelly Fay
07/28/99

42688

- S: Kelly is a pleasant 23-year-old married white female, a patient of Dr. Kommu, who comes into the office today complaining of a 4-day history of what initially presented as diarrhea progressing to nausea, malaise and fatigue, fevers, chills, sweats and some mild abdominal discomfort with poor p.o. intake and lack of appetite. Otherwise is generally in good health with no recent sick contacts and is generally otherwise without complaints.
- O: Weight 167 lbs., blood pressure 118/94, pulse 96/min, temperature 100.2°F. GENERAL: She is alert and oriented, appears in no acute distress and is well hydrated with good color. HEENT: TMs and external auditory canals bilaterally are within normal limits. Oropharynx is clear without erythema or exudates. NECK: Supple without lymphadenopathy, thyromegaly or other masses. LUNGS: Clear to auscultation bilaterally. CVS: Regular rate and rhythm. No audible murmurs, rubs, gallops or clicks. ABDOMEN: Thin, soft, nontender, non-distended. Bowel sounds are present. There is no palpable organomegaly.
- A: Probable viral gastroenteritis.
- P:
1. Patient is to begin clear liquid diet and advance as tolerated.
 2. Push fluids.
 3. Begin Phenergan 25 mg p.o. q.4-6 p.r.n. nausea.
 4. Patient is to return to clinic if symptoms worsen or persist. Otherwise, she may return to clinic p.r.n.
 5. Patient is to be out of work x 2 days.

RL, P.A.-C/am - per SK, M.D.

PI 27

Kelly Fay
42688

Wed., August 18, 1999

S: 23 year old who is here to discuss crying spells that she has been having over the last 1-2 months. Of note, her father has had a significant psychiatric history in the past, in fact, has attempted suicide previously. In addition, her mom was an alcoholic and she states being the eldest she had to take care of younger siblings. She has been married for four years but has been in a relationship with Sean Fay for the last six years. She feels they are both compatible and get along very well. Over the last 1-2 months she has difficulty trying to focus at work and has had some trouble with crying very easily. She has been more irritable. She feels symptoms definitely get worse prior to her cycle and seem to improve somewhat afterwards. She has had some difficulty sleeping over the last week but in general has not had a tremendous amount of trouble. She does not get involved in activities very well. She states that generally she is a very positive person, leaving notes for herself across her desk but lately she has not been at all interested. She has been very withdrawn and eating by herself. She does work in the same office with her husband. Though they are in the same dept. they generally have different work duties. She is not as excited about seeing him in the evenings when she comes home. They have also been having some mild marital difficulties.

O: Wt. 165 lbs., blood pressure 118/88, temperature 98.9, pulse 68. CHEST: clear. CVS: RRR, normal S1 and S2.

A: 1. Major depression.

P: 1. Will begin Prozac 20 mg qam, samples given for one month.
2. Patient is reluctant to use medications. She states that her father was on medications for a number of years for depression and very sedated during the day; did not feel the medications were particularly helpful. I have suggested that Prozac may be very helpful for her and have asked her to take it for the time frame to see how she does. I suspect we will have to treat her for 6-9 months and will try a trial off the medication then though with the family history she may need to be on long term therapy.

CK, MD/jw d8/18/99 t8/19/99

Kelly Fay
42688

Thur., September 9, 1999

S: Returns for F/U of her depression, states that she is doing better. She feels a significant improvement since she has begun the Prozac. She states that she is not getting as emotional as she has previously though the problems that she has faced previously still exist. She is able to deal with them more effectively. Her husband has not sought any medical care and she feels he is profoundly depressed. She is unable to discuss a lot of the issues that are pertinent between them with him very well. The problems identified in her last visit continue to be a problem. She reports that she is sleeping more effectively, more productive during the day and does not "get down". She reports no adverse reactions to the Prozac.

O: Wt. 162 lbs., blood pressure 136/88, temperature 98.3, pulse 72. Physical exam deferred.

A: 1. Depression responding well to medications.

P: 1. Continue Prozac 20 mg qam.
2. I have encouraged her to have her husband come see me to discuss the underlying marital difficulties and possible treatment for depression.
3. I have suggested that she continue the Prozac for the time being and will F/U with me in 2-3 months.

CK, MD/jw d9/9/99 19/10/99

12/1/99 I called in Nesogen as directed c
SRF to Eckerd Cam/Hm Rd @ 520P all

PI 29

Kelly Fay

Wednesday, December 15, 1999

S: Twenty three year old here for F/U of depression. She unfortunately has not been on the Prozac for the last three weeks. She ran out of the samples I had given her and was not sure if I wished for her to continue it. She also felt that off the medication she would be able to see if it was helping her. She has noticed that while on the Prozac her energy level is better, sleeping more effectively and able to finish projects more easily at work. She also felt the relationship with her husband was improved though she still continues to feel he is fighting depression on his own in spite of his reluctance to initiate treatment. Since being off the medication for the last three weeks she has become to feel more tired, states she takes more naps during the day and has not been able to finish her work at her job. Her husband has noticed some difference. She feels the Prozac has made a tremendous difference and would like to restart the medication. She reports no other health problems today.

O: Wt. 167 pounds, blood pressure 128/78, pulse 72, temperature 98.3. Physical exam deferred.

A: 1. Depression.
2. Recovery from recent upper respiratory infection.

P: 1. Restart Prozac 20 mg. q.a.m., samples given x 3 months.
2. Patient to call back at the time her prescriptions are running out at which time we can give her additional samples for two months if available.

CK, MD/jw d12/15/99 t12/20/99

Monday, January 24, 2000

S: 23 year old here for evaluation of upper respiratory infection. Symptoms began 3-4 days ago she feels. She complains of an intense sore throat, difficulty swallowing and has had some ear fullness / congestion since Friday. Cough has been non-productive.

She is still not sure what she would like to do a long term basis but clearly she feels the Prozac has been tremendously helpful in this transition.

O: Wt. 166 pounds, blood pressure 118/86, pulse 74, temperature 98.1 degrees Fahrenheit. CHEST: clear. CVS: RRR, normal S1 and S2. Oropharynx with generalized erythema. (R) tonsil is enlarged. NECK: supple with tender lymphadenopathy.

A: 1. Upper respiratory infection.

P: 1. Z-pack to be taken as directed.
2. Vicodin Tuss 1 tsp. at night as needed for cough.
3. Patient having mental dis...

3. Patient having marital difficulties

4. Continue Prozac 20 mg. q.a.m. for now. They are undergoing counseling at this time and she will let me know if I can be of any other assistance.

CK MDAw d1/24/00 t1/27/00

6/19/00 9:30am
called in, Dose given as directed #1
pack 2 3pk to Joe S. New to CKRC
I informed Rt needs to make an
appt for Pap with in the next
4 to 6 months. Samples of Prozac
30mg Given XI month well

6/12/00 NS mm

8/9/00 Proze song jam # 6273
Leckard, J. Mills Dr. K. K. K.

Dr. Kinnel Brown

PI 31

Kelly Fay
Monday, August 21, 2000

S: 24 year old here for pap smear, doing very well, reports no significant difficulties. Previous pap smears have shown mild vaginitis but otherwise normal.

O: Wt. 174 lbs., BP 118/76, pulse 76. CHEST: clear. CVS: RRR, normal S1 and S2. PELVIC: normal. BREASTS: patient would like to defer to another time.

A: 1. Normal pelvic exam.

P: 1. Pap smear completed, will F/U results when available.
2. Previous history of benign cellular changes associated with inflammation. Noticed some discharge today which likely represents inflammation, will treat as needed.

Sekhar Kommu, MD/jw

PI 32

Kelly Fay
Tuesday, September 5, 2000

S: 24 year old here for evaluation of upper respiratory infection. She complains of a sore throat, significant congestion that she is unable to bring up, nonproductive cough, low grade fever and chills. Onset was approximately one week ago, no sick contacts at home but several people at work have missed days.

O: Wt. 172 lbs., BP 112/70, pulse 76, temperature 97.2. TM's are clear.
Oropharynx with mild erythema, no exudates. NECK: anterior lymphadenopathy.
CHEST: upper airway congestion.

A: 1. Upper respiratory infection.

P: 1. Z-pack to be taken as directed, samples given of Dura Tuss 1 bic x 5 days.

Sekhar Kommu, MD/jw

PI 33

Kelly Fay
Thursday, November 2, 2000

S: Here for evaluation of a suspected strep pharyngitis. Onset was yesterday, states that she is having difficulty swallowing, has not eaten since yesterday because of the pain. She has had a fever last night and complains of chills, no known exposures.

O: Wt. 170 lbs., BP 120/80, pulse 88, temperature 99.0. TM's are clear. Oropharynx is enlarged. Left tonsil is clear. Exudates are noted. NECK: tender tonsils palpable and anterior left sided cervical adenopathy.

A: 1. Strep pharyngitis.

P: 1. Augmentin 875 mg 1 bid x 10 days.
2. F/U if no improvement.

Sekhar Kommu, MD/jw

11/31/01 to ER per G Chest & left shoulder pain.
MD Kommu/Harter

2/22/01 Deagen + Pugh #1 pk + 5 RF
B. Dikoman/Harter
rechecked
4840154

PI 34

Kelly Fay
Chart # 42688
Thursday, March 29, 2001

S: 25 year old here for complete physical exam. She did have a pap smear in 8/00 and scheduled to have another one in the coming year. She is doing well, reports no problems, generally been in excellent health. She has no history of smoking or alcohol use. No drug use. She has had a history of depression in the past, likely due to marital difficulties. She is currently on Prozac 20 mg qd and tolerating this well.

O: Weight 185 pounds, blood pressure 130/80. HEENT: TM's within normal limits bilaterally, conjunctivae and sclerae clear. No scleral icterus, no arcus senilis. EOMI, PERRLA. Nose and throat clear. No oropharyngeal lesions seen. NECK: without thyromegaly or masses, no JVD, no carotid bruits, no cervical or supraclavicular adenopathy. CHEST: clear. CVS: full and equal pulses including dorsalis pedis pulses. S1 and S2 regular without murmur, gallop, rub or click. ABDOMEN: slightly obese, soft, non-tender. No masses or hepatosplenomegaly. Femoral pulses 2+. No inguinal adenopathy. EXTREMITIES: without clubbing, cyanosis or edema. Mild changes of osteoarthritis. No acute synovitis. SKIN: without lesions.

A: 1. Normal 25 year old exam.

P: 1. Lab work as follows:
WBC 8.1, Hgb 12.5, HCT 36.9, Plt 319.
2. UA is normal with SG of 1.010, pH 7.0.
3. Fasting lab work drawn.
4. Continue Prozac 20 mg qd.
5. F/U in 8/01 for pap smear and routine basis.
6. F/U otherwise as needed or as scheduled.

Sekhar Kommu, MD/jw

Kelly Fay Date 03-29-01
Lab Test CBC, Cml, Lipid,
TSU
Drawn By: AK

PI 35

Kelly Fay
Thursday, May 3, 2001

S: 25 year old here for evaluation of an injury she suffered to her chin. She states that she was playing softball three days ago when attempting to catch a line drive. She was hit in the jaw by another player attempting to do the same. She states that the impact was very significant. The other player was a very large man. Unfortunately she developed significant edema at the site. As the swelling has improved she has noted more bruising. What is concerning is her persistent headache, some mild photophobia and nausea. She states her po-intake is normal; does not have blurry vision; no syncopal episodes. The bruising has increased in diameter since the initial injury.

O: Weight 185 pounds; blood pressure 120/80; pulse 64. CHEST: clear. CVS: RRR, normal S1 and S2. Examination of the chin does show some ecchymosis. Point tenderness noted across the (R) side of the mandible.

- A: 1. S/P injury to the chin in playing softball.
- P: 1. Check x-ray to r/o any underlying fracture.
2. Continue to apply ice.
3. Patient does not wish any pain medicine currently; states it is bearable.
4. Continue to take Ibuprofen for non-inflammatory response.

Sekhar Kommu, MD/jw

6/19/01 Prozac 20mg qd #30 + 3dr
tech 10 Sekhar Kommu / Starter
H. Muller

Kelly Fay
Chart # 42688
Wednesday, July 25, 2001

SUBJECTIVE:

Here for evaluation of suspected upper respiratory infection, onset of symptoms two weeks ago. She has had a very difficult time recently. Her grandfather passed away and she traveled to Chicago. In addition she has changed jobs recently. She is in good health but does describe a low grade fever, post nasal drip and fullness in her ears bilaterally.

OBJECTIVE:

TM's are clear. Oropharynx with mild erythema, no exudates. NECK: supple without adenopathy. CHEST: clear.

ASSESSMENT:

1. Upper respiratory infection.

PLAN:

1. Will treat with Z-pack to be taken as directed.
2. Patient will be moving to Myrtle Beach and will be employed there on consultation services to a golfing resort.
3. Prescription today for Desogen 1 every day and Prozac 20 mg every day.

Sekhar Kommu, MD/jw

10/8/01 I called in Desogen BCP
1 pack = 2RF to Walmart
S.C. 843 445 7953 on dr line
@ 253p (A)

12/20/01 I called in Prozac 20mg OD #30z
and Desogen 28 day # 1 pack
= 3RF to Walmart Myrtle Beach
1843 445 7851 @ 1245p (A)

PI 37

GRAND STRAND REGIONAL MEDICAL CENTER
POLICY AND PROCEDURE
JANUARY 2001 - APRIL 2003

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0001

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Purpose and Objectives

MANAGEMENT OF THE ENVIROMENT OF CARE

Decontamination

MANAGEMENT OF HUMAN RESOURCES

3/3

12-01-2005

02:44:36 p.m.

SACU EMERGENCY KU

843 839 01 46

SOUTH STRAND EMERGENCY DEPARTMENT TIME SHEET

FIRE AND EMERGENCY DEPARTMENT TIME SHEET																													
31-Dec	M	T	W	T	F	S	S	M	T	W	T	F	S	S	M	T	W	T	F	S	S	M	T	W	T	F	S	S	
27-Jan-02	31	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	
Gjellum, T					11	7	7		7	7	7																		
Partyka, L	7					7	7		7	7	7								7	7	7		7	7					
Dressel, D	7			7	7	7	7			7	7								7	7	7		7	7					
Russell, L	7				7			7	7				7	7	7	7		7	7	7		7	7						
New, G.		7	7	7						7		7			7		7	7									7	7	7
Doolittle, M		7	7	7					7				7	7		7	7	7		R		7	R		7	7	7	7	
Cuthbert, A		7	R		7	7			7	7		7	7	7		7	7	7						7			7	7	
Mealge, S	R	11			11				7	7		7				7										7	7	7	
Willm, D				11	11				11	11			11			11	11			11	7		7	7		7			
Warren, M										11	11								11			11	11			11			
Motley, V																		11	11					11	11				
Crane, G		R	R	R		R	R		R		R			R	R														
Didlo, D	7			7	7				7										7-3	R	R		R					R	
Staples, K	R			7	7				7				7	7	7			7	7				7						
Dowling, K	7			7	7				7				7	7	7			7	7				7				7	7	
Pezzullo, S									7				7	7	7			7	7				7				7	7	
Leski, P					7	7	7			7	7	7										7					7	7	
Ligon, S	11					11	11				7	7	7						7	7	7			7	7	7			
Lee, J		7														11	11			7	7	7		7	7	7			
Rhodes, S	7					7	7		7	7	7								3-7	11	11						11	11	
McDonald, R		7			7											7				7	7		7	7	7				
Cheever, M		7							7															7					
Jones, S					R	R	R		7			7							7				7				7		

SSACC
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ROA_0936

STRAND EMERGENCY DEPARTMENT TIME SHEET

DATE:	M	T	W	T	F	S	S	M	T	W	T	F	S	S	M	T	W	T	F	S	S	M	T	W	T	F	S	S
31-Dec-01	31	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27
27-Jan-02																												
Leilich, A																												
Lemba, J	9-3																											
White, G	7					7	7-3	9-3	7	7	9-3	9-11				7	7		7	7								
Richards, N	R	7	7	7		7	7	7		7	7					7	7	7	7	7		9-3	7	7	9-3	7	7	7
Cooper, S	7a					7	7a	7a	7		7a	7	7	7		7	7	7		7	7	7	7	7	7	7	7	7

Master

GRAND STRAND REGIONAL MEDICAL CENTER

~~(MEDICAL-STAFF-BYLAWS)~~

RECEIVED
JAN 22 2007

AND

RULES AND REGULATIONS

BY:-----

REVISED: 1988
1989
1990
1991
1992
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1998
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2001
2002

1/08/02 - 4.3-3C(a)&(b), 6.5-2(a)&(b)

8/13/02 - 7.6, 12.4-1(b), 12.4-2(b),

R&Rs B. General Patient Care B.2

12/10/02 R&Rs C.5(a) (b) (c) (d) Verbal Orders

2002

6/10/03 - #19 Definitions, 4.5, 4.5-2, 7.5, 7.6

R&Rs C.7, C.8

2003

8/12/03 - 6.4-2 Verification of Information (Applicant's Burden)

2003

7.5-3 - Conditions for use of Temporary Privileges
(7.5.3.1 Pendency of Application)

10/14/03 -

2003

11.1-5 - Election

11.1-6 - Term of Elected Officers

11.3-2 - Selection and Appointment

11.3-3 - Term of Office

11.3-4 - Assessing the Quality of Care

12.2-3 - Frequency of M.E.C. Meetings

Rules & Regulations Addition of Section I

MEDICAL STAFF BYLAWS
GRAND STRAND REGIONAL MEDICAL CENTER

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FAIR HEARING PLAN/Revised 1/13/98

DEFINITIONS

1. HOSPITAL means Myrtle Beach Hospital, Inc. d/b/a Grand Strand Regional Medical Center of Myrtle Beach, South Carolina.
2. BOARD OF TRUSTEES or BOARD means the advisory body of the hospital.
3. ADMINISTRATOR or CHIEF EXECUTIVE OFFICER means the individual appointed by the governing authority to act on its behalf in the overall administrative management of the hospital.
4. MEDICAL STAFF or STAFF means the formal organization of all licensed physicians, dentists and podiatrists who are privileged to attend patients in the hospital.
5. MEDICAL EXECUTIVE COMMITTEE or MEC means the executive committee of the medical staff.
6. CLINICAL PRIVILEGES or PRIVILEGES means the permission granted to a practitioner to render specific diagnostic, therapeutic, medical, dental, pediatric, or surgical services.
7. PREROGATIVE means a participatory right granted, by virtue of staff category or otherwise, to a staff member or allied health professional, and exercisable subject to the conditions imposed by these bylaws and by other hospital and medical staff policies.
8. PHYSICIAN means an individual with an MD or DO degree who is properly licensed to practice medicine in South Carolina.
- 10/9/01
9. PRACTITIONER means, unless otherwise expressly limited, any physician, dentist, podiatrist as well as others with clinical privileges in this hospital.
10. MEDICAL STAFF YEAR means the period from April 1 to March 31.
11. EX OFFICIO means service as a member of a body by virtue of an office or position held and, unless otherwise expressly provided, without voting rights.
12. SPECIAL NOTICE means written notification sent by certified or registered mail, return receipt requested.
- 04/03/01
13. ALLIED HEALTH PROFESSIONAL may, subject to any licensure requirements or other legal limitations, exercise independent judgment within the areas of his/her professional competence, and may participate under the supervision of a physician who has been accorded privileges to provide such care and who has ultimate responsibility for that patient's care.
14. PEER means appropriate practitioners in the same discipline as the applicant.

15. **CRIMINAL CONVICTIONS** means conviction of, or a plea of guilty or nolo contendere for any felony, or for any misdemeanor related to the practice of a health care profession, Federal health care program fraud or abuse, third-party reimbursement, or controlled substances.
16. **FEDERAL HEALTH CARE PROGRAM** means any plan or program that provides health benefits, whether directly, through insurance, or otherwise, which is funded directly, in whole or in part, by the United States Government or a State health care program (with the exception of the Federal Employees Health Benefits Program). The most significant Federal health care programs are Medicare, Medicaid, Blue Cross Federal Employee Program (FBP)/Tricare / Champus and the Veterans programs.
17. **INELIGIBLE PERSON** means any individual who: (1) is currently excluded, suspended, debarred, or ineligible to participate in any Federal health care program; or (2) has been convicted of a criminal offense related to the provision of health care items or services and has not been reinstated in a Federal health care program after a period of exclusion, suspension, debarment, or ineligibility.
- 10/9/01
18. **IMPAIRED PHYSICIAN** - Impaired practitioner is one who is unable to perform the clinical privileges that have been granted with reasonable skill and safety to patients or perform other Medical Staff duties because of physical, mental, emotional or personality disorders, including deterioration through the aging process, loss of motor skill, or excessive use or abuse of drugs, including alcohol.
- 6/10/03
✓ 19. **ENCOUNTER** - Encounters is defined as any interaction that would require some documentation to include, but not limited to, admission history and physical, emergency consultation, emergency procedure, daily rounds and elective procedure, telephone orders for admission even if a different physician subsequently sees that patient and performs the H&P.

PREAMBLE

WHEREAS, Grand Strand Regional Medical Center is an investor owned general hospital organized under the laws of the State of South Carolina; and

WHEREAS, its purpose is to serve as an acute care general hospital providing patient care, education and research; and

WHEREAS, it is recognized that one of the aims and goals of the medical staff is to strive for quality patient care in the hospital, that the medical staff must work with and is subject to the ultimate authority of the board, and that the cooperative efforts of the medical staff, administration and board are necessary to fulfill the hospital's aims and goals in providing quality care to its patients;

THEREFORE, the physicians, dentists and podiatrists practicing in this hospital hereby organize themselves into a medical staff in conformity with these bylaws.

Article I

The name of the organization will be the Medical Staff of Grand Strand Regional Medical Center of Myrtle Beach, South Carolina.

ARTICLE II - PURPOSES AND RESPONSIBILITIES

2.1 PURPOSES

The purposes of the medical staff are:

- (a) to be the formal organizational structure through which the benefits of membership and clinical privileges on the staff may be obtained by individual practitioners and the obligations of staff membership may be fulfilled.
- (b) to serve as a primary means for accountability to the board for the appropriateness of the professional performance and ethical conduct of its members and to strive toward the continual upgrading of the quality and efficiency of patient

care delivered in the hospital consistent with the state of the healing arts and the resources locally available.

- (c) to provide a means through which the medical staff may participate in the hospital's policy making and planning processes.

2.2 RESPONSIBILITIES OF THE MEDICAL STAFF

The responsibilities of the medical staff are to:

- (a) to implement and conduct the following specific activities to supervise the quality and efficiency of patient care provided by all practitioners authorized to practice in the hospital through the following measures:
 - (1) Review and evaluation of all medical and surgical services as related to the appropriateness of diagnosis and treatment. 1/9/01
 - (2) Participate, in a leadership role, in organizational performance improvement activities when the performance of a process is dependent primarily on the activities of practitioners with clinical privileges. The medical staff shall provide leadership for process measurement, assessment, and improvement of patient care process including though are not limited to, those related to:
 - (a) medical assessment and treatment of patients;
 - (b) use of medications;
 - (c) use of blood/blood components;
 - (d) use of operative and other procedures;
 - (e) efficiency of clinical practice patterns;
 - (f) significant departures from established patterns of clinical practice;
 - (g) education of patients and families;
 - (h) coordination of care with other practitioners and hospital personnel as relevant to the care of an individual patient;
 - (i) accurate, timely and legible completion of patients' medical records;
 - (j) surveillance of nosocomial infections; 1/09/01
 - (k) ensure that when the findings of the assessment are relevant to an individual's performance, the medical staff is responsible for determining their use in peer review or the ongoing

evaluations of a licensed independent practitioner's competence for the renewal or revising clinical privileges.

- (1) ensure that the medical staff, with other appropriate hospital staff, develops and uses criteria that identify deaths in which an autopsy should be performed.
 - (3) Credentials evaluation, including mechanisms for appointment and reappointment and the matching of clinical privileges to be exercised or of specified services to be performed with the verified credentials and current demonstrated performance of the applicant.
 - (4) Continuing education programs, fashioned at least in part on the needs demonstrated through the quality review, evaluation and monitoring programs.
 - (5) Utilization review to allocate inpatient medical and health services based upon patient-specific determinations of individual medical needs.
 - (6) All organized services related to patient care, including services furnished by a contractor must be evaluated. 1/09/01
- (b) to recommend to the board, action with respect to appointments, reappointments, department assignments, clinical privileges, specified services for allied health professionals, and corrective action.
 - (c) to recommend to the board programs for the establishment, maintenance, continuing improvement and enforcement of professional standards in the delivery of health care within the hospital.
 - (d) to account to the board for the quality and efficiency (of patient care through regular reports and recommendations concerning the implementation, operation and results of the quality review, evaluation and monitoring activities.
 - (e) to initiate and pursue corrective action with respect to practitioners, when warranted.
 - (f) to develop, administer, recommend amendments to and seek compliance with these bylaws, the rules and regulations of the staff and other hospital policies.

- (g) to assist in identifying community health needs and in setting appropriate institutional goals and implementing programs to meet those needs.
- (h) to exercise the authority granted by these bylaws as necessary to adequately fulfill the foregoing responsibilities.
- (i) to review and recommend to the administrator, those forms and documents dealing with medical staff functions or delivery of patient care.

ARTICLE III - MEDICAL STAFF MEMBERSHIP

3.1 NATURE OF MEDICAL STAFF MEMBERSHIP

Membership on the medical staff or the exercise of temporary privileges will be extended only to professionally competent practitioners who continuously meet the qualifications, standards and requirements set forth in these bylaws. Appointment to and membership on the staff will confer on the appointee or member only such clinical privileges and prerogatives as have been granted by the board in accordance with these bylaws. No practitioner will admit or provide services to patients in the hospital unless he is a member of the staff or has been granted temporary privileges in accordance with the procedures set forth in Article VII.

3.2 QUALIFICATIONS FOR MEMBERSHIP

3.2-1 BASIC QUALIFICATIONS

Only practitioners licensed to practice in the State of South Carolina, who:

- (a) provide his patients with continuous care at the generally recognized professional level of quality and efficiency. Provide documentation pertaining to evidence of current licensure, relevant training or experience and current competence and ability to perform the privileges requested with sufficient adequacy to demonstrate to the medical staff and the Board that any patient treated by them will receive care of the generally recognized professional level of quality and efficiency and that they are qualified to

provide a needed service within the hospital; and patient treated by them will receive care of the generally recognized professional level of quality and efficiency and that they are qualified to provide a needed service within the hospital; and

- (b) are proficient in the English language; and
- (c) are determined, on the basis of documented references, to adhere strictly to the ethics of their respective professions, to work cooperatively with others, and to be willing to participate in the discharge of staff responsibilities will be qualified for membership on the medical staff.

3.2-2 APPLICANT'S DUTY TO REPORT POTENTIAL IMPAIRMENT

The applicant shall possess the ability to perform the clinical privileges requested. In the event that the applicant has a physical or mental impairment that adversely affects his/her ability to practice within the clinical privileges requested, the applicant shall notify the Chief of Staff. Upon receipt of such notification, the Chief of Staff will meet with the applicant to determine the extent of the impairment. If it is determined that the impairment could affect the applicant's ability to perform the essential functions of the clinical privileges requested, the Chief of Staff and applicant will discuss whether there is a reasonable accommodation that would enable the applicant to perform such functions. The hospital, at its sole discretion, will provide such necessary and reasonable accommodation.

3.2-3 EFFECT OF OTHER AFFILIATIONS

No practitioner shall be automatically entitled to membership on the medical staff or to the exercise of particular clinical privileges merely because he is licensed to practice in this or in any other state, or because he is certified by any clinical board, or because of past or present staff membership at this hospital or at another health care facility or in another practice setting.

3.2-4 NONDISCRIMINATION

No aspect of medical staff membership or particular clinical privileges will be denied on the basis of gender, race, creed or national origin or on the basis of any other criterion unrelated to the delivery of quality patient care in the hospital, to

professional qualifications, to the hospital's purposes, needs and capabilities, or to community need.

3.3 BASIC RESPONSIBILITIES OF INDIVIDUAL STAFF MEMBERSHIP

Each member

- (b) abide by the medical staff bylaws and by all other lawful standards, policies and rules of the hospital.
- (c) discharge such staff, department, committee and hospital functions for which he is responsible by staff category assignment, appointment, election or otherwise.
- (d) Prepare and complete, in timely fashion, the medical and other required records for all patients he admits or in any way provides care to in the hospital.
- (e) abide by the ethical principles of his profession.

3.4 DURATION OF APPOINTMENT

3.4-1 DURATION OF INITIAL APPOINTMENTS AND MODIFICATIONS

All initial appointments, and all modifications of membership status or privileges pursuant to Section 6.6, will be for not more than 1 year.

3.4-2 REAPPOINTMENTS

Reappointments to any category of the medical staff will be for a period of not more than 2 years.

3.5 PERIOD OF OBSERVATION

3.5-1 FOR INITIAL APPOINTMENTS

All initial appointments to any category of the staff are provisional and will be subject to a period of observation for 12 months. Each initial appointee will be assigned to a department where his performance will be observed by the chairman of the department, or such chairman's designee, to determine his eligibility for continued staff membership in the staff category to which he was initially appointed and for exercising the

clinical privileges initially granted in that department. His exercise of clinical privileges in any other department will also be subject to observation by that department's chairman or his designee.

3.5-2 FOR MODIFICATION OF MEMBERSHIP STATUS OR PRIVILEGES

The medical executive committee may recommend to the board that a change in staff category or department assignment of a current staff member pursuant to Section 6.6 be made provisional and subject to observation in accordance with procedures similar to those outlined in Section 3.5-1 for initial appointments.

3.5-3 TERMINATION OF PERIOD OF OBSERVATION

At the end of the period of observation, the chairman of the department of the appointee will recommend to the credentials committee, reappointment of the appointee to the medical staff, or at any time during the period of observation, the chairman of the department may recommend termination of staff membership or particular clinical privileges. The initial appointee or staff member so affected will be given special notice of such termination and will be entitled to the procedural rights afforded in Article IX in the Fair Hearing Plan.

3.6 LEAVE OF ABSENCE

3.6-1 LEAVE STATUS

A staff member may obtain a voluntary leave of absence from the medical staff by submitting written notice to the medical executive committee (MEC) and to the administrator stating the approximate period of time of the leave, which may not exceed 2 years. During the period of the leave, the staff member's clinical privileges, prerogatives and responsibilities will be suspended. This request may be granted upon completion of all current responsibilities.

3.6-2 TERMINATION OF LEAVE

At least 60 days prior to the termination of the leave, or at any earlier time, the staff member may request reinstatement of his privileges and prerogatives by submitting a written notice to that effect to the administrator for transmittal to the MEC. The staff member will submit a written summary of his relevant activities during the leave, if the MEC or the board (or appropriate committee thereof) so requests. The MEC will make a recommendation to the board concerning the reinstatement of the

member's privileges and prerogatives. Thereafter, the procedure provided in Sections 6.4-6 through 6.4-11 will be followed.

Failure, without good cause, to request reinstatement or to provide a requested summary of activities as above provided will be deemed a voluntary resignation from the staff and will result in automatic termination of staff membership, privileges, and prerogatives. A practitioner whose membership is so terminated will be entitled to the procedural rights provided in Article IX and in the Fair Hearing Plan for the sole purpose of determining the issue of good cause. A request for staff membership subsequently received from a staff member so terminated will be submitted and processed in the manner specified for applications for initial appointments.

3.7 TERMINATION OF MEDICO-ADMINISTRATIVE PRACTITIONERS

Physicians, dentists and podiatrists engaged by the hospital either full-time or part-time in administratively responsible capacities, but whose activities include clinical responsibilities, must have achieved and maintained medical staff membership through the same procedures provided for all medical staff members. (Clinical responsibilities will be construed to include, but not be limited to, direct medical care of patients and/or supervision of the professional activities of practitioners under such physician's, dentist's, or podiatrist's direction.) Continued medical staff membership may not be made contingent on continued engagement by the hospital. Any physician, dentist or podiatrist whose engagement by the hospital requires membership on the medical staff as described above will not have his medical staff privileges terminated without the same due process provisions as must be provided for any other member of the medical staff.

3.8 HEALTH STATUS/ABILITY TO PERFORM 10/9/01

3.8-1 PREAMBLE

The hospital and its Medical Staff have an obligation to protect patients and others from harm. In this regard, the Medical Staff has designed a process to provide education about health issues related to practitioners and others with clinical privileges. The process addresses physical, psychiatric, and emotional illness and facilitates confidential diagnosis, treatment, and rehabilitation of practitioners who suffer from a potentially impairing condition. It is the policy of the Medical Staff to properly investigate and act upon concerns that

a practitioner who is a member of the Medical Staff or who has clinical privileges is suffering from impairment. The Medical Staff, through its Practitioner Advocacy Committee (PAC) will investigate and act in accordance with pertinent state and Federal law. The process by which the Committee investigates and acts is detailed below and in Section 12.4-15. An "Impaired Practitioner" is one who is unable to perform the clinical privileges that have been granted with reasonable skill and safety to patients or perform other Medical Staff duties because of physical, mental, emotional or personality disorders, including deterioration through the aging process, loss of motor skill, or excessive use or abuse of drugs, including alcohol.

3.8-2 REPORTING OF SUSPECTED PRACTITIONER IMPAIRMENT

A) SELF REPORTING. During the application process, all applicants must report information about their ability to perform the clinical privileges that they are requesting. Any practitioner with clinical privileges is responsible for reporting any change in his/her abilities that could affect the quality of patient care rendered by him/her as related to the performance of his/her clinical privileges and/or Medical Staff duties. Such reports should be made immediately upon the practitioner becoming aware of the change. The Practitioner seeking assistance shall submit a confidential, written request for same to the Practitioner Advocacy Committee.

B) THIRD PARTY REPORTS. If any person witnesses warning signs of impairment in a practitioner while the practitioner is in the hospital or on call, they should report the incident. Medical Staff members, nurses and others, as appropriate, shall be educated about illness and impairment recognition issues specific to practitioners, including education about warning signs. Warning signs may include, but are not restricted to, perceived problems with judgement or speech, alcohol odor, emotional outbursts, behavior changes and mood swings, diminishment of motor skills, unexplained drowsiness or inattentiveness, progressive lack of attention to personal hygiene, or unexplained frequent illnesses.

In such cases, an oral or (preferably) written report shall be given to any member of the hospital administration (including charge nurses and supervisors), any officer of the medical staff, or directly to any member of the Practitioner Advocacy Committee. Third party reports should be factual and include a description

of the incident(s) that led to the belief that a practitioner may be impaired. The person making the report does not need to have proof of the impairment, but must state the facts leading to the concern. Care should be taken by the reporting person to strictly avoid speculation, conclusions, gossip, and any discussions of the matter with anyone outside those described in this section of the Bylaws. Any recipient of such a report shall forward the report directly to the Practitioner Advocacy Committee for timely consideration. The identity of the reporting individual shall be kept confidential.

3.8-3 INVESTIGATION

Following a written request to investigate, the Practitioner Advocacy Committee shall investigate the concerns raised and any and all incidents that led to the belief that the practitioner may be impaired. The committee's investigation may include, but is not limited to, any of the following:

(A) Review of any and all documents or other materials relevant to the investigation;

(B) Interviews with any and all persons involved in the incidents or who may have information relevant to the investigation, provided that any specific inquiries made regarding the practitioner's health status are related to the performance of the practitioner's clinical privileges and Medical Staff duties and are consistent with proper patient care or the operations of the Hospital;

(C) A requirement that the practitioner under investigation undergo a complete medical and/or psychological examination as directed by the Committee, so long as the exam is related to the performance of the practitioner's clinical privileges and Medical Staff duties and is consistent with proper patient care or the operations of the Hospital. The Practitioner will consent to release of the results of this examination to the PAC;

(D) The Committee may meet with practitioner under investigation as part of its investigation. This meeting does not constitute a hearing under the due process provisions of the Hospital's Medical Staff Bylaws or pertinent policies and thus may not be attended by such practitioner's legal counsel. At this meeting, the Committee may ask the individual under investigation health-related questions so long as they are related to the concerns related to performance of the practitioner's

clinical privileges and Medical Staff duties, and are consistent with proper patient care and operations of the Hospital. In addition, if the Committee feels that the practitioner may have an impairment that significantly affects his/her ability to perform essential functions concerning patient care, it may discuss with the practitioner under investigation whether a reasonable accommodation is needed or could be made so that the practitioner could competently and safely exercise his/her clinical privileges and/or the duties and responsibilities of medical Staff appointment.

3.8-4 OUTCOME OF INVESTIGATION

Based on all of the information it reviews as part of its investigation, the Practitioner Advocacy Committee shall determine:

(A) Whether the practitioner is impaired, or what other problem, if any and if known, is affecting the practitioner under investigation;

(B) If the practitioner is impaired, the nature of the impairment;

(C) If the practitioner's impairment could be considered a disability, whether a reasonable accommodation can be made for the practitioner's impairment such that with the reasonable accommodation, the impaired individual would be able to competently and safely perform his/her clinical privileges and the essential duties and responsibilities of Medical Staff appointment;

(D) Whether the impairment could negatively impact the quality of care or the health or safety of the impaired practitioner, patients, Hospital employees, physicians or others within the Hospital. Such negative impact must involve a risk of substantial harm based upon medical analyses and/or other objective evidence;

(E) If the Committee in conjunction with the Hospital CEO determines that there is a reasonable accommodation that can be made as described above, the Committee shall attempt to work out a voluntary agreement with the impaired practitioner, as long as that arrangement would neither impose an undue hardship upon the Hospital or

create a direct threat, also as described above. The Chief Executive Officer shall be kept informed of attempts to work out a voluntary agreement before it becomes final and effective if the agreement requires or directly affects hospital resource utilization;

(F) When the Committee feels there is convincing evidence that a practitioner is impaired (as defined in 3.8-1) due to substance abuse and/or dependence, the practitioner shall be required to undergo a formal evaluation by the South Carolina Recovering Professional Program (SCRPP). The practitioner shall consent to the SCRPP submitting a report of this evaluation to the PAC. Should it be indicated, the SCRPP shall manage the practitioner's treatment, recovery and monitoring from that point forward, and shall notify the PAC if and when the practitioner is ready to resume clinical duties safely.

(G) If the Committee determines that there is no reasonable accommodation that can be made as described above, or if the Committee cannot reach a voluntary agreement with the practitioner felt to be impaired, the Practitioner Advocacy Committee shall make a recommendation to the Medical Executive Committee. The MEC shall decide what action to be taken, if any. If the MEC's action would provide the practitioner with a right to a hearing as described in the Medical Staff Bylaws, the fair hearing plan shall be followed. The recommendation shall not be forwarded to the Board of Trustees until the practitioner has exercised or has been deemed to waive the right to a hearing as provided under Article IX of the Medical Staff Bylaws

(H) If action is taken by the PAC, the original report, documentation of the investigation, and a description of the actions taken shall be included in the practitioner's credentials file. If the initial or follow-up investigation reveals that there may be some merit to the report, but not enough to warrant immediate action, the report shall be included in a confidential portion of the practitioner's credentials file and further monitoring or other follow-up, upon the initial complaint, shall be at the discretion of the Practitioner Advocacy Committee.

(I) Throughout this process, all parties shall avoid speculation, conclusions, gossip, and any discussions of the matter with anyone outside those described in this section of the Bylaws.

3.8-5 TREATMENT/REHABILITATION AND REINSTATEMENT GUIDELINES

If it is determined that the practitioner suffers from an impairment that could be reasonably accommodated through rehabilitation or medical/psychological treatment the following are requirements for rehabilitation or treatment and reinstatement.

(A) A practitioner with an impairment shall not be reinstated until it is established to the Medical Staff's satisfaction, that the practitioner has successfully completed a rehabilitation program in which the Medical Staff has confidence, or has received treatment for a medical or psychological impairment such that the condition is under sufficient control.

(B) The Medical Staff is not required to extend membership or privileges to a practitioner with an impairment, and may have certain requirements of the practitioner in order to consider or grant privileges or membership to the individual.

(C) Upon sufficient proof that the practitioner who has been found to be suffering from impairment has completed a program or received treatment as described above, the Medical Staff, in its discretion, may consider the impaired practitioner for reinstatement of Medical Staff membership or clinical privileges. Such a request for reinstatement shall be directed to the Practitioner Advocacy Committee, which will formulate and forward a recommendation to the MEC for decision.

D) In considering an impaired practitioner for reinstatement, the Hospital and Medical Staff leadership must consider patient care interests paramount.

(E) The Practitioner Advocacy Committee must first obtain a letter from the physician director of the rehabilitation program where the impaired practitioner was treated, or the physician directing the impaired practitioner's medical or psychological treatment. The impaired practitioner must authorize the release of this information, which should include:

1. Whether the impaired practitioner is participating in the program or treatment;
2. Whether the impaired practitioner is in compliance with all of the terms of the program or treatment plan;

3. Whether the impaired practitioner attends AA/NA meetings or other treatment sessions regularly (if appropriate);
4. To what extent the impaired practitioner's behavior and conduct are monitored;
5. Whether, in the opinion of the treating physician, the impaired practitioner is rehabilitated or the medical/psychological impairment is under control so that patient care will not be compromised;
6. Whether an after-care program has been recommended to the impaired individual (if appropriate), and if so, a description of the after-care program; and,
7. Whether, in the opinion of the treating physician, the impaired practitioner is capable of resuming practice and providing continuous, competent care to patients.

(F) The Medical Staff has the right to require opinion(s) from other physician(s) or consultants of its choice.

(G) Assuming the information received convincingly indicates that the practitioner is sufficiently in recovery or rehabilitated or the medical/psychological condition is under control, the Medical Staff shall take the following additional precautions when restoring clinical privileges:

1. The impaired practitioner must identify a physician or peer, or group thereof who will assume responsibility for the care of his/her patients in the event of his/her inability or unavailability;
2. The practitioner shall be required to obtain periodic reports for the Practitioner Advocacy Committee from the rehabilitation program, after-care program, or treating physician for a period of time specified by the Committee stating that the practitioner is continuing treatment or therapy, as appropriate, and that his/her ability to treat and care for patients in the Hospital is not impaired.

(H) As a condition of reinstatement, the impaired practitioner's credentials shall be re-verified from the primary source and the verification documented, in accordance with the procedures of Article VI of the Bylaws. Minimally, licensure, DEA, state narcotics registration, and professional liability insurance shall be verified. Additionally, the Hospital shall query the National Practitioner Data Bank, the OIG Sanction Report and the GSA List. The Hospital may also re-verify any other qualification or competence if there is reasonable belief

that it may have been adversely affected by the circumstances related to the impairment.

If at any point during the process of investigation, rehabilitation or treatment, or reinstatement the practitioner refuses or fails to comply with these procedures, he/she will be subject to a suspension and/or other sanctions from the Medical Staff and afforded due process as defined in the provisions of the Medical Staff Bylaws, unless the practitioner's contract with the Medical Executive Committee states otherwise, such as when automatic termination is the penalty stated in the contract.

(J) If at any time during the diagnosis, treatment, or rehabilitation phase of this process, The Practitioner Advocacy Committee becomes aware that the practitioner is unable to safely perform the privileges he/she has been granted, the matter shall be forwarded to the Medical Executive Committee for appropriate corrective action that includes strict adherence to any state or federally mandated reporting requirements.

(K) All requests for information concerning the impaired practitioner shall be forwarded to the Chief Executive Officer for response. Information concerning a practitioner seeking referral or referred for assistance shall be maintained with confidentiality, except as limited by law, ethical obligation or when the safety of a patient is threatened.

ARTICLE IV - CATEGORIES OF THE MEDICAL STAFF

4.1 CATEGORIES

The staff will include Active I, Active II, Associate, Courtesy, Emergency Services, Honorary, Affiliate and Consulting categories.

4.2 ACTIVE STAFF I

The hospital based physicians will be in the Active Staff I category.

4.2-1 QUALIFICATIONS

Active Staff I category will consist of physicians, each of whom:

- (a) meets the basic qualifications set forth in Section 3.2-1.
- (b) is located closely enough (office and residence) to the hospital to provide continuous care to his/her patients. Determination of "closely enough" will be the prerogative of the MEC.
- (c) require a competency evaluation at each reappointment.

4.2-2 PREROGATIVES

The prerogatives of an Active staff I member are:

- (a) will have more than 10 hospital admissions and or surgical procedures or E.R. consultations each year to retain Active Staff I category status. Certain specialties, by nature of their practice (e.g., ophthalmology, dermatology) will be exempt from this volume requirement for admissions, surgical procedures, and E.D. consultations. Exempt specialties shall be determined by the M.E.C. with approval of the Medical Staff and Board of Trustees.
- (b) each request for medical staff membership will be decided on a case by case basis taking into consideration the practitioners' capability to respond to an emergency request which is reasonably expected to be within one hour and the ability to provide continuing care to his or her patients.
- (c) vote on all matters presented at general and special meetings of the medical staff and of the department and committees of which he is a member.
- (d) hold office in the Staff organization and in the department and committees of which he/she is a member.
- (e) with the concurrence of the chief of staff, or the appropriate chief of service, call in any non-staff consultant provided that a written report of the consultation be made a part of the patient's permanent record.

4.2-3 RESPONSIBILITIES

Each member of Active Staff I will:

- (a) meet the basic responsibilities set forth in Section 3.3.
- (b) retain responsibility within his/her area of professional competence for the continuous care and supervision of each patient in the hospital for whom he/she is providing services, or arrange a suitable alternative for such care and supervision.
- (c) actively participate in patient care evaluation, utilization review and other quality evaluation and monitoring activities required of the staff, in supervising initial appointees of his/her same profession, in the emergency services program, and in discharging such other staff functions as may be required from time to time.
- (d) satisfy the requirements set forth in Article XIII for attendance at meetings of the staff and of the department and committees of which he is a member.

4.3 ACTIVE STAFF II

The initial appointment process will remain the same as for the other staff categories.

4.3-1 QUALIFICATIONS:

The Active Staff II category will consist of those physicians who hold membership status only. 1/09/01

- (a) will meet the basic qualifications set forth in 3.2-1.
- (b) 12/14/99 surgeons are not eligible for membership and privileges in the Active Staff II category due to the nature of the specialty.

4.3-2 PREROGATIVES:

Each Active Staff II member: 1/09/01

- (a) will not have admitting or clinical privileges;
- (b) will not hold office;

- (c) may have voting privileges after the provisional year reappointment provided he/she volunteers for committee assignment and attends 50% of the assigned committee meetings or 50% of medical staff and department meetings each year.

4.3-3 RESPONSIBILITIES:

Each Active Staff II member: 1/09/01

- (a) will meet the basic responsibilities set forth in Section 3.3.
- (b) will actively participate in the emergency services referral program;
- (c) be available, or his physician designee, will be available by telephone 24 hours, 7 days each week to answer any questions of the admitting and/or the emergency physician when his/her patients of the physician present to the emergency room. 1/8/02
 - a) will request in writing coverage for his/her patients by an Active Staff I member;
 - b) will provide the hospital with the letter of request for coverage to the Active Staff I member and the letter requesting the coverage.

4.4 ASSOCIATE STAFF

4.4-1 QUALIFICATIONS

The associate staff will consist of dentists and podiatrists, each of whom meets the same qualifications specified for members of the active staff. 4/03/01 Oral surgeons may elect to apply for Active Staff category.

4.4-2 PREROGATIVES

The prerogatives of an associate staff member will be to:

- (a) admit patients 04/03/01 conjointly with an Active Staff I physician to the hospital. Oral surgeons may be exempted from conjoint admissions, if privileged to do histories, physicals, and preoperative assessments; however, the general medical condition of patients admitted by oral surgeons will be the prearranged responsibility of a qualified physician-member of the medical staff as outlined

in D7 of the Rules and Regulations of these bylaws.

- (1) 04/03/01 If oral surgeon is an Active Staff member, prearrangements for coverage of medical conditions will be necessary as deemed appropriate.
- (b) exercise such clinical privileges as are granted to him pursuant to Article VII.
- (c) vote on all matters presented at general and special meetings of the medical staff and of the department and committees of which he is a member.
- (d) hold office in the staff organization and in the department and committees of which he is a member.

4.4-3 RESPONSIBILITIES

Each member of the associate staff will be required to discharge the same responsibilities as those specified in Section 4.2-3 for members of the active staff. Failure to fulfill those responsibilities will be grounds for termination of staff privileges or denial of reappointment.

4.5 COURTESY STAFF

4.5-1 QUALIFICATIONS

The courtesy staff will consist of physicians, dentists, and podiatrists, each of whom:

- (a) Meet the basic qualifications set for them in Section 3.2-1.
- (b) Is located close enough to the hospital or otherwise arranges to provide continuous care to his patients.
- (c) 6/10/01 Is a member of the active staff of another Horry County or Waccamaw Neck area hospital where he/she actively participates in peer review or other quality maintenance activities similar to those required of the medical staff at this hospital. In addition, he/she must maintain a practice in Horry County and Waccamaw Neck area.

✓ 4.5-2 PREROGATIVES

The prerogatives of a courtesy staff member will be to:

✓ (a) Prerogatives - 6/10/03

The Courtesy staff is to have no more than 20 encounters per year. There is no minimum encounter requirement for courtesy staff. Encounters are as defined in these bylaws.

✓ The number of encounters will be tracked on a quarterly basis. If the practitioner exceeds the limit over the past 12 months, he/she will have the opportunity to transition to the Active Staff or withdraw their courtesy privileges. The practitioner will have the option to present to the M.E.C. a reasonable plan for being able to stay under the limit while continuing in the courtesy status. If this plan is accepted, the practitioner may remain on courtesy staff and continue to be tracked quarterly. If the limit is once again exceeded the options of active staff or withdrawal will be offered.

- (b) Exercise such clinical privileges as are granted to him/her pursuant to Article VII.
- (c) Attend meetings of the staff and service which he is a member and any staff or hospital education programs.
- (d) Courtesy staff members will not be eligible to vote or to hold office in the medical staff organization.

4.5-3 RESPONSIBILITIES

- (a) Each member of the courtesy staff will be required to discharge the basic responsibilities specified in Section 3.3 and further will retain responsibilities within his/her area of professional competence for the care and supervision of each patient in the hospital for whom he is providing services or arrange a suitable alternative for such care and supervision.
- (b) Will pay dues and assessments in the same manner as active and associate staff members of the Grand Strand Regional Medical Center.

4.6 EMERGENCY SERVICES STAFF

4.6-1 QUALIFICATIONS

The emergency services staff will consist of physicians, each of whom:

- (a) meets the basic qualifications set forth in Section 3.2-1.
- (b) intends to practice acute care medicine in the Grand Strand Regional Medical Center Emergency Room.

4.6-2 PREROGATIVES

The prerogatives of an emergency services staff member will be to:

- (a) exercise such clinical privileges as are granted to him/her pursuant to Article VII.
- (b) vote on all matters presented at general and special meetings of the medical staff and of the department and committees of which he/she is a member.
- (c) hold office in the staff organization and in the department and committees of which he/she is a member.

This category of membership does not have admitting privileges.

4.6-3 RESPONSIBILITIES

Each member of the emergency services staff will:

- (a) meet the basic responsibilities set forth in Section 3.3.
- (b) retain responsibility within his/her area of professional competence for the continuous care and supervision of each patient in the hospital for whom he/she is providing services, or arrange a suitable alternative for such care and supervision.
- (c) actively participate in patient care evaluation, utilization review and other quality evaluation and monitoring activities required of the staff, in supervising initial appointees of his same profession, in the emergency services program, and in discharging such other staff functions as may be required from time to time.
- (d) satisfy the requirements set forth in Article XIII for attendance at meetings of the staff and of the department

and committees of which he/she is a member.

- (e) be actively engaged in the practice of medicine in the Grand Strand Regional Medical Center Emergency Room.

4.7 HONORARY STAFF

4.7-1 QUALIFICATIONS

The honorary staff will consist of practitioners recognized for their outstanding reputations, their noteworthy contributions to the health and medical sciences, or their previous long-standing service to the hospital.

4.7-2 PREROGATIVES

Honorary staff members are not eligible to admit patients to the hospital. They may, however, attend staff and department meetings and any staff or hospital education meetings. Honorary staff members will not be eligible to vote or to hold office in this medical staff organization. Membership on honorary staff does not entitle the member to any rights under the medical staff Fair Hearing Plan.

4.7-3 RESPONSIBILITIES

Each member of the honorary staff will be required to discharge the basic responsibilities specified in paragraphs (b) and (e) of Section 3.3. These members will not be liable for dues and/or assessments.

4.8 CONSULTING STAFF

4.8-1 QUALIFICATIONS

The consulting staff shall consist of a special category of physicians, dentists, and podiatrists each of whom:

- (a) is recognized by the medical community as an authority with his/her specialty and/or;
- (b) is on the faculty of a medical teaching institution.

4.8-2 PREROGATIVES

Prerogatives of a consulting staff member shall be to:

- (a) consult on patients by special invitation of an active staff member; and
- (b) attend by invitation all such meetings that he/she may wish to attend as a nonvoting visitor.

4.8-3 RESPONSIBILITIES

Consulting staff responsibilities shall be limited solely to his/her rendered consultation and ramifications thereof.

Requirements:

- (a) each request to Administration by an active staff member for a consulting physician will be in writing and;
- (b) consultant will not be primary surgeon in surgical cases and;
- (c) consultant will furnish a letter stating he/she is a member in good standing stating his/her specialty in consulting, from either the hospital administrator, chief of staff or chief of service of the hospital or medical center of which he/she is a member and;
- (d) Furnish this hospital with current state licensure, professional insurance with limits as stated in the hospital bylaws, Article VIII, and medical staff bylaws Section 8.1-3 and state and federal drug controlled certificates; and
- (e) National Practitioner Data Bank query to be made by Grand Strand Regional Medical Center.
- (f) approval for consulting status will be issued or denied by the department chairman involved.

4.9 AFFILIATE STAFF 1/09/01

4.9-1 QUALIFICATIONS:

The Affiliate Staff will consist of practitioners recognized for their outstanding reputations, their noteworthy contributions to the health and medical sciences, or their previous service with the hospital.

- (a) this category of the medical staff has no clinical privileges;
- (b) a practitioner may be invited to be a member of the

affiliate staff of GSRMC. The invitation may be issued by the Chief of Staff, The Medical Executive Committee and/or the Department Chiefs.

4.9-2 PREROGATIVES:

- (a) may attend social events;
- (b) may attend meetings for education opportunities.

4.9-3 RESPONSIBILITIES:

assessed annual medical staff dues.

Membership on the affiliate staff does not entitle the member to any rights under the medical staff Fair Hearing Plan.

4.10 LIMITATION OF PREROGATIVES

The prerogatives set forth under each staff category are general in nature and may be subject to limitation by special conditions attached to a practitioner's staff membership, by other sections of these bylaws, and by other policies of the hospital.

ARTICLE V - ALLIED HEALTH PROFESSIONALS

5.1 DEFINITION

04/03/01 An allied health professional may, subject to any licensure requirements or other legal limitations, exercise independent judgment within the areas of his/her professional competence, and may participate under the supervision of an active or associate staff physician who has been accorded privileges to provide such care and who has ultimate responsibility for that patient's care.

5.2 QUALIFICATIONS

04/03/01 Allied Health Practitioners shall document their qualifications with sufficient adequacy to demonstrate that:

- (a) they can exercise judgment within their areas of competence, although a Medical Staff member may be ultimately responsible for patient care;
- (b) they may participate in patient care within the scope authorized by law and the Hospital;
- (c) they are qualified to provide a needed service in the Hospital.
- (d) should the physician relinquish his/her membership or clinical privileges, the allied health

professional would no longer hold AHP staff status and must reapply under another sponsor

(e) Should the allied health professional leave employment of the medical staff member, the allied health professional would no longer hold AHP status and must reapply under another sponsor.

Allied Health Professionals shall be determined, on the basis of documented references; to adhere strictly to the ethics of their respective professions and to work cooperatively with others; will be individually assigned to an appropriate clinical department; and shall carry out their activities subject to the policies, procedures, rules and regulations of the Hospital and these Bylaws.

Where appropriate the Medical Executive Committee may establish particular qualifications required of members of specific categories of allied health professional provided that such qualification are not found to be arbitrary or discriminatory and are in conformance with applicable law.

5.3 DELINEATION OF PRIVILEGES

An application for privileges for an allied health professional will be submitted and processed in the same manner as provided in Article VII for clinical privileges for other categories of staff members. The department chairman under which these allied health professionals practice will be responsible or may delegate this responsibility to a sectional chief for specific monitoring. An allied health professional will be individually assigned to a specific department appropriate with his professional training and will be subject in general to the same terms and conditions as specified in Sections 3.4, 3.6 for medical staff appointment.

5.4 PREROGATIVES

The prerogatives of an allied health professional will be:

- (a) Provide specific patient care services under the supervision or direction of a physician member of the medical staff. An allied health professional will not have admitting privileges;
- (c) Write orders only to the extent established by the medical staff but not beyond the scope of the allied health professional's license. Serve on staff, department and hospital committees;

- (c) Follow the written policies adopted either by the medical staff or any of its departments, committees which refer to the prerogatives of an allied health professional.
- (d) should the Allied Health Professional be an employee of a staff physician, the scope of services shall terminate should the staff physician no longer hold Medical Staff membership and clinical privileges;
- (e) Membership on the Allied Health Professional Staff will not entitle the member to any rights under the Medical Staff Fairing Hearing Plan. In the event of an adverse M.E.C. recommendation regarding renewal, revocation or revisions of clinical privileges, the Allied Health Professional staff member shall be afforded a hearing with the Chief of Staff, the Credentials Committee Chairman and the hospital Chief Executive Officer. The practitioner shall present any relevant facts pertaining to the adverse recommendation at that time. Within (5) days of this hearing, a decision regarding the adverse recommendation will be forwarded to the Allied Health professional and the Board of Trustees by the chief of Staff. Should the Allied Health Professional disagree with this decision, he/she shall be entitled to present his/her appeal to the Board of Trustees at the meeting following the Board of Trustees receipt of that Chief of Staff, Credentials Committee Chairman and the Chief Executive Officer's decision. Following this appeal to the Board of Trustees, the Board of Trustees shall make a final decision regarding the adverse recommendation and notify the Allied Health Professional within (5) days of such decision. This decision shall be final.

5.5 RESPONSIBILITIES

Each allied health professional will:

- (a) Meet the basic responsibilities as required by Section 3.3 for medical staff members.
- (b) Participate in patient care evaluation and other quality review activities as required by the staff or departments.
- (c) Satisfy all attendance requirements as required by the department in which the allied health professional is assigned.

5.6 APPLICATION CONTENT 04/03/02

Information to be contained in the Allied Health Professional Application: Allied Health Professionals shall document their qualifications on a form provided and Approved by the C.E.O. Information to be provided by the applicant includes;

- (a) a copy of a current license and/or certification to practice in the State of SC;
- b) evidence of current applicant experience, current competence and relevant training.
- (c) a statement attesting to the ability to perform the privileges requested;

Applicant will provide information including a previously successful or currently pending challenges to:

- (1) licensure, registration or certification or the voluntary relinquishment of such licensure, registration or certification;
- (2) staff membership, clinical privileges / duties ever been refused, revoked, suspended, not renewed, and/or involuntarily relinquished in any healthcare setting;
- (3) previously successful or currently pending challenges to your State Prescriptive Authority, Federal or State Controlled Substance Certificates or have there been voluntary or involuntarily relinquishment of such authority or certificates;
- (4) request for any specific clinical privilege(s) / duties ever been denied or granted with stated limitations;
- (5) defendant in a criminal proceeding related to the practice of your specialty;
- (6) any involvement in a professional liability action occurring in the preceding 5 years;
- (7) felony conviction;
- (8) eligibility to participate in Federal Programs.

- (e) names and addresses of 3 peer references.

ARTICLE VI - PROCEDURES FOR APPOINTMENT AND REAPPOINTMENT

6.1 GENERAL PROCEDURE

The medical staff through its designated departments, committees and officers will investigate and consider each application for appointment or reappointment to the staff and each request for modification of staff membership status or privileges and will adopt and transmit recommendations thereon to the board.

The medical staff will perform the same investigation, evaluation, and recommendation functions in connection with any allied health professional or other individual who seeks to exercise clinical privileges or provide specified services in any department or service of the hospital, whether or not such individual is eligible for medical staff membership.

6.2 APPLICATION FOR INITIAL APPOINTMENT

6.2-1 APPLICATION FORM 10/14/98

- (a) The hospital will accept a written request for an application by an applicant who wishes to join the staff.
- (b) An oral request for an application form can be made by an individual staff member in good standing when the practitioner who is being recruited accepts an offer to join the individual staff practice or the group practice.
- (c) When a written request or an oral request is received, as stated under 6.2-1(a) and (b), he/she will be provided with an application form, a copy of these bylaws, the staff rules and regulations, and access to other hospital and staff policies relating to clinical practice in the hospital.

6.2-2 CONTENT

The Hospital will verify information provided by the applicant regarding licensure, specific training, experience, and current competency and ability to perform privileges requested from the primary source(s) whenever feasible.

The application form will include:

- (a) Acknowledgment and Agreement: A statement that the applicant has received and read the bylaws, rules and regulations of the medical staff and that he agrees to be bound by the terms thereof if he is granted membership and to be bound by the terms thereof in all matters relating to consideration of his application without regard to whether or not he is granted membership.

- (b) Qualifications: Detailed information concerning the applicant's qualifications, including information in satisfaction of the basic qualifications specified in Section 3.2-1 and of any additional qualifications specified in these bylaws for the particular staff category to which the applicant requests appointment.
- (c) Requests: Requests stating the staff category, department and clinical privileges for which the applicant wishes to be considered.
- (d) References: The names of at least three (3) peers ^{1/09/01} who have recently worked with the applicant and directly observed his professional performance over a reasonable period of time and who can and will provide reliable information regarding the applicant's current clinical ability, ethical character, and ability to work with others. At least one reference must be from a peer (that is, appropriate practitioners in the same professional discipline as the applicant and is of the same specialty.)
- (e) Professional Sanctions: Information as to whether any of the following have ever been or are in the process of being denied, revoked, suspended, reduced, not renewed or voluntarily or involuntarily relinquished:
 - (1) medical staff membership;
 - (2) clinical privileges at any other hospital or health care institution;
 - (3) Membership at another hospital or advancement in medical staff status;
 - (4) specific clinical privileges(s) or granted with stated limitations;
 - (5) voluntarily or involuntarily relinquished any medical staff membership or clinical privilege(s);
 - (6) taken a leave of absence while under investigation or disciplinary action;
 - (7) taken a leave of absence from a hospital or medical practice;
 - (8) specialty board certification/eligibility;

- (9) license to practice any profession in any jurisdiction;
 - (10) state drug control registration or federal DEA number;
 - (11) membership or renewal thereof, or been subject to disciplinary action in any medical organization;
 - (12) subjected to probationary conditions, instituted or recommended by a medical staff official or committee or governing board; and
 - (13) 04/03/01 eligibility to participate in Federal Programs. If any of such actions ever occurred or are pending, the particulars thereof will be included.
- (f) 1/09/01 Professional Liability Insurance: An applicant will submit a statement concerning the current status of his professional liability insurance coverage and information on his malpractice claims history and experience;
- (a) at a minimum, final judgments or settlements involving the individual are reported;
 - (b) provide consent to release information by his/her present and past malpractice insurance carrier(s).
- (g) Notification of Release and Immunity Provisions: Statements notifying the applicant of the scope and extent of the authorization, confidentiality, immunity and release provisions of Section 6.3 and Article XIV.
- (h) Administrative Remedies: A statement whereby the practitioner agrees that, when an adverse ruling is made with respect to his staff membership, staff status, and/or clinical privileges, he will exhaust the administrative remedies afforded by these bylaws before resorting to formal legal action.
- (i) Health Status: The applicant's health status must be evaluated, but only in terms of his or her ability to practice in the area in which privileges are sought.

6.2-3

04/03/01 An application will not be considered complete until receipt

of all the above referenced information including verification of all necessary items, letters of reference and receipt of an American Medical Association Profile (AMA profile) and evidence that the National Practitioner Data Bank has been queried and that the practitioner is eligible to participate in Federal programs.

6.2-4

An applicant will not begin hospital practice until he/she has complied with the hospital tuberculosis screening policy.

6.3 EFFECT OF APPLICATION

By applying for appointment to the medical staff, each applicant:

- (a) 4/98 will participate in personal interview with the Credentials Committee.
- (b) authorizes hospital representatives to consult with others who may have information bearing on his competence and qualifications.
- (c) consents to hospital representatives inspecting all records and documents that may be material to an evaluation of his professional qualifications and competence and any condition that would compromise the applicants ability to perform any of the mental and physical functions related to the specific clinical privileges requested and of his professional ethical qualifications.
- (d) releases from any liability all hospital representatives for their acts performed in good faith and without malice in connection with evaluating the applicant and his credentials.
- (e) releases from any liability all individuals and organizations who provide information, including otherwise privileged or confidential information, to hospital representatives in good faith and without malice concerning the applicant's competence, professional ethics, character, physical and mental health, emotional stability, and other qualifications for staff appointment and clinical privileges.

- (f) authorizes and consents to hospital representatives providing other hospitals, medical associations, licensing boards, and other organizations concerned with provider performance and the quality and efficiency of patient care with any information relevant to such matters that the hospital may have concerning him, and releases hospital representatives from liability for so doing, provided that such furnishing of information is done in good faith and without malice.

For purposes of this Section, the term "hospital representative" includes the board, its directors and committees; the administrator or his designee; the medical staff organization and all medical staff members, departments and committees which have responsibility for collecting or evaluating the applicant's credentials or acting upon his application; and any authorized representative of any of the foregoing.

- (g) 04/03/01 immediately notify the Credentials Committee of any investigation or change in the status of any of the following at the time the practitioner is notified or becomes aware of such investigation or change in:
1. licensure or certification (i.e. current or pending challenges);
 2. any professional liability suit involvement (case filed, settled or judgment made);
 3. current or pending challenges to the Federal (DEA) or State DHEC Drug certifications;
 4. Fair Hearing proceedings at another healthcare facility; or
 5. any change in personal health status (including treatment of any alcohol or drug abuse) that has the potential to affect the practitioners' abilities to perform current clinical privileges.
 6. 04/03/01 Notify and update the medical staff and hospital immediately upon a change in any qualifications for membership or clinical privileges, as listed in Article IV of these Bylaws or in any Rules and Regulations outlining criteria for clinical privileges, (including but not limited to becoming an Ineligible Person).
- (h) 4/98 fully understands that misstatements in or omissions from this application constitutes cause for denial of requested membership and medical staff privileges or cause for revocation of membership or privileges.

6.4 PROCESSING THE APPLICATIONS

6.4-1 APPLICANT'S BURDEN

04/03/01 The applicant will have the burden of producing adequate information for a proper evaluation of his experience, background, training, demonstrated ability, and physical and mental health status, information as to any current or pending sanctions affecting participation in any Federal Health Care Program, or any actions which might cause the Practitioner to become an Ineligible Person, as well as any sanctions from a professional review organization, "whether the applicant has ever been subject to a criminal conviction for a health care related offense, as defined in these bylaws" and of resolving any doubts about these or any of the other basic qualifications specified in Section 3.2-1.

04/03/01 As a condition of consideration for initial and continued appointment to the Medical Staff, every applicant shall specifically agree to provide to the Medical Staff and the Hospital, with or without request, any new or updated information that is pertinent to the individual's professional qualifications or any question on the application form, including but not limited to any change in Ineligible Person status, including but not limited to any exclusion or other sanctions imposed or recommended by the Federal Department of Health and Human Services of any state, the receipt of a PRO citation, and/or a quality denial letter concerning alleged quality problems in patient care.

6.4-2 VERIFICATION OF INFORMATION

6.4-2 1/09/01 The applicant will deliver an application with all applicable blanks completed and supporting information provided to the administrator who will notify each member of the medical staff of the pending application and in a timely fashion seek to verify applicable information from the primary source to include;

04/03/01

1. checking the OIG Sanction Report and the GSA List to ensure that the applicant is not listed;

2. To ensure that the practitioner is not excluded, debarred, or otherwise ineligible to participate in the Federal Health Care Programs (the OIG Sanction Report and the GSA list shall be checked every six months.

Should such collection or verification efforts be nonproductive after 30 days from being initiated, the administrator will promptly notify the applicant of any problems in obtaining the information required, and it will be the applicant's obligation to obtain the required information within 60 days of such notification.

8/12/03 Failure to provide requested supportive information necessary for verification process within 120 days of notification by the administrator or failure to appear for any requested interview shall be deemed a voluntary withdrawal from the application process.

Voluntary withdrawal from the application process shall not be considered an adverse action, and shall not entitle the applicant to exercise procedural rights outlined in these bylaws in the event of such withdrawal. The administrator shall provide special notice to an individual regarding his/her withdrawal from the application process due to lack of requested information or failure to appear for an interview.

When collection and verification is accomplished, the administrator will transmit the application and all supporting materials to the 1/09/01 department chairman.

6.4-3 DEPARTMENT ACTION

Upon receipt, 1/01/01 the department chairman, or designee, of each such department will review the application and supporting documentation, and transmit to the credentials committee a written report as to staff appointment and, as to staff category, department affiliation, clinical privileges to be granted, and any special conditions to be attached to the appointment.

A department chairman may also recommend that the medical executive committee defer action on the application. The reasons for a deferral will be stated and supported by reference to the completed application and all other documentation considered by a chairman, all of which will be transmitted with the report. Any member of the medical staff may also submit a written report to

the department chairman which will be transmitted with the chairman's report.

6.4-4 CREDENTIALS COMMITTEE ACTION

The credentials committee will review the application, the supporting documentation, the department chairman's report and such other information available to it that may be relevant to consideration of the applicant's qualifications for the staff category, department affiliation, and clinical privileges requested. The credentials committee will then transmit to the medical executive committee a written report and recommendations as to staff appointment and, if appointment is recommended, as to staff category, department affiliation, clinical privileges to be granted, and any special conditions to be attached to the appointment.

The committee may also recommend that the medical executive committee defer action on the application. The reason for a deferral recommendation will be stated and supported by references to the completed application and all other documentation considered by the committee, all of which will be transmitted with the report. Any minority views will also be reduced to writing, supported by reasons and references, and transmitted with the majority report.

6.4-5 MEDICAL EXECUTIVE COMMITTEE (MEC) ACTION

At its next regular meeting after receipt of the credentials committee report and recommendations, the MEC will consider the report and such other relevant information available to it. The committee will then forward to the administrator for transmittal to the board a written report and recommendations as to staff appointment and, if appointment is recommended, as to staff category, department affiliation, clinical privileges to be granted, and any special conditions to be attached to the appointment.

The committee may also defer action on the application pursuant to Section 6.4-6(a).

The reasons for deferral recommendations will be stated and supported by reference to the completed application, all of which will be transmitted with the report. Any minority views will be in writing supported by reasons and reference, and transmitted with the majority report.

6.4-6 EFFECT OF MEC ACTION

- (a) Deferral: Action by the MEC to defer the application for further consideration must be followed up within sixty (60) days with a subsequent recommendation for appointment with specified clinical privileges, or for rejection for staff membership.
- (b) Favorable Recommendations: When the recommendation of the MEC is in favor of the applicant, the administrator will promptly forward it, together with all supporting documentation, to the board. For the purposes of this Section 6.4-6(b), "All supporting documentation" includes the application form and its accompanying information and the reports and recommendations of the department chairman and of the credentials committee and minority views.
- (c) Adverse Recommendation: When the recommendation of the MEC is adverse to the applicant, the administrator will immediately so inform the practitioner by special notice, and he will be entitled to the procedural rights as provided in Article IX and in the Fair Hearing Plan. For the purposes of this Section 6.4-6(c), an "adverse recommendation" by the MEC is as defined in Section 9.2-2.

6.4-7 BOARD ACTION

- (a) On Favorable MEC Recommendation: The board will, in whole or in part, adopt or reject a favorable recommendation of the MEC, or refer the recommendation back to the MEC for further consideration stating the reasons for such referral back and setting a time limit within which a subsequent recommendation will be made.

If the board's action is adverse to the applicant as defined in Section 9.2-2, the administrator will promptly so inform the applicant by special notice, and he will be entitled to the procedural rights as provided in Article IX and in the Fair Hearing Plan.

- (b) Without Benefit of MEC Recommendation: If the board does not receive an MEC recommendation within the time period specified in Section 6.4-12, it may, after notifying the MEC, take action on its own initiative in the manner set forth in the hospital corporate bylaws. If such action is favorable, it will become effective as the final decision of

the board. If such action is adverse, as defined in Section 9.2-2, the administrator will promptly so inform the applicant by special notice, and he will be entitled to the procedural rights as provided in Article IX and in the Fair Hearing Plan.

- (c) After Procedural Rights: In the case of an adverse MEC recommendation pursuant to Section 6.4-6 (c) or an adverse board decision pursuant to Section 6.4-7 (a) or (b), the board will take final action in the matter only after the applicant has exhausted or has waived his procedural rights as provided in Article IX and in the Fair Hearing Plan. Action thus taken will be the conclusive decision of the board, except that the board may defer final determination by referring the matter back for further reconsideration. Any such referral back will state the reasons therefor, will set a time limit within which a subsequent recommendation to the board will be made, and may include a directive that an additional hearing be conducted to clarify issues which are in doubt. After receipt of such subsequent recommendation and of new evidence in the matter, if any, the board will make a final decision.

6.4-8 DENIAL FOR HOSPITAL'S INABILITY TO ACCOMMODATE

A recommendation by the MEC, or a decision by the board, to deny staff membership, a department affiliation or staff category assignment, or particular clinical privileges either:

- (a) on the basis of the hospital's present inability, as supported by documented evidence, to provide adequate facilities, supportive services or patient load for the applicant and his patients, or
- (b) on the basis of inconsistency with the hospital's written plan of development, including the mix of patient care services to be provided, as currently being implemented, will be considered adverse in nature and will entitle the applicant to the procedural rights as provided in Article IX and in the Fair Hearing Plan.

6.4-9 CONFLICT RESOLUTION

Whenever the board's proposed decision will be contrary to the MEC's recommendation, the board will submit the matter to a joint conference of equal numbers of medical staff and board members for review and recommendation before making its final decision

and giving notice of final decision required by Section 6.4-10.

6.4-10 NOTICE OF FINAL DECISION

- (a) Notice of the board's final decision will be given, through the administrator, to the chairman of the MEC and the credentials committee, to the chairman of each department concerned, and to the applicant by means of special notice.
- (b) A decision and notice to appoint will include:
 - (1) the staff category to which the applicant is appointed;
 - (2) the department to which he is assigned;
 - (3) the clinical privileges he may exercise; and
 - (4) any special conditions attached to the appointment.

6.4-11 REAPPLICATION AFTER ADVERSE APPOINTMENT DECISION

An applicant who has received a final adverse decision regarding appointment will not be eligible to reapply to the medical staff for a period of 12 months from date of original application. Any such reapplication will be processed as an initial application, and the applicant will submit such additional information as the staff or the board may require in demonstration that the basis for the earlier adverse action no longer exists.

6.4-12 TIME PERIODS FOR PROCESSING

Applications for staff appointments will be considered in a timely and good faith manner by all individuals and groups required by these bylaws to act thereon and, except for good cause, will be processed within the time period specified in this Section 6.4-12.

The administrator will transmit an application to the medical staff upon completing his information collection and verification tasks, but in any event within 60 days after receiving the application. The applicable department chairman and the credentials committee will act on a completed application within 6/13/2000 45 days after receiving it from the administrator. The medical executive committee will review the application and make its recommendation to the board within 6/13/2000 45 days after

receiving the credentials committee report. The board or the appropriate committee thereof will then take final action on the application 6/13/2000 within 30 days. The time periods specified herein are to assist those named in accomplishing their tasks and will not be deemed to create any right for the practitioner to have his application processed within those periods.

6.5 REAPPOINTMENT PROCESS

6.5-1 INFORMATION FORM FOR REAPPOINTMENT

The administrator will, at least 6/13/2000 120 days prior to the expiration date of the present staff appointment of such medical staff member, provide such staff member with an interval information form for use in considering his reappointment. 4/98 The applicant fully understands that any significant misstatements in or omissions from this application for reappointment constitutes cause for denial of requested reappointment to the medical staff or cause for revocation of privileges. Each staff member who desires reappointment will, at least 6/13/2000 90 days prior to such expiration date, send his interval information form to the administrator.

6/13/2000 Failure, without good cause, to so return the form will be deemed a voluntary resignation from the staff and will result in automatic termination of membership and privileges at the expiration of the member's current term. If the practitioner wishes to be on staff, he/she will be required to reapply for staff membership and privileges.

6.5-2 CONTENT OF INTERVAL INFORMATION FORM

1/8/02

The interval information form will request data necessary to update the medical staff file on the staff member's health-care related activities other than as a member of the staff. This form will include, without limitation, information about the following:

6.5-2(a) appraisal for reappointment to the medical staff or renewal or revisions of clinical privileges is based on ongoing monitoring of information concerning the individuals professional performance; judgment; and clinical or technical skills.

(b) 1/09/02 continuing training to comply with state regulations that requires the applicant for re-licensure must have a minimum of 40 hours of approved continuing education during

2 consecutive years of which 75% must be related to the type of patient care the licensure renders.

- (c) ability to perform the privileges requested.
- (d) the name and address of any other health care organization or practice setting where the staff member provided clinical services during the preceding period
- (e) membership, awards, or other recognition conferred or granted by any professional health care societies, institutions, or organizations
- (f) previously successful or currently pending challenges to any licensure or registration (state, Drug Enforcement Administration) or the voluntary relinquishment of such licensure or registration
- (g) voluntary or involuntary termination of medical staff membership or voluntary or involuntary limitations, or loss of clinical privileges at another hospital.
- (h) malpractice insurance information (including cancellations, non-renewals and limits), claims, suits, and settlements
- (i) such other specifics about the staff member's professional ethics, qualifications and ability that may bear on his ability to provide good patient care in the hospital
- (j) .04/03/01 eligibility to participate in the Federal Health Care Programs.

6.5-2(b)

Content of Interval Information Form for the Active Staff II Membership Category 1/8/02

This form will include, without limitation, information about the following:

- (a) previously successful or currently pending challenges to license, Federal and State Drug certificates or the voluntary relinquishment of such licensure or registration;
- (b) voluntary or involuntary termination of medical staff membership or loss of clinical privileges at another hospital;
- (c) involvement in professional liability action;
- (d) final judgments or settlements;
- (e) eligibility to participate in the Federal Health Care

- Programs;
- (f) question regarding criminal conviction for a health care related offense, as defined in the Medical Staff bylaws;
 - (g) question regarding current problems with alcohol and drug abuse.

6.5-3 VERIFICATION OF INFORMATION

The administrator will, in timely fashion seek to collect or verify licensure, training, current competence from the Primary Source as well as the additional information made available on each interval information form and to collect any other materials or information deemed pertinent, including information regarding the staff member's professional activities, performance and conduct in this hospital and his fulfillment of staff membership obligations.

The administrator will promptly notify the staff member of any problems in obtaining the information required. The staff member will then have the same burden of producing adequate information and resolving doubts as provided in Section 6.4-1. When collection and verification are accomplished, the administrator will transmit the information form and supporting materials to the chairman of each department in which the staff member requests privileges 6/12/2000 within 15 days and to the credentials Committee within 30 days.

04/03/01 The OIG Sanction Report and the GSA List shall be checked every six months to ensure that the practitioner is not excluded, debarred, or otherwise ineligible to participate in the Federal Health Programs.

- (a) The reappointment application will not be processed until there is evidence of state licensure, insurance as required by the medical staff and hospital bylaws, certificate of registration issued pursuant to the SC Controlled Substances Act, Federal Controlled Substances Registration Certificate and evidence that the National Practitioners Data Bank has been queried and the OIG Sanction Report and the GSA List has been checked to ensure that the applicant is not listed.

Query the National Practitioner's Data Bank for all new applicants to the medical staff and for all reappointments at least every two years.

- (b) Pathologists are not required to possess Federal Controlled Substances Registration Certification of South Carolina Controlled Substances license unless specifically requesting privileges to prescribe controlled drugs or narcotics.

6.5-4 DEPARTMENT ACTION

A department chairman will review the information form and the staff member's file and will transmit to the credentials committee on the prescribed form a report and recommendation that appointment be renewed, renewed with modified staff category, department affiliation and/or clinical privileges, or terminated.

A chairman may also recommend that the MEC defer action. Each such report will satisfy the requirements of Section 6.5-8. Any member of the medical staff may also submit a written report to the department chairman which will be transmitted with the chairman's report.

6.5-5 CREDENTIALS COMMITTEE ACTION

The credentials committee will review each information form and all other pertinent information available on each member being considered for reappointment, including the recommendation of each department in which the staff member has requested privileges, and will transmit to the MEC on the prescribed form its report and recommendation that appointment be either renewed, renewed with modified staff category, department affiliation and/or clinical privileges, or terminated. The committee may also recommend that the MEC defer action. Each such report will satisfy the requirements of Section 6.5-8. Any minority views will also be reduced to writing and transmitted with the majority report.

6.5-6 MEC ACTION

The MEC will review each information form and all other relevant information available to it and will, on the prescribed form, forward to the administrator for transmittal to the board its report and recommendation that appointment be either renewed, renewed with modified staff category, department affiliation, and/or clinical privileges, or terminated. The committee may also defer action. Each such report will satisfy the requirements of Section 6.5-8. Any minority views will also be reduced to writing and transmitted with the majority report.

6.5-7 FINAL PROCESSING AND BOARD ACTION

Thereafter, the procedure provided in Sections 6.4-6 through 6.4-11 will be followed. For purposes of reappointment, the terms "applicant" and "appointment" as used in those Sections will be read, respectively, as "staff member" and "reappointment."

6.5-8 BASIS FOR RECOMMENDATIONS

Each recommendation concerning the reappointment of a staff member and the clinical privileges to be granted upon reappointment will be based upon documented evidence of such member's professional ability and clinical judgment in the treatment of patients, his professional ethics, his discharge of staff obligations, his compliance with the medical staff bylaws, rules and regulations, his cooperation with other practitioners and with patients, and other matters bearing on his ability and willingness to contribute to quality patient care in the hospital.

6.5-9. TIME PERIODS FOR PROCESSING

Transmittal of the interval information form to a staff member and his return of it will be carried out in accordance with Section 6.5-1. Thereafter and except for good cause, each person, department and committee required by these bylaws to act thereon will complete such action in timely fashion such that all reports and recommendations concerning the reappointment of a staff member will have been transmitted to the MEC for its consideration and action pursuant to Section 6.5-6 and to the board for its action pursuant to Section 6.5-7, all prior to the expiration date of the staff membership of the member being considered for reappointment. The time periods specified herein are to guide the acting parties in accomplishing their tasks.

5/13/2000 Failure, without good cause, to so return the form will be deemed a voluntary resignation from the staff and will result in automatic termination of membership and privileges at the expiration of the member's current term. If the practitioner wishes to be on staff, he/she must reapply for staff membership and privileges.

6.6 REQUESTS FOR MODIFICATION OF MEMBERSHIP STATUS OR PRIVILEGES

A staff member may, either in connection with reappointment or at any other time, request modification of his staff category,

department assignment, or clinical privileges by submitting a written application to the administrator. Such application will be processed in the same manner as provided in Section 6.5 for reappointment. Any modification of staff category, department assignment, or clinical privileges will be for a provisional period of not more than 12 months.

ARTICLE VII - DETERMINATION OF CLINICAL PRIVILEGES

7.1 EXERCISE OF PRIVILEGES

A practitioner providing direct clinical services at this hospital by virtue of medical staff membership will, in connection with such practice and except as otherwise provided in Sections 7.5 and 7.6, be entitled to exercise only those clinical privileges or specified services granted to him by the board. Said privileges and services must be within the scope of the license, certificate or other legal credential authorizing him to practice in this State and consistent with any restrictions thereon.

7.2 DELINEATION OF PRIVILEGES IN GENERAL

7.2-1 REQUESTS

Each application for appointment and reappointment to the medical staff must contain a request for the specific clinical privileges desired by the applicant. A request by a staff member pursuant to Section 6.6 for a modification of privileges must be supported by documentation of additional training and/or experience supportive of the request.

USE OF ANCILLARY SERVICES BY NON-STAFF PRACTITIONERS

04/03/01 A practitioner who is not a medical staff member and who has not been granted clinical privileges may order outpatient ancillary services providing the following requirements are met:

1. The practitioner is permitted to order such tests pursuant to the medical staff bylaws and rules and regulations and hospital policy.
2. The hospital shall ensure that the practitioner is eligible to participate in federal and state health programs by checking the OIG Sanction Report and the GSA List at the time of ordering tests or services and at least every six months thereafter.

3. The hospital shall verify the applicant's status as an Ineligible Person. For this purpose, the applicant shall provide his/her Medicare UPIN and the hospital shall check the OIG Sanction Report and the GSA List. If the applicant is excluded from such participation, temporary privileges shall not be granted; any exclusion subsequent to having been granted temporary privileges shall result in immediate termination of such privileges.

7.2-2 BASIS FOR PRIVILEGES DETERMINATION

Requests for clinical privileges will be evaluated on the basis of the practitioner's education, training, experience, and demonstrated ability and judgment. The basis for privileges determinations to be made in connection with periodic reappointment or otherwise will include observed clinical performance and the documented results of the patient care evaluation and other quality review, evaluation and monitoring activities required by these and the hospital corporate bylaws to be conducted at the hospital. Privileges determinations will also be based on pertinent information concerning clinical performance obtained from other sources, especially other institutions and health care settings where a practitioner has exercised clinical privileges. This information will be added to and maintained in the medical staff file established for a staff member.

7.2-3 PROCEDURE

All requests for clinical privileges will be processed pursuant to the procedures outlined in Article VI.

7.3 SPECIAL CONDITIONS FOR DENTAL AND PODIATRIC PRIVILEGES

Requests for clinical privileges from dentists and podiatrists will be processed in the manner specified in Section 7.2. Surgical procedures performed by dentists and podiatrists will be under the overall supervision of the chairman of the department of surgery or his designee. All dental and podiatric patients will receive the same basic medical appraisal as patients admitted to other surgical services. A physician member of the medical staff will be responsible for the care of any medical problem that may be present at the time of admission or that may arise during hospitalization and will determine the risk and effect of the proposed surgical procedure on the total health status of the patient.

USE OF ANCILLARY SERVICES BY NON-STAFF PRACTITIONERS

04/03/01 A practitioner who is not a medical staff member and who has not been granted clinical privileges may order outpatient ancillary services providing the following requirements are met:

1. The practitioner is permitted to order such tests pursuant to the medical staff bylaws and rules and regulations and hospital policy.

2. The hospital shall ensure that the practitioner is eligible to participate in federal and state health programs by checking the OIG Sanction Report and the GSA List at the time of ordering tests or services and at least every six months thereafter.

3. The hospital shall verify the applicant's status as an Ineligible Person. For this purpose, the applicant shall provide his/her Medicare UPIN and the hospital shall check the OIG Sanction Report and the GSA List. If the applicant is excluded from such participation, temporary privileges shall not be granted; any exclusion subsequent to having been granted temporary privileges shall result in immediate termination of such privileges.

- 7.4 SPECIAL CONDITIONS FOR ALLIED HEALTH PROFESSIONAL SERVICES
- Requests to perform specified patient care services from allied health professionals will be processed in the manner specified in Section 6.2. An allied health professional may, subject to any licensure requirements or other legal limitations, exercise independent judgment within the areas of his professional competence, and may participate directly in the medical management of patients under the supervision of an active or associate staff physician who has been accorded privileges to provide such care and who has ultimate responsibility for the patient's care.

USE OF ANCILLARY SERVICES BY NON-STAFF PRACTITIONERS

04/03/01 A practitioner who is not a medical staff member and who has not been granted clinical privileges may order outpatient ancillary services providing the following requirements are met:

1. The practitioner is permitted to order such tests pursuant to the medical staff bylaws and rules and regulations and hospital policy.

2. The hospital shall ensure that the practitioner is eligible to participate in federal and state health programs by checking the OIG Sanction Report and the GSA List at the time of ordering tests or services and at least every six months thereafter.

3. The hospital shall verify the applicant's status as an Ineligible Person. For this purpose, the applicant shall provide his/her Medicare UPIN and the hospital shall check the OIG Sanction Report and the GSA List. If the applicant is excluded from such participation, temporary privileges shall not be granted; any exclusion subsequent to having been granted temporary privileges shall result in immediate termination of such privileges.

7.5 TEMPORARY PRIVILEGES

Revised 6/10/03

Temporary clinical privileges shall be granted only to individuals defined as Practitioners in these Bylaws, as stated in 7.5.1. In granting temporary privileges, special requirements may be imposed in order to monitor and assess the quality of care rendered by the Practitioner exercising such privileges. A Practitioner shall not be entitled to the procedural rights afforded by these Bylaws because of his/her inability to obtain temporary privileges or because of any termination of temporary privileges.

7.5.1 Qualifications

Prior to temporary privileges being granted, an applicant for such privileges must demonstrate that he/she possesses a current license within this state, a current and unrestricted DEA registration and the South Carolina state registration (if the practitioner will be prescribing or administering controlled substances), evidence of relevant training and experience, evidence of current competence related to the temporary privileges requested, ability to perform the privileges requested, and documentation of professional liability insurance coverage.

As required by the Board, except as specified in Section 7.5.4 in this Article. Qualifications for temporary privileges shall be verified from a primary source and documented.

The National Practitioner Data Bank shall be queried prior to the granting of temporary privileges. Additionally, the Hospital shall verify the applicant's status as an Ineligible Person. For this purpose, the applicant shall provide his/her Medicare UPIN, and the Hospital shall check the OIG Sanction Report and the GSA List. If the applicant is excluded from such participation, temporary privileges shall not be granted; any exclusion subsequent to having been granted temporary privileges shall result in immediate termination of such privileges.

When applying for temporary privileges, each applicant shall agree

to be bound by the Medical Staff Bylaws, Rules and Regulations, departmental rules and regulations, and applicable Hospital policies.

7.5.2 Authority for Granting Temporary Privileges:

Temporary privileges may be granted by the Chief Executive Officer or his/her designee upon receiving a recommendation from the appropriate department chairperson or Chief of Staff under the conditions noted below. Individuals practicing based on temporary privileges shall be acting under the supervision of the chairperson of the department to which he/she is assigned. All temporary privileges shall be time-limited, as specified for the type of temporary privileges listed below. Temporary privileges shall automatically terminate at the end of the specific period for which they were granted, without the Hearing and Appeal rights set forth in these Bylaws. Temporary privileges shall be specifically delineated, and may include the privilege to admit patients. A request for temporary privileges shall be made in writing, on forms approved for that purpose by the Hospital.

7.5.3 Conditions for use of Temporary Privileges

8/22/03

Pendency of application Revised to read:

After receipt of a complete application for medical staff membership, as defined in these bylaws, which includes a written request for temporary privileges, an applicant qualified as described in Article VII, Section 7.5.1 may be granted temporary privileges while his/her application undergoes processing. Temporary privileges granted under this condition shall not exceed one hundred and twenty (120) days.

7.5.3.2 Care of a Specific Patient: Temporary privileges can be granted on a case-by-case basis when an important patient care need justifies the authorization to practice, for a limited period of time as defined herein, while full credentials information is verified and approved. After receipt of a written request for temporary privileges, a Practitioner qualified as described in Article Seven, Section 7.5.2 may be granted temporary privileges to a Practitioner who has a specific skill not possessed by a privileged Practitioner, and the specific skill is needed for a specific patient, authorization may be granted to provide care for that specific patient. Temporary privileges granted under this condition shall not exceed the length of stay of the specific patient or one hundred and twenty (120) consecutive days, whichever

is less. A Practitioner may be granted temporary privileges under this condition for no more than two patients in a twelve-month period. After a Practitioner has been granted temporary privileges under this condition for the care of a second patient within twelve months, he/she shall be invited to apply for Medical Staff membership.

7.5.3.3 Locum Tenens

Temporary privileges may be granted on a case-by-case basis when an important patient care need justifies the authorization to practice, for a limited period of time as defined herein, while full credentials information is verified and approved. After receipt of a written request for temporary privileges, a Practitioner qualified as described in Article Seven, Section 7.5.1, who has been hired to substitute for a member of the Medical Staff who is temporarily unable to provide services, may be granted temporary privileges in order to fulfill an important patient care need that would be created by the Medical Staff member's absence and could not otherwise be met by the existing members of the Medical Staff. The locum tenens Practitioner shall not be granted temporary privileges that are in excess of those granted to the Medical Staff member being temporarily replaced. Temporary privileges granted under this condition shall not exceed one hundred and twenty (120) consecutive days or the term of absence of the Medical Staff member, whichever is less.

7.5.4 Disaster Response and Recovery:

Potential disaster situations shall be described in the Hospital Emergency Management Plan and is defined as any occurrence that inflicts destruction or distress and that creates demands exceeding the capabilities of the Hospital to handle in a normal or routine way. Such occurrence may be due to a natural disaster or a man-made disaster.

Upon activation of the Hospital's All Hazards Procedures, temporary disaster privileges may be granted to an appropriately qualified Practitioner as described in Article Seven, Section 7.5.1, based upon the needs of the Hospital to augment staffing due to the disaster situation. Privileges shall be approved by the Hospital Emergency Incident Commander (CEO/designee) handling the disaster upon recommendation by the Chief of Staff or the

designated Medical Staff member directing Medical Staff response during an emergency situation. Approvals shall be documented in writing.

Practitioners who are employees of any Federal agency, and Practitioners acting on behalf of a Federal agency in an official capacity, temporarily or permanently in the service of the United States government, whether with or without compensation, are immune from professional liability for malpractice committed within the scope of employment under the provisions of the Federal Tort Claims Act, and are therefore exempt from the requirement to have professional liability insurance coverage. Temporary privileges granted to Practitioners who are acting as agents of the Federal government shall be limited in their privileges at this Hospital to the scope of their Federal employment. Temporary privileges granted to anyone under a disaster situation shall not exceed the disaster response and recover period or one hundred and twenty (120) consecutive days.

Temporary disaster privileges may be granted upon presentation of any of the following, and the qualifications required in Section 7.5.1 of this Article shall be verified as soon as possible given the disaster situation.

7.5.4.1 The following information must be provided and if possible, verified, in order for a Practitioner to be granted temporary disaster privileges.

- A current picture hospital ID card;
- A current license to practice in the State of South Carolina, and a valid picture ID issued by a state, federal or regulatory agency;
- Identification indicating that the individual is a member of a Disaster Medical Assistance Team (DMAT);
- Identification indicating that the individual has been granted authority to render patient care in emergency circumstances, such authority having been granted by a federal, state or municipal entity; or,
- Presentation by a current hospital or medical staff member(s) with personal knowledge regarding the practitioner's identity.

7.5.4.2 The following order of preference should be used in granting temporary disaster privileges:

Expert Practitioners from government agencies and medical staff members from other HCA hospitals;

Volunteer Practitioners sent from known agencies (e.g., American Red Cross); Presentation by a current hospital or medical staff member(s) with personal knowledge regarding the practitioner's identity.

Volunteers from the community or surrounding areas.

7.5.4.3 If possible, photocopies of the above-listed credentials should be made and retained as part of a credentials file.

7.5.4.4 Upon approval, the practitioner should be issued appropriate Hospital security identification as required by the Hospital, and should be assigned to a Medical Staff member if possible, with whom to collaborate in the care of disaster victims.

7.5.4.5 In the event that verification of information results in negative or unsubstantiated information about qualifications of the Practitioner, privileges should be immediately terminated. When the emergency situation no longer exists, or when Medical Staff members can adequately provide care, temporary disaster privileges terminate.

7.5.5 TERMINATION

On the discovery of any information or the occurrence of any event of a nature which raises question about a practitioner's professional qualifications or ability to exercise any or all of the temporary privileges granted, the administrator or the chief of staff, may, after consultation with the department chairman responsible for supervision, terminate any or all of such practitioner's temporary privileges, provided that where the life or well-being of a patient is determined to be endangered by continued treatment by the practitioner, the termination may be effected by any person entitled to impose summary suspensions under Article VIII. In the event of any such termination, the practitioner's patients then in the hospital will be assigned to another practitioner by the department chairman responsible for supervision. The wishes of the patient will be considered, where feasible, in choosing a substitute practitioner.

7.5.5.1 RIGHTS OF THE PRACTITIONER

A practitioner will not be entitled to the procedural rights afforded by Article IX and the Fair Hearing Plan because his request for temporary privileges is refused or because of all or any portion of his temporary privileges are terminated or suspended.

7.5.5.2 (a) In the event of an adverse M.E.C. recommendation regarding renewal, revocation or revisions of clinical privileges, the locum tenens practitioner shall be afforded a hearing with the Chief of Staff, the Credentials Committee chairman and the hospital Chief Executive Officer. The practitioner shall present relevant facts pertaining to the adverse recommendation at that time. Within (5) days of this hearing, a decision regarding the adverse recommendation will be forwarded to the locum tenens practitioner and the Board of Trustees by the Chief of Staff. Should the locum tenens practitioner disagree with this decision, he/she shall be entitled to present his/her appeal to the Board of Trustees at the meeting following the Board of Trustees receipt of that Chief of Staff, Credentials Committee Chairman and the Chief Executive Officer's decision. Following this appeal to the Board of Trustees, the Board of Trustees shall make a final decision regarding the adverse recommendation and notify the locum tenens practitioner within (5) days of such decision. This decision shall be final.

7.6 EMERGENCY PRIVILEGES

8/13/02 In an emergency, any practitioner, to the extent permitted by his/her license, and regardless of Medical Staff membership status, staff category or clinical privileges, shall be permitted to do everything possible to save the life of a patient or to save the patient from serious injury, including the loss of limb or function. When the emergency no longer exists, care of the patient shall be assigned to the patient's own clinician or a qualified member of the Medical Staff. An emergency is a condition in which serious or permanent harm would result to a patient or in which the life of a patient is in immediate danger and any delay in administering treatment add to that danger.

7.6-1 Credentialing Practitioners in the Event of Disaster:

8/13/02 The process for credentialing for privileges in the event of a disaster will be carried out in accordance with the Credentialing Practitioners in the Event of Disaster Policy.

ARTICLE VIII

CORRECTIVE ACTION

8.1 ROUTINE CORRECTIVE ACTION

8.1-1 CRITERIA FOR INITIATION

Whenever the activities or professional conduct of any practitioner with clinical privileges are detrimental to patient safety or to the delivery of quality patient care or are disruptive to hospital operations, corrective action against such practitioner may be initiated by any officer of the medical staff, by the chairman of any department in which he holds membership or exercises clinical privileges, by the chairman of any standing committee of the medical staff, by the chief executive officer, by the board, or by the chairman of the board.

8.1-2 REQUESTS AND NOTICES

All requests for corrective action will be in writing, submitted to the medical executive committee (MEC), and supported by reference to the specific activities or conduct which constitute the grounds for the request. The chairman of the MEC will promptly notify the administrator in writing of all requests for corrective action received by the committee and will continue to keep him fully informed of all action taken in conjunction therewith.

No adverse communication or document can be used in any proceeding against a medical staff member without documentation that the practitioner has been notified that such a document exists. This notification must occur within 30 days and if there has been a response by the affected practitioner, this will be placed with the adverse communication or document.

No such document, without notification of the practitioner, will be introduced into any medical staff proceeding, the credentialing process for reappointment, unless the adverse documentation has been officially introduced into medical staff proceedings. No such document under any circumstances will be introduced into staff proceedings after 5 years.

8.1-3 INVESTIGATION

After deliberation and appropriate investigation, the MEC may either act on the request or direct a further investigation concerning the grounds for the corrective action requested.

The MEC may conduct such investigation itself or may assign this task to an officer, department or committee of the medical staff.

This investigative process will not be deemed a "hearing" as that term is used in Article IX and in the Fair Hearing Plan, but must include notification and/or consultation with the practitioner involved.

If the investigation is accomplished by a group or individual other than the MEC, such group or individual will forward a written report of the investigation to the MEC as soon as practicable after the assignment to investigate has been made.

8.1-4 MEC ACTION

As soon as is practicable after the conclusion of the investigative process, but in any event within 45 days after receipt of the request for corrective action, unless deferred pursuant to Section 8.1-5, the MEC will take action upon such request. Such action may include, without limitation:

- (a) Rejection of the request for corrective action
- (b) Issuing a warning, a letter of admonition, or a letter of reprimand
- (c) Recommending terms of probation or individual requirements of consultation
- (d) Recommending reduction, suspension or revocation of clinical privileges
- (e) Recommending reduction of staff category or limitation of any staff prerogatives directly related to the practitioner's delivery of patient care
- (f) Recommending suspension or revocation of staff membership

8.1-5 DEFERRAL

If additional time is needed to complete the investigative process, the MEC may defer action on the request, but only upon the written consent of the affected practitioner. A subsequent recommendation for any one or more of the actions provided in

Sections 8.1-4 (a) through (f) above must be made within the time specified in such written consent, and if no such time is specified, then within 30 days of the deferral.

8.1-6 PROCEDURAL RIGHTS

Any recommendation by the MEC pursuant to Section 8.1-4 (c), (d), (e), or (f), or any combination of such actions, will entitle the practitioner to the procedural rights as provided in Article IX and in the Fair Hearing Plan.

8.1-7 OTHER ACTION

- (a) If the MEC's action is to reject the request for corrective action, all supporting documentation will be transmitted to the board. Thereafter, the procedure to be followed will be as provided in Sections 6.4-7, 6.4-9 and 6.4-10, as applicable.
- (b) If the MEC's action is a warning, admonition or reprimand, all supporting documentation will be transmitted to the board together with any written response from the practitioner.
- (c) If the MEC fails to act within the time limits specified in Section 8.1-4 and 8.1-5 the board may, after notifying the MEC, take action on its own initiative. If such action is favorable, it will become effective as the final decision of the board. If such action is adverse as defined in Section 9.2-2, the administrator will promptly so inform the practitioner by special notice, and he will be entitled to the procedural rights as provided in Article IX and in the Fair Hearing Plan.

8.2 SUMMARY SUSPENSION

8.2-1 CRITERIA FOR INITIATION

Whenever a practitioner's conduct requires that immediate action be taken to protect the life of any patient(s) or to reduce the substantial likelihood of immediate injury or damage to the health or safety of any patient, employee or other person present in the hospital, either the chairman of the MEC or of a department, the administrator or any officer of the

medical staff will have the authority to summarily suspend the medical staff membership status or all or any portion of the clinical privileges of such practitioner.

Such summary suspension will become effective immediately upon imposition, and the administrator will promptly give special notice of the suspension to the practitioner. In the event of any such suspension, the practitioner's hospitalized patients will be assigned to another practitioner(s) by the department chairman or his designee. The wishes of the patient will be considered, where feasible, in choosing a substitute practitioner.

8.2-2 MEC ACTION

As soon as possible after such summary suspension, a meeting of the MEC will be convened to review and consider the action taken. The MEC may modify, continue or terminate the terms of the summary suspension.

8.2-3 PROCEDURAL RIGHTS

Unless the MEC immediately terminates the suspension and ceases all further corrective action, the practitioner will be entitled to the procedural rights as provided in Article IX and in the Fair Hearing Plan.

8.2-4 OTHER ACTION

If the MEC's action pursuant to Section 8.2-2 is to terminate the suspension and to cease all further corrective action, such action will be transmitted immediately, together with all supporting documentation, to the board. Thereafter, the procedure to be followed will be as provided in Sections 6.4-7, 6.4-9 and 6.4-10(a), as applicable.

8.3 AUTOMATIC SUSPENSION

8.3-1 LICENSE

- (a) Revocation: Whenever a practitioner's license, certificate or other legal credential authorizing him to practice in this State is revoked, his staff membership and clinical privileges or specified services will be immediately and automatically revoked.
- (b) Suspension: Whenever a practitioner's license, certificate or other legal credential is suspended, his staff membership and clinical privileges or specified service will be

automatically suspended effective upon and for at least the term of the suspension.

- (c) Restriction: Whenever a practitioner's license, certificate or other legal credential is limited or restricted by the applicable licensing authority, those clinical privileges or specified services which he has been granted that are within the scope of said limitation or restriction will be immediately and automatically revoked. Further action on the matter will proceed pursuant to Section 8.3-3.
- (d) Probation: Whenever a staff member is placed on probation by the applicable licensing authority, action on the matter will proceed pursuant to Section 8.3-3.

8.3-2 DRUG ENFORCEMENT AGENCY (DEA)

- (a) Revocation: Whenever a practitioner's DEA NUMBER is revoked, he will immediately and automatically be divested at least of his right to prescribe medications covered by the number. Further action on the matter will proceed pursuant to Section 8.3-3.
- (b) Suspension: Whenever a practitioner's DEA number is suspended, he will be divested at least of his right to prescribe medications covered by the number effective upon and for at least the term of the suspension. Further action on the matter will proceed pursuant to Section 8.3-3.
- (c) Probation: Whenever a practitioner is placed on probation insofar as the use of his DEA number is concerned, action on the matter will proceed pursuant to Section 8.3-3.

8.3-2 (1) 04/03/01 ELIGIBILITY TO PARTICIPATE IN FEDERAL PROGRAMS

If a practitioner becomes an "Ineligible Person" or has a "Criminal Conviction" for a crime related to the practice of health care, his/her staff membership and clinical privileges or specified services will immediately and automatically be terminated.

8.3-3 MEC DELIBERATION

As soon as practicable after action is taken as described in Sections 8.3-1 (c) or (d) or in Sections 8.3-2 (a), (b) or (c), or 8.3-2 (1), the MEC will convene to review and consider the facts under which such action was taken. The MEC may then

recommend such additional corrective action as is appropriate to the facts disclosed in its investigation, including limitation of prerogatives; the procedure to be followed will be provided in Sections 8.1-6 and 8.1-7, as applicable.

8.3-4 FAILURE TO SATISFY SPECIAL APPEARANCE REQUIREMENT

A practitioner who fails to satisfy the requirements of Section 13.8-3 will automatically be suspended from exercising all or such portion of his clinical privileges in accordance with the provisions of said Section 13.8-3.

8.3-5 MEDICAL RECORDS

For failure to complete medical records in a timely fashion, a practitioner's clinical privileges (except with respect to his patients already in the hospital) and his right to admit patients and to consult with respect to patients will, after written warning of delinquency, be suspended and will remain suspended until medical records are completed.

8.3-6 MALPRACTICE INSURANCE

For failure to maintain the amount of professional liability insurance, if any, required under Section 15.3, a practitioner's medical staff membership and clinical privileges will immediately be suspended.

A practitioner under suspension by operation of this Section will be entitled to the procedural rights provided in Article IX and in the Fair Hearing Plan. Medical staff membership and clinical privileges will be immediately and automatically reinstated when the requirements of Section 15.3 are met.

ARTICLE IX - INTERVIEWS, HEARINGS AND APPELLATE REVIEW

9.1 INTERVIEWS

When the Medical Executive Committee, other relevant staff committee, or the board or any appropriate committee thereof receives or is considering initiating an adverse recommendation concerning a practitioner, the practitioner may be afforded an interview. The interview will not constitute a hearing, will be preliminary in nature, and will not be conducted according to the

procedural rules provided with respect to hearings. The practitioner will be informed of the general nature of the circumstances and may present information relevant thereto. A record of the findings of such interview will be made.

9.2 HEARINGS AND APPELLATE REVIEW

9.2-1 ADVERSE MEC RECOMMENDATION

When any practitioner receives special notice of an adverse recommendation of the MEC as defined in Section 9.2-2, he will be entitled, upon request, to a hearing before an ad hoc hearing committee of the medical staff.

If the recommendation of the MEC following such hearing is still adverse to the practitioner, he will then be entitled, upon request, to an appellate review by the board before a final decision is rendered.

9.2-2 ADVERSE RECOMMENDATIONS OR ACTIONS DEFINED

- (a) The following recommendations or actions will, if deemed adverse pursuant to Section 9.2-2 (b) below, entitle the practitioner affected thereby to a hearing, upon his timely request for the same:
 - (i) Denial of initial staff appointment
 - (ii) Denial of reappointment
 - (iii) Suspension of staff membership
 - (iv) Revocation of staff membership
 - (v) Denial of requested advancement in staff category
 - (vi) Reduction in staff category
 - (vii) Limitation of the right to admit patients
 - (viii) Denial of requested department or section affiliation
 - (ix) Denial of requested clinical privileges
 - (x) Reduction in clinical privileges
 - (xi) Suspension of clinical privileges

(xii) Revocation of clinical privileges

(xiii) Terms of probation

(xiv) Individual imposition or application of mandatory consultation requirement

(b) A recommendation or action listed in Section 9.2-2 (a) above will be deemed adverse only when it has been:

(i) recommended by the MEC; or

(ii) taken by the board contrary to a favorable recommendation by the MEC under circumstances where no right to hearing existed; or

(iii) taken by the board on its own initiative without benefit of a prior recommendation by the MEC.

9.2-3 PROCEDURE AND PROCESS

All hearings and appellate reviews will be in accordance with the procedure and safeguards set forth in the Fair Hearing Plan.

9.2-4 EXCEPTIONS

Neither the issuance of a warning, a letter of admonition, or a letter of reprimand, nor the denial, termination or reduction of temporary privileges, nor any other actions except those specified in Section 9.2-2 will give rise to any right to a hearing or appellate review.

ARTICLE X - STAFF CLINICAL DEPARTMENTS

10.1 ORGANIZATION OF DEPARTMENTS

Each department will be organized as a separate part of the medical staff and will have a chairman who is selected and has the authority, duties, and responsibilities as specified in Article XI.

10.2 DESIGNATION

10.2-1 CURRENT DEPARTMENTS

The current departments are: Medicine and Surgery. The sections under medicine and surgery include, but are not limited to:

MEDICINE

Cardiology
Dermatology
Emergency Medicine
Endocrinology
Family Practice
General Practice
Infectious Disease
Internal Medicine
Nephrology
Neurology
Pathology
Pediatrics
Psychiatry
Radiology
Rheumatology
Pulmonary &
Critical Care Medicine

SURGERY

Anesthesiology
Dentistry
General Surgery
Neurosurgery
Obstetrics/Gynecology
Ophthalmology
Oral Surgery
Otorhinolaryngology
Orthopedics
Plastic Surgery
Podiatry
Thoracic Surgery
Urology
Vascular Surgery

10.2-2 FUTURE DEPARTMENTS

When deemed appropriate and consistent with the provisions of Section 10.5, the Medical Executive Committee (MEC) and the Board, by their joint action, may create anew, eliminate, subdivide, further subdivide or combine departments.

10.3 ASSIGNMENT TO DEPARTMENTS

Each member of the staff will be assigned membership in only one department, but may be granted clinical privileges or specified services within any department and will be subject to the rules and regulations of that department and the authority of the department chairman.

10.4 FUNCTIONS OF DEPARTMENTS

The primary responsibility delegated to each department is to implement and conduct specific review and evaluation activities that contribute to the preservation and improvement of the quality and efficiency of patient care provided in the department. To carry out this responsibility, each department will:

- (a) 10/14/98 conduct retrospective peer review evaluations with the Medical Performance Improvement and Surgical Performance Improvement Committees of the medical staff for the purpose of analyzing, reviewing and evaluating the quality of care within the department. The number of such evaluations to be conducted during the year will be as determined by the Medical Executive Committee, but will not be less than the number currently required by the Joint Commission on Accreditation of Hospitals or the number required by law. Each department will review all clinical work performed under its jurisdiction whether or not any particular practitioner whose work is subject to such review is a member of that department.
- (b) establish guidelines for the granting of clinical privileges and the performance of specified services within the department and submit the recommendations required under Articles VI and VII regarding the specific privileges each staff member or applicant may exercise.
- (c) conduct or participate in, and make recommendations regarding the need for, continuing education programs pertinent to changes in the state-of-the-art and to findings of review, evaluation and monitoring activities.
- (d) monitor, on a continuing and concurrent basis, adherence to:
 - (1) staff and hospital policies and procedures;
 - (2) requirements for alternate coverage and for consultations;
 - (3) sound principles of clinical practice;
 - (4) fire and other regulations designed to promote patient safety.
- (e) coordinate the patient care provided by the department's members with nursing and ancillary patient care services and with administrative support services.
- (f) submit written reports to the MEC on a regularly scheduled basis concerning: (1) findings of the department's review, evaluation and monitoring activities, actions taken thereon, and the results of such action; (2) recommendations for maintaining and improving the quality of care provided in the department and the hospital; and (3) such other matters as may be requested by the MEC.
- (h) 1/09/01 meet at least quarterly for the purposes indicated above and for receiving reports on other department and staff functions.

- (h) establish such committees or other mechanisms as are necessary and desirable to properly perform the functions assigned to it.
- (i) 1/09/01 The Staff Clinical Departments of the staff established to perform one or more staff functions required by these bylaws will meet as often as is necessary to discharge its assigned duties, but no less often than quarterly.

10.5 MODIFICATIONS IN CLINICAL ORGANIZATION UNIT

In creating, eliminating, subdividing or combining departments, sections or any other clinical organizational units that may exist or be contemplated, the following guidelines will be followed:

- (a) Creation or Subdivision: A sufficient number of practitioners will be appointed to and actively participate in the new organizational component to enable accomplishment of the functions generally assigned to such components in these Bylaws and the Rules and Regulations, and the patient or service activity to be associated with the new component is adequate to warrant transfer of the responsibility to accomplish those functions.
- (b) Eliminations: If the number of practitioners available is no longer adequate and will not be so in the foreseeable future to accomplish assigned functions, or the patient or service activity associated with the component to be dissolved is no longer adequate to warrant transfer of the responsibility to accomplish those assigned functions.
- (c) Combination: The union of the two or more organizational components will result in more effective and efficient accomplishment of assigned functions, and the patient or service activity to be associated with the combination is adequate, without being unwieldy, to warrant transfer of the responsibility to accomplish those assigned functions.

In all instances of modification, the hospital's written plan of

development as currently implemented and any constraints or mandates imposed by external planning authorities will also be considered.

ARTICLE XI - OFFICERS OF THE STAFF

11.1 GENERAL OFFICERS OF THE STAFF

11.1-1 IDENTIFICATION

The general officers of the staff will be:

- (a) Chief of Staff
- (b) Vice Chief of Staff
- (c) Immediate past Chief of Staff
- (d) Secretary-treasurer

11.1-2 OTHER OFFICIALS OF THE STAFF

Department Chairmen will be officials of the staff.

11.1-3 QUALIFICATIONS

General officers must be members of the Active I staff and associate staff and actively practicing in the hospital at the time of their nomination and election and must remain members in good standing during their term of office. Failure to maintain such status will immediately create a vacancy in the office involved. The chief of and vice chief of staff must be practitioners with demonstrated competency in their specialty and demonstrated qualifications on the basis of training, experience and ability to direct the medico-administrative aspects of staff activities. No medical staff member actively practicing in the hospital is ineligible for membership on the Medical Executive Committee solely because of his/her professional discipline or specialty. Any nominees for chief of staff should have served on the Medical Executive Committee in some capacity for one year in order to be eligible for nomination for chief of staff.

11.1-4 NOMINATIONS

- (a) By Nominating Committee: The staff nominating committee will convene one month prior to the January meeting and will

submit to the staff secretary one or more qualified nominees for each office. The names of such nominees will be reported to the staff at least 14 days prior to the annual meeting.

- (b) By Petition: Nominations may also be made by petition signed by at least 10 percent of the members of the active, associate, or emergency service staff and filed with the staff secretary at least 7 days prior to the January meeting. As soon thereafter as reasonably possible, the names of these additional nominees will be reported to the staff.
- (c) By Other Means: Nomination from the floor may be made but the nominator must have received consent of the nominee and the nominee agrees to serve.

11.1-5 ELECTION

Officers will be elected at the January meeting of the staff in each year. Only staff members accorded the prerogative to vote for general staff officers under Article IV will be eligible to vote. Voting will be by secret written ballot, and voting by proxy will not be permitted. A nominee will be elected upon receiving a majority of the valid votes cast. If no candidate for the office receives a majority vote on the first ballot, a runoff election will be held promptly between the two candidates receiving the highest number of votes. 10/14/03 The Board will ratify the appointment of medical staff officers and other medical staff leaders performing credentialing or peer review activities.

11.1-6 TERM OF ELECTED OFFICE

Each officer will serve a one-year term, 10/14/03 with the exception of the department chairmen and the department vice chairmen commencing at the end of the annual meeting of the medical staff year in which they have been elected to the end of the annual meeting in the next year. Each officer will serve until the end of his term and until a successor is elected, unless he will sooner resign or be removed from office.

11.1-7 REMOVAL OF ELECTED OFFICERS

Except as otherwise provided, removal of a general staff officer may be effected by a majority vote of the members of the staff eligible to vote for staff officers. Removal may be based only upon failure to perform the duties of the position held as described in these bylaws.

11.1-8 VACANCIES IN ELECTED OFFICE

Vacancies in offices, other than that of the immediate past Chief of Staff, will be filled by a special election conducted as soon after the vacancy occurs as possible following the general mechanism outlined in Sections 11.1-4 and 11.1-5. If there is a vacancy in the office of the Chief of Staff, the Vice Chief of Staff will serve out the remaining term. When the Vice Chief of Staff occupies a vacancy in the office of Chief of Staff, he will serve out the remaining term and may also serve a succeeding term.

11.2 DUTIES OF GENERAL OFFICERS

11.2-1 CHIEF OF STAFF

The Chief of Staff will serve as the chief medical officer of the hospital. As the principal elected official of the staff, the Chief of Staff will:

- (a) aid in coordinating the activities and concerns of the hospital administration and of the nursing and other patient care services with those of the medical staff.
- (b) communicate and represent the opinions, policies, concerns, needs and grievances of the medical staff to the Board, the administrator, and other officials of the staff.
- (c) be responsible for the enforcement of medical staff bylaws, rules and regulations, for implementation of sanctions where these are indicated, and for the medical staff's compliance with procedural safeguards in all instances where corrective action has been requested against a practitioner.
- (d) call, preside at, and be responsible for the agenda of all general meetings of the medical staff.
- (e) serve as chairman of the Medical Executive Committee, as a member of the joint conference committee and as an ex officio member of all other staff committees.
- (f) serve as an ex officio member of the Board.

11.2-2 VICE CHIEF OF STAFF

The Vice Chief of Staff must agree, following his term of office,

to be the nominee for the position of Chief of Staff. The vice chief of staff will be a member of the Bylaws Committee. He will be a member of the Medical Executive Committee and a member of the joint conference committee. In the absence, temporary or permanent, of the Chief of Staff, he will assume all the duties and have the authority of the Chief of Staff. He will perform such additional duties as may be assigned to him by the Chief of Staff, the Medical Executive Committee, or the Board.

11.2-3 IMMEDIATE PAST CHIEF OF STAFF

The immediate past chief of staff will be a member of the Medical Executive Committee and will perform such other advisory duties as are assigned to him by the chief of staff, the Medical Executive Committee, or the Board.

11.2-4 SECRETARY-TREASURER

The Secretary-Treasurer will be a member of the Medical Executive Committee, and:

- (a) give proper notice of all staff meetings on order of the appropriate authority.
- (b) prepare accurate and complete minutes of all meetings.
- (c) supervise the collection and accounting for any funds that may be collected in the form of staff dues, assessments, or application fees.
- (d) maintain and safeguard all medical staff records, including applications.
- (e) perform such other duties as ordinarily pertain to his office.
- (f) to perform additional duties as assigned by Chief of Staff or MEC.

11.3 DEPARTMENT CHAIRMAN

11.3-1 QUALIFICATIONS

The chairman of each medical staff department is certified by an appropriate specialty board, or affirmatively establishes,

through the privileges delineation process, that the person possesses comparable competence. The chairman will be willing and able to faithfully discharge the duties of his/her office.

11.3-2 SELECTION AND APPOINTMENT

The chairman and vice chairman will be elected by the department from nominees submitted by the department members.

10/14/03 Such appointments will be ratified by the Board.

11.3-3

10/14/03 A department chairman and a vice department chairman will serve two year terms. A department chairman and vice department chairman may succeed themselves, but may serve no more than 2 successive full terms in office.

Removal of a department chairman or vice chairman from office may be initiated by the Board acting upon its own initiative or upon the recommendation of the Medical Executive Committee, or by a majority vote of the department members eligible to vote on departmental matters.

11.3-4 RESPONSIBILITIES

Each chairman or, in his absence, vice chairman will:

- (i) all clinically related activities of the department;
- (ii) all administratively related activities of the department unless otherwise provided or by the hospital;
- (iii) continuing surveillance of the professional performance of all individuals in the department who have delineated clinical privileges.
- (iv) recommending to the medical staff the criteria for clinical privileges that are relevant to the care provided in the department;
- (v) submits a report for clinical privileges for each member of the department;
- (vi) assessing and recommending to the relevant hospital authority off-site sources for needed patient care services not provided by the department or the organization.

- (vii) integrates the department's services with the hospital's primary functions;
- (viii) coordinates and integrates services with their department and with other departments;
- (ix) develops and implements policies and procedures that guide and support the provision of services;
- (x) recommends a sufficient number of qualified and competent persons to provide care;
- (xi) determines the qualifications and competence of department personnel who provide patient care services and who are not licensed independent practitioners;
- (xii) 10/14/03 continuous assessment and improve the quality of care and services provided within the departments;
- (xiii) the maintenance of quality control programs, as appropriate;
- (xiv) provide for orientation, in-service training, and continuing education of all persons in the department;
- (xv) recommends space and other resources needed by department.

ARTICLE XII - COMMITTEES AND FUNCTIONS

12.1 DESIGNATION AND SUBSTITUTION

There will be a medical executive committee (MEC) and such other standing and special committees of the staff responsible to the MEC as may from time to time be necessary and desirable to perform the staff functions listed in Section 12.3 and elsewhere in these bylaws. The MEC may, by resolution and upon approval by the board, establish a staff committee to perform one or more of the required staff functions. Those functions requiring participation of, rather than direct oversight by, the staff may be discharged by medical staff representation on such hospital committees as are established to perform such functions.

Whenever these bylaws require that a function be performed by, or

that a report or recommendation be submitted to:

- (a) A named medical staff committee but no such committee exists, the MEC will perform such function or receive such report or recommendation or will assign the functions of such committee to a new or existing committee of the staff or to the staff as a whole.
- (b) The MEC, but a standing or special committee has been formed to perform the function, the committee so formed will act in accordance with the authority delegated to it.
- (c) Medical Staff representation will be present at any deliberations affecting the Medical Staff.

12.2 MEDICAL EXECUTIVE COMMITTEE (MEC)

12.2-1 COMPOSITION

The medical executive committee will consist of at least 6 members. The Chief of Staff, who acts as chairman, Past Chief of Staff, Vice Chief of Staff, Secretary-Treasurer, and Chairman of Department of Medicine and Chairman of Department of Surgery. The Chief Executive Officer of the hospital or his/her designee attends each executive committee meeting on an ex-officio basis.

12.2-2 DUTIES

The duties of the medical executive committee will be to provide guidance and leadership and to:

- (a) receive and act upon reports and recommendations from the departments, committees, assigned activity groups, and officers of the staff concerning patient care evaluations and other quality review, evaluation and monitoring functions and the discharge of their delegated administrative responsibilities and recommend to the Board specific programs and systems to implement these functions.
- (b) coordinate the activities of and policies adopted by the staff, departments and committees.
- (c) report results and recommendations concerning staff functions to the staff and the Board.
- (d) recommend to the Board all matters relating to, but not limited to the following:

- 1) the medical staff's structure.
 - 2) the mechanism used to review credentials and to delineate individual clinical privileges.
 - 3) recommendations of individuals for medical staff membership.
 - 4) recommendation for delineated clinical privileges for each eligible individual.
 - 5) participation of medical staff in organizational performance improvement activities.
 - 6) mechanism by which medical staff membership may be terminated.
 - 7) mechanism for fair hearing procedures.
- (e) account to the Board and to the staff for the overall quality and efficiency of patient care in the hospital.
- (f) take reasonable steps to insure professionally ethical conduct and competent clinical performance on the part of staff members, including initiating investigations, and initiating and pursuing corrective action, when warranted.
- (g) make recommendations on medico-administrative and hospital management matters.
- (h) inform the medical staff of the accreditation program and the accreditation status of the hospital.
- (i) annually review and assure the adequacy of the hospital disaster plan and the participation by the medical staff:
- (j) participate in identifying community health needs and in setting hospital goals and implementing programs to meet those needs.
- (k) represent and act on behalf of the staff in the intervals between medical staff meetings.
- (l) levy and collect fines, assessments, and dues subject to the limitations outlined in the Rules and Regulations.
- (m) Through their authorized representative, report to the National Physician's Data Bank, within 15 days:
- (1) any action that will adversely affect the period of longer than 30 days;
 - (2) any voluntary surrender of staff privileges while a practitioner is under investigation for possible

- incompetence or improper professional conduct or the
surrender is in lieu of investigation;
(3) any revisions of professional review actions.

12.2-3 MEETINGS

The medical executives committee will meet monthly at least 6
times each year and maintain a permanent record of its
proceedings and actions.

12.3 STAFF COMMITTEE FUNCTIONS

Committees will be appointed by the Chief of Staff, with the
approval of the MEC, for the effective performance of:

- (a) Conduct, coordinate and review patient care evaluation and monitoring activities, including tissue, blood usage and antibiotic reviews and analysis of autopsy reports.
- (b) Conduct, coordinate and review, or oversee the conduct of, utilization review activities.
- (c) Conduct, coordinate and review credentials investigations and recommendations regarding staff membership and the granting of clinical privileges and specified services.
- (d) Monitor and evaluate care provided in and develop clinical policy for: special care areas, such as intensive or coronary care units; patient care support services, such as respiratory therapy, physical medicine and anesthesia; and emergency, outpatient, and other ambulatory care services.
- (e) Provide continuing education opportunities responsive to quality activity findings, new state-of-the-art developments and other perceived needs and supervise the hospital's professional library.
- (f) Review the completeness, timeliness and clinical pertinence of patient medical and related records.
- (g) Develop and maintain surveillance over drug utilization policies and practices.
- (h) Prevent, investigate and control hospital-acquired infections, and monitor the infection control program.
- (i) Plan for response to fire and other disasters, for hospital growth and development, and for the provision of services required to meet the needs of the community.

- (j) Direct staff organizational activities, including staff bylaws review and revision, staff officer and committee nominations, liaison with the board and hospital administration, and review and maintenance of hospital accreditation.
- (k) Coordinate the care provided by practitioners with the care provided by the nursing service and with the activities of other hospital patient care and administrative services.

12.4 SPECIFIC FUNCTIONS OF COMMITTEES

12.4-1 MEDICAL PERFORMANCE IMPROVEMENT COMMITTEE

The Medical Performance Improvement Committee shall:

- (a) be chaired by the Vice-Chairman of the Department;
- (b) 8/13/02 meet no less than quarterly;
- (c) monitor and evaluate clinical performance of members of the Department of Medicine;
- (d) review medical records to properly describe the condition and progress of the patient, the therapy provided, the results thereof, and the identification of responsibility for all actions taken.
- (e) monitor and evaluate care of the medical patient;
- (f) establish and utilize objective criteria, occurrence screens, and/or medical case reviews;
- (g) report its findings and make recommendations to the Department of Medicine and the Medical Executive Committee.

12.4-2 SURGICAL PERFORMANCE IMPROVEMENT COMMITTEE

The Surgical Performance Improvement Committee Shall:

- (a) be chaired by the Vice-Chairman of the Department of Surgery;
- (b) 8/13/02 meet no less than quarterly;
- (c) monitor & evaluate clinical performance by members of the Department of Surgery;

- (d) monitor and evaluate care of the surgical patient;
- (e) review medical records to properly describe the condition and progress of the patient, the therapy provided, the results thereof, and the identification of responsibility for all actions taken.
- (f) monitor & review use of blood product transfusions;
- (g) establish and utilize objective criteria, occurrence screen, and/or surgical case reviews;
- (h) report its findings and make recommendations to the Department of Surgery and the Medical Executive Committee.

12.4-3 CREDENTIALS COMMITTEE

The duties involved in conducting, coordinating and reviewing credentials investigations and recommendations are to:

- (a) review and evaluate the qualifications and competence of each applicant for initial appointment, reappointment, or modification of appointment for clinical privileges, and in connection therewith to obtain and consider the recommendations of the appropriate departments.
- (b) post and distribute to staff members the agenda of each meeting relative to specific applications for initial appointment, reappointment or modification of appointment for clinical privileges.
- (c) submit reports, in accordance with Articles VI and VII, on the qualifications of each applicant for staff membership and/or delineation of clinical privileges. Such reports will include recommendations with respect to appointment, staff category, department affiliation, clinical privileges and special conditions attached.
- (d) investigate, review and report on matters, including the clinical or ethical conduct of any practitioner, assigned or referred by: (1) the Chief of Staff, (2) the MEC, (3) departmental chairmen, (4) Medical Review and QA Committee, (5) Surgical Review and QA Committee, (6) Utilization Review Committee, (7) Medical Records Committee, (8) Pharmacy and Therapeutics Committee, or the (9) Infection Control Committee.
- (e) submit reports monthly to the MEC on the status of pending applications, to include specific reasons for any inordinate delay in processing an application or request.

12.4-4 PROFESSIONAL EDUCATION COMMITTEE

The duties involved in organizing continuing education programs and supervising the hospital's professional library services are to:

- (a) develop and plan, or participate in, programs of continuing education that are designed to keep the medical staff informed of significant new developments and new skills in medicine and that are responsive to audit findings.
- (b) evaluate, through the patient care evaluation function, the effectiveness of the educational programs developed and implemented.
- (c) analyze, on a continuing basis, the hospital's and staff's needs for professional library services.
- (d) act upon continuing education recommendations from the MEC, the departments, or other committees responsible for patient care evaluation and other quality review functions.
- (e) maintain a record of education activities and submit periodic reports to the MEC concerning these activities, specifically including their relationship to the findings of patient care evaluation and quality review functions.

12.4-5 MEDICAL RECORDS COMMITTEE

The duties involved in reviewing the completeness, timeliness and clinical pertinence of patient medical records are to:

- (a) review medical charts to see they are sufficiently complete at all times so as to facilitate continuity of care and communications between all those providing patient care services in the hospital.
- (b) review staff and hospital policies, rules and regulations relating to medical records, including medical records completion, forms, formats, filing, indexing, storage, destruction and availability and recommend methods of enforcement thereof and changes therein.
- (c) act upon recommendations from the MEC, the departments, and other committees responsible for patient care evaluation and other quality review functions.

- (d) provide liaison with hospital administration and the medical records professionals in the employ of the hospital on matters relating to medical records practices.
- (e) maintain records of all actions taken and submit periodic reports and recommendations to the MEC concerning medical records practices in the hospital.

12.4-6 PHARMACY AND THERAPEUTICS COMMITTEE

The duties involved in developing and maintaining surveillance over drug utilization policies and practices are to:

- (a) formulate broad professional policies regarding the evaluation, appraisal, selection, procurement, storage, distribution, use, safety procedures and all other matters relating to drugs in the hospital.
- (b) advise the medical staff and the hospital's pharmaceutical department on matters pertaining to the choice of available drugs.
- (c) perform a criteria-based, ongoing, planned and systematic process of monitoring and evaluating the prophylactic, therapeutic, and empiric use of drugs to assure that they are provided appropriately, safely, and effectively.
- (d) advise the medical staff and the hospital's pharmaceutical department on matters pertaining to the choice of available drugs.
- (e) make recommendations concerning drugs to be stocked on the nursing unit floors and by other services.
- (f) develop and review periodically a formulary or drug list for use in the hospital.
- (g) evaluate clinical data concerning new drugs or preparations requested for use in the hospital.
- (h) establish standards concerning the use and control of investigational drugs and of research in the use of recognized drugs.
- (i) perform such other duties as assigned by the Chief of Staff of the MEC.

- (j) maintain a record of all activities relating to the pharmacy and therapeutics function and submit periodic reports and recommendations to the MEC concerning drug utilization policies and practices in the hospital.

12.4-7 INFECTION CONTROL COMMITTEE

The duties involved in preventing, investigating, and controlling hospital-acquired infections are to:

- (a) maintain surveillance over the hospital infection control program and assure compliance with pertinent governmental regulations.
- (b) develop a system for reporting, identifying and analyzing the incidence and cause of all infections.
- (c) develop and implement a preventive and corrective program designed to minimize infection hazards, including establishing, reviewing and evaluating aseptic, isolation and sanitation techniques.
- (d) develop, evaluate and revise preventive, surveillance and control policies and procedures relating to all phases of the hospitals activities, including: operating rooms, delivery rooms, special care units; central service, housekeeping and laundry; sterilization and disinfection procedures by heat, chemicals or otherwise; isolation apparatus or inhalation therapy equipment; testing of hospital personnel for carrier status; disposal of infectious material; food sanitation and waste management; and other situations as requested.
- (e) act upon recommendations related to infection control received from the Chief of Staff, the MEC, the departments and other staff and hospital committees.
- (f) maintain a record of all activities relating to infection control and submit periodic reports thereon to the MEC and to the administrator.
- (g) meet not less than quarterly.

12.4-8 BYLAWS COMMITTEE

The duties involved in maintaining the appropriate bylaws, rules, regulations and other organizational documents pertaining to the staff are to:

- (a) conduct an annual review of the bylaws and the rules, regulations, procedures, and forms promulgated in connection therewith will be reviewed every 3 years.
- (b) submit recommendations to the MEC for all changes in these documents.
- (c) receive and consider all matters specified in subparagraph (a) as may be referred by the board, the joint conference, the MEC, the departments, the Chief of Staff, the Administrator and the committees of the staff.
- (d) act as custodian for the current master copy of the Bylaws, Rules and Regulations, and the Fair Hearing Plan of the medical staff.

12.4-9 NOMINATING COMMITTEE

The nominating committee will consist of the past Chief of Staff, the Chief of Staff, the Secretary-Treasurer, and the department chairmen. The duties involved in presenting to the staff qualified candidates for the offices of Chief of Staff, Vice Chief of Staff and Secretary-Treasurer are to:

- (a) consult with members of the staff concerning the qualifications and acceptability of prospective nominees.
- (b) submit, at the appropriate times as provided in these bylaws, one or more nominations for each elective office of the staff to be filled. A minimum of two nominees is expected for the offices of Vice Chief of Staff and Secretary-Treasurer.

12.4-10 QUALITY RESOURCE MANAGEMENT STEERING COMMITTEE

6/13/2000 The Quality Resource Management Committee will consist of at least five (5) members of the staff appointed by the Chief of Staff. Membership will consist of sufficient members to afford, insofar as feasible, representation from the major clinical services. Members shall also include representatives of

Administration, Finance, Quality Resource Management, Case Management, Health Information Management, and Nursing Service appointed by the CEO. Terms of appointment to the committee will be staggered. Other medical staff members and hospital representatives may attend the meetings at the request of the chairperson. The duties of the Quality Resource Management Steering Committee will include:

- (a) development and oversight of a hospital-wide Plan For Improving Organizational Performance and a hospital-wide Utilization Management Plan;
- (b) selection and coordination of clinical process improvement projects (ie) critical pathway development, standing order review, etc.);
- (c) review, approve and monitor multi-disciplinary performance improvement projects;
- (d) routine review of clinical performance indicators, development and distribution of physician practice profiles;
- (e) provide regular summaries of the above to the Medical Executive Committee and the Board of Trustees.
- (f) hold no less than 10 meetings each year;
- (g) review and monitor reports of admissions, continued stays, and patterns and trends of utilization;
- (h) review annual efficiency study;
- (i) review discussions of Peer Review Organization, outlier cases, and denials by third party payors; and
- (j) review patient and employee satisfaction data, clinical outcome data and risk management data.

12.4-11 ICU COMMITTEE

The duties of the Intensive Care Unit Committee are to monitor policies and procedures, assure the appropriateness and quality of care of patients treated in the ICU, and to make recommendations on all matters pertaining specifically to the Intensive Care Units.

- (a) The committee should be made up of members of the medical staff who routinely care for patients in the ICU.
- (b) The committee should develop and periodically review those policies and procedures which effect the care of patients in the ICU.
- (c) The committee will assist in determining the needs of the department regarding new equipment and supplies.
- (d) The ICU Committee will evaluate those areas of conflict which may occur and recommend to the MEC solutions to any problems which the committee itself cannot resolve.
- (e) The chairman of the ICU Committee will serve as the Medical Director of the ICU and will be responsible for the implementation of policies established by the medical staff for the continuing operation of the unit.
- (f) Minutes and reports of this committee will be submitted to the MEC.

12.4-12 PERINATAL COMMITTEE 4/98

The duties of the Perinatal Mortality and Morbidity Committee shall be medical chart review for all maternal and infant cases which are identified as; problem prone, serious risk, not meeting established criteria, and/or approved clinical indicators, through the chart screening process. Monitor policies and procedures, assure the appropriateness and quality of care of patients treated in the perinatal areas and to make recommendations on all matters pertaining to the perinatal services.

- (a) members of the Perinatal Mortality and Morbidity Committee are composed of Obstetricians, Pediatricians, Anesthesiology, Pathology, Registered Nurse, Quality Resource Management and Administration.
- (b) the committee shall meet at least once every three months.
- (c) the committee shall review all maternal and newborn stays which reflect performance improvement needs.
- (d) the committee shall function as a sub-committee of the Medical and Surgical Performance Improvement Committees and

will share the results of all reviewed cases with those committees.

- (e) all performance improvement needs not resolved at the Perinatal Mortality and Morbidity Committee shall be referred to the appropriate committee(s) for assessment and follow-up action.
- (f) when appropriate, the Regional Perinatal Center shall be used as a resource in conjunction with these reviews.
- (g) indicators for review are as outlined in the Perinatal Department Policies and Procedures.
- (h) the committee will develop and periodically review those policies and procedures which effect the care of the patients in the perinatal areas.
- (i) the committee will assist in determining the needs of the department regarding new equipment and supplies.
- (j) the Perinatal Committee will evaluate those areas of conflict which may occur and recommend to the M.E.C. solutions to any problems which the committee itself can not resolve.
- (k) minutes and reports of this committee will be submitted to the M.E.C.

12.4-13 CANCER COMMITTEE

The Cancer Committee shall:

- (a) meet at least quarterly;
- (b) have a chairman appointed by the Chief of Staff;
- (c) be multidisciplinary in composition with representatives from surgery, internal medicine, gynecology, pediatrics, medical oncology, diagnostic radiology, radiation oncology, pathology, cancer liaison physician, quality assurance, family practice, as well as nonvoting members from administration, nursing services, social services, the cancer registrar, and others as the Committee considers appropriate.

- (d) plan, initiate, stimulate, and assess cancer related activities in the hospital;
- (e) organize regular educational conferences that are multidisciplinary, hospital-wide, and clinically oriented.;
- (f) monitor and evaluate patient care, either directly or by interaction with study data from other committees, at least annually;
- (g) supervise the maintenance of a cancer registry;
- (h) document all its activities and report periodically and make recommendations to the MEC;
- (i) assist with coordination of access to consultative and rehabilitative services.

12.4-14 TRAUMA COMMITTEE

The Trauma Committee shall:

- (a) be chaired by a Board Certified Surgeon;
- (b) meet at least quarterly unless required more frequently for accreditation or by a licensing body;
- (c) monitor and evaluate the quality and appropriateness of trauma services;
- (d) periodically review and approve policies and procedures that effect trauma patients;
- (e) be multi-disciplinary in form and may include representative from the Emergency Department, Orthopaedic Surgery, Neurosurgery, Pathology, Plastic Surgery, Anesthesia, Trauma Registry, Quality resource and Administration;
- (f) report its findings and make recommendations to the MEC.

The Medical Staff's Practitioner Advocacy Committee (PAC) exists to investigate reports of possible practitioner impairment and recommend an appropriate course of action. In addition, the PAC serves to review applications for reinstatement following treatment for an impairment (as defined in Section 3.8-1) in order to formulate a recommendation for the MEC. The Committee's approach is non-adversarial and strives to compassionately evaluate each referred practitioner, and if impairment is found, directs the practitioner to appropriate specialty evaluation and treatment. This may include medical and/or psychological evaluation and management. Cases involving substance abuse and/or dependence are referred to the South Carolina Recovering Professional Program (SCRPP), in accordance with Section 3.8.

Membership - The PAC shall consist of five members of the medical staff. The Chief of Staff chairs this committee and appoints the four other members. The Chair will endeavor to select a diverse committee by appointing members who are impartial and from different practice groups. Every effort should be made to appoint at least one member who has special competency in impairment-related issues, if possible.

Meetings - This committee meets when called by the chair to consider a particular referred practitioner or when necessary, in the opinion of the chair, to conduct other business related to the PAC's mission.

C) Decision-Making:

1) Process of Investigation (Detailed in Section 3.8)

2) Rules of Order - A quorum consists of at least three of the committee members, providing all five have been notified of the time and place of a given meeting. A simple majority of all committee members present at a meeting will decide an issue; ties will be broken by the chair or chair-designate. Should a member of the committee be referred to the committee for evaluation, said member shall have no vote and the remaining committee members shall conduct the evaluation.

(D) Education - The PAC will facilitate efforts to educate medical staff and hospital employees with respect to practitioner impairment recognition and confidential reporting.

E) Immunity - the committee performs a type of peer review function, and, as such, its deliberations are privileged under the state law. In addition, all participants in the PAC's processes (including individuals making reports) acting in good faith are immune from liability.

F) Recommendations - the PAC will make recommendations to the Medical Executive Committee in accordance with Section 3.8.

12.5 PARTICIPATION ON INTERDISCIPLINARY HOSPITAL COMMITTEES

Staff functions and responsibilities relating to liaison with the board and the hospital administration, hospital accreditation, disaster planning, facility and services planning and financial management will be discharged by the appointment of medical staff members to such hospital committees as are established to perform those functions.

Appointment of medical staff members to any hospital committees will be made by the Chief of Staff, with the concurrence of the MEC, and such committees will operate in accordance with the hospital corporate bylaws and the written policies of the hospital and of the staff.

The MEC and the Board of Trustees acting together will function as a joint conference committee to resolve disputes between the medical staff and administration.

12.6 COMMITTEES OF THE STAFF

12.6-1 COMPOSITION AND APPOINTMENT

A staff committee will be composed of members of the active, associate and emergency services staffs and may include, where appropriate, as ex officio members, allied health professionals and representation from hospital administration, nursing service, medical records service, pharmacy service, social service, and such other hospital departments as are appropriate to the

function to be discharged. Unless otherwise specifically provided, the medical staff members will be appointed by the Chief of Staff, with the concurrence of the MEC, and the administrative staff members will be appointed by the Administrator. The Chairman will be appointed by the Chief of Staff, with the approval of the MEC. The Chief of Staff and the Administrator, or their respective designees, may serve as ex officio members, without vote, of any committee, unless otherwise expressly provided.

12.6-2 TERM AND PRIOR REMOVAL

A medical staff committee member (other than one serving ex officio) will continue as such until a successor is elected or appointed, unless he will sooner resign or be removed from the committee. A medical staff committee member, other than one serving ex officio, may be removed by a majority vote of the MEC. An administrative staff committee member will serve for a term equivalent to that of a medical staff committee member and until a successor is elected or appointed, unless he will sooner resign or be removed from the committee. An administrative staff committee member may be removed by action of the Administrator.

12.6-3 VACANCIES

Vacancies on any staff committee will be filled in the same manner in which original appointment to such a committee is made.

12.6-4 MEETINGS

A standing medical staff committee established to perform one or more of the staff functions required by these bylaws will meet as often as is necessary to discharge its assigned duties, but no less often than quarterly.

ARTICLE XIII - MEETINGS

13.1 ANNUAL MEETING

13.1-1 MEETING TIME

The annual staff meeting will be held in March before the end of the staff year and will replace the last regular medical staff meeting.

13.1-2 ORDER OF BUSINESS AND AGENDA

The order of business at an annual meeting will be determined by the Chief of Staff. The agenda will include at least:

- (a) Reading and ratification of the minutes of the last regular and of all special meetings held since the last regular meeting.
- (b) Reports from the Chief of Staff, the hospital administrator, chiefs of service and appropriate committee chairmen.
- (c) Recommendations for maintenance and/or improvement of patient care.
- (d) Other old and new business as appropriate.
- (e) Installation of Medical Staff officers elected at the January meeting.

13.2 REGULAR MEDICAL STAFF MEETINGS

13.2-1 MEETING TIME

The staff may, by resolution, provide the time for holding regular meetings and no notice other than such resolution will then be required. The frequency of such meetings will be as required by these bylaws, but will be at least once a year. If the date, hour or place of a regular staff meeting must be changed for any reason, the notice procedure in Section 13.4 will be followed.

13.2-2 ORDER OF BUSINESS AND AGENDA

The order of business at a regular meeting will be determined by the Chief of Staff. The agenda will include at least:

- (a) Reading and ratification of the minutes of the last regular and of all special meetings held since the last regular meeting.
- (b) Reports from the Chief of Staff, the hospital administrator, chiefs of service and committee chairmen.
- (c) Other old and new business as appropriate,
- (d) the election of officers will take place at the regular meeting preceding the annual meeting.

13.2-3 SPECIAL MEETINGS

Special meetings of the staff may be called at any time by the Board of Trustees, the Chief of Staff, by action of the MEC or not less than 20% of the members of the active staff, and will be held at the time and place designated in the meeting notice. No business will be transacted at any special meeting except that stated in the meeting notice.

13.3 COMMITTEE AND DEPARTMENT MEETINGS

13.3-1 REGULAR MEETINGS

Committees and departments may, by resolution, provide the time for holding regular meetings and no notice other than such resolution will then be required. The frequency of such meetings will be as required by these bylaws.

13.3-2 SPECIAL MEETINGS

A special meeting of any committee or department may be called by, or at the request of, the chairman thereof, the Chief of Staff or by one-third of the group's current members. No business will be transacted at any special meeting except that stated in the meeting notice.

13.4 NOTICE OF MEETINGS

Written notice stating the place, day and hour of any general staff meeting, of any special meeting, or of any regular committee or department meeting not held pursuant to resolution will be delivered either personally or by mail to each person entitled to be present not less than 5 days before the date of such meeting. Notice of department or committee meetings may be given orally. If mailed, the notice of the meeting will be deemed delivered 72 hours after deposited, postage prepaid, in the United States mail addressed to each person entitled to such notice at his address as it appears on the records of the hospital.

Personal attendance at a meeting will constitute a waiver of notice of such meeting.

13.5-1 MANNER OF ACTION

Except as otherwise specified, the action of a majority of the members present and voting at a meeting will be the action of the group. Action may be taken without a meeting by a department or committee by a writing setting forth the action so taken signed

by a majority of the members entitled to vote.

13.6 MINUTES

Minutes of meetings will be the responsibility of the secretary of the meeting and will include a record of attendance and the vote taken on each matter. When there is no designated secretary, or the recorder is not a member of the medical staff, the responsibility for the minutes will reside with the presiding officer. Copies of the minutes will be furnished to each member and to the MEC.

13.7 ATTENDANCE REQUIREMENTS

13.7-1 REGULAR ATTENDANCE

Each member of the staff category required to attend committee meetings under Article IV will be required to attend:

13.7-1-(a) At least 50 percent of all meetings of each committee of which he is a member.

13.7-2 ABSENCE FROM MEETINGS

Any member who is compelled to be absent from any assigned committee meeting will promptly provide to the regular presiding officer thereof, the reason for each absence, if he wishes an excused absence. Unless excused for good cause, failure to meet the attendance requirements may be grounds for any of the corrective actions specified in Section 8.1-4, and including, in addition, removal from such committees. Reinstatement of a staff member whose membership has been revoked because of absence from meetings will be made only on application, and any such application will be processed in the same manner as an application for initial appointment.

13.8-3 SPECIAL APPEARANCE

A practitioner whose patient clinical course of treatment is scheduled for a discussion beyond a routine review at a regular department or committee meeting will be so notified. Whenever apparent or suspected deviation from standard clinical practice is involved, special notice will be given at least 7 days prior to the meeting and will include the time and place of the meeting, a statement of the issue involved and that the

practitioner's appearance is mandatory. Failure of a practitioner to appear at any meeting with respect to which he was given such special notice will, unless excused by the medical executive committee upon a showing of good cause, result in an automatic suspension of all or such portion of the practitioner's clinical privileges as the MEC may direct. Such suspension will remain in effect until the matter is resolved by subsequent action of the MEC or of the board or through corrective action, if necessary.

13.9 PARLIAMENTARY AUTHORITY

The rules contained in the current edition of Robert's Rules of Order will govern the medical staff in all cases to which they are applicable and in which they are not inconsistent with these bylaws and any special rules of order the medical staff may adopt.

ARTICLE XIV - CONFIDENTIALITY, IMMUNITY AND RELEASES

14.1 SPECIAL DEFINITIONS

For the purpose of this Article, the following definitions will apply:

- (a) INFORMATION means recording of proceedings, minutes, records, reports, memoranda, statements, recommendations, data and other disclosures whether in written or oral form relating to any of the subject matter specified in Section 14.5-2.
- (b) MALICE means the dissemination of a known falsehood or of information with a reckless disregard for whether or not it is true or false.
- (c) PRACTITIONER means a staff member or applicant.
- (d) REPRESENTATIVE means a board and any director or committee thereof; the Administrator or his designee; a medical staff organization and any member, officer, department or committee thereof; and any individual authorized by any of the foregoing to perform specific information gathering or disseminating functions.
- (e) THIRD PARTIES means both individuals and organizations providing information to any representative.
- (f) An allied health professional may, subject to any licensure

requirements or other legal limitations, exercise independent judgment within the areas of his professional competence, and may participate under the supervision of an active or associate staff physician who has been accorded privileges to provide such care and who has ultimate responsibility for the patient's care.

14.2 AUTHORIZATIONS AND CONDITIONS

By applying for, or exercising, clinical privileges or providing specified patient care services within this hospital, a practitioner:

- (a) Authorizes representatives of the hospital and the medical staff to solicit, provide and act upon information bearing on his professional ability and qualifications.
- (b) Agrees to be bound by the provisions of this article and to waive all legal claims against any representative who acts in accordance with the provisions of this Article.
- (c) Acknowledges that the provisions of this article are express conditions to his application for, or acceptance of, staff membership and the continuation of such membership, or to his exercise of clinical privileges.

14.3 CONFIDENTIALITY OF INFORMATION

Information with respect to any practitioner submitted, collected or prepared by any representative of this or any other health care facility or organization or medical staff for the purpose of achieving and maintaining quality patient care, reducing morbidity and mortality, or contributing to clinical research will, to the fullest extent permitted by law, be confidential and will not be disseminated to anyone, nor be used in any way except as provided herein or except as otherwise required by law. Such confidentiality will also extend to information of the like kind that may be provided by third parties. This information will not become part of any particular patient's file or of the general hospital records.

14.4 IMMUNITY FROM LIABILITY

14.4-1 FOR ACTION TAKEN

No representative of the hospital or medical staff will be liable to a practitioner for damages or other relief for any action taken or statement or recommendation made within the scope of his duties as a representative, if such representative acts in good faith and without malice after a reasonable effort under the circumstances to ascertain the truthfulness of the facts and in

the reasonable belief that the action, statement or recommendation is warranted by such facts. Truth will be an absolute defense in all circumstances.

14.4-2 FOR PROVIDING INFORMATION

No representative of the hospital or medical staff and no third party will be liable to a practitioner for damages or other relief by reason of providing information, including otherwise privileged or confidential information, to a representative of this hospital or medical staff or to any other health care facility or organization of health professionals concerning a practitioner or allied health professional who is or has been an applicant to or member of the staff or who did or does exercise clinical privileges at this hospital, provided that such representatives or third party acts in good faith and without malice.

14.5 ACTIVITIES AND INFORMATION COVERED

14.5-1 ACTIVITIES

The confidentiality and immunity provided by this article will apply to all acts, communications, reports, recommendations or disclosures performed or made in connection with this or any other health care facility's or organization's activities concerning, but not limited to:

- (a) Applications for appointment, clinical privileges or specified services.
- (b) Periodic reappraisals for reappointment, clinical privileges or specified services.
- (c) Corrective action.
- (d) Hearings and appellate reviews.
- (e) Patient care audits.
- (f) Utilization review.
- (g) Other hospital, department, committee or staff activities related to monitoring and maintaining quality patient care and appropriate professional conduct.

14.5-2 INFORMATION

The acts, communication, reports, recommendations, disclosures and other information referred to in this Article may relate to a practitioner's professional qualifications, clinical ability, judgment, character, physical and mental health, emotional stability, professional ethics, or any other matter that might directly or indirectly affect patient care.

14.6 RELEASES

Each practitioner will, upon request of the hospital, execute general and specific releases in accordance with the tenor and import of this Article, subject to such requirements, including those of good faith, absence of malice and the exercise of a reasonable effort to ascertain truthfulness, as may be applicable under the laws of this state. Execution of such releases will not be deemed a prerequisite to the effectiveness of this Article.

14.7 CUMULATIVE EFFECT

Provisions in these bylaws and in application forms relating to authorizations, confidentiality of information and immunities from liability will be in addition to other protections provided by law and not in limitation thereof, and in the event of conflict, the applicable law will be controlling.

ARTICLE XV GENERAL PROVISIONS

15.1 STAFF RULES AND REGULATIONS

The medical staff will adopt such rules and regulations as may be necessary to implement more specifically the general principles found in these bylaws.

These will relate to the proper conduct of medical staff organization activities as well as embody the level of practice that is to be required of each practitioner in the hospital. Such rules and regulations will be a part of these bylaws, except that they may be amended or repealed at any regular meeting and without previous notice, or at any special meeting on notice, by a majority vote of those present and eligible to vote. Neither the Medical Staff nor the Board of Trustees may unilaterally amend the Medical Staff Rules and Regulations.

15.2 DEPARTMENTAL RULES AND REGULATIONS

The medical staff will adopt such rules and regulations as may be

necessary to implement more specifically the general principles found in these bylaws. These will relate to the proper conduct of medical practice that is to be required of each practitioner in the hospital. Such rules and regulations will be a part of these bylaws, except that they may be amended or repealed at any regular meeting and without previous notice, or at any special meeting on notice, by a majority vote of those present eligible to vote.

15.3 PROFESSIONAL LIABILITY INSURANCE

Each practitioner granted clinical privileges in the hospital will maintain professional liability insurance coverage as defined by the hospital bylaws. The practitioner will also inform the MEC and the hospital administrator of any change in professional liability insurance coverage.

15.4 STAFF DUES

The medical executive committee will have the power to set the amount of annual dues for each category of staff membership and the amount of the processing fee for initial applications and to determine the manner of expenditure of funds received. The amount of annual dues may vary among the staff categories, but will not exceed One Hundred and No/100 (\$100.00) Dollars per member for any category.

15.5 FORMS

Application forms and any other prescribed forms required by these bylaws for use in connection with staff appointments, reappointments, delineation of clinical privileges, corrective action, notices, recommendations, reports, and other matters will be subject to adoption by the board after considering the advice of the medical executive committee.

15.6 CONSTRUCTION OF TERMS AND HEADINGS

Words used in these bylaws will be read as the masculine or feminine gender and as the singular or plural, as the context requires. The captions or headings in these bylaws are for convenience only and are not intended to limit or define the scope or effect of any provision of these bylaws.

15.7 TRANSMITTAL OF REPORTS

Reports and other information which these bylaws require the medical staff to transmit to the board will be deemed so transmitted when delivered, unless otherwise specified, to the administrator.

15.8 BOARD ACTION

Whenever these bylaws require or authorize action by the board, such action may be taken by a committee of the board to which the board has delegated the responsibility and authority to act for it on the particular subject matter, activity or function involved.

ARTICLE XVI - ADOPTION AND AMENDMENT OF BYLAWS

16.1 MEDICAL STAFF RESPONSIBILITY

The medical staff will have the initial responsibility to formulate, adopt and recommend, to the Board and medical staff, bylaws and amendments thereto which will be effective when approved by the Board.

Such responsibility will be exercised in good faith and in a reasonable, timely and responsible manner, reflecting the interests of providing patient care of the generally recognized professional level of quality and efficiency and of maintaining a harmony of purpose and effort with the Board and with the community.

16.2 METHODOLOGY

Medical staff bylaws may be adopted, amended, or repealed by the following combined action:

16.2-1 MEDICAL STAFF

The affirmative vote of a majority of the staff members eligible to vote on this matter at a meeting, provided at least 30 days written notice, accompanied by the proposed bylaws and/or alterations, has been given of the intention to take such action; and

- (a) The period between reviews of the bylaws and rules and regulations shall not exceed (3) years. Revisions may be made at other times in accordance with the need of the medical staff to reflect current practices in its organization and function.

16.2-2 BOARD

The affirmative vote of a majority of the Board.

16.2-3

Neither the Medical Staff nor the Board of Trustees has the authority to unilaterally revise or amend these bylaws, rules, or regulations without the approval of the other body.

16.2-4

If significant changes are made in the medical staff bylaws, rules and regulations, or policies medical staff members and other individuals who have delineated clinical privileges are provided with revised texts of the written materials. The provision of the written texts is accomplished by the practitioners requesting a copy of the revised text from the Chief Executive Officer or the Medical Staff Coordinator.

MEDICAL STAFF RULES & REGULATIONS

A. ADMISSION AND DISCHARGE AND TRANSFER OF PATIENTS

1. A patient may be admitted to the hospital only by an active, associate, courtesy member of the medical staff or by a physician who has been granted 10/10/00 temporary privileges. All practitioners will be governed by the official admitting policy of the hospital. A dentist or podiatrist with associate staff privileges must admit conjointly with a member of the active medical staff, who will be responsible for the patient's overall medical care. The medical history and physical examination will be completed by the active medical staff member. Oral surgeons who are credentialed to do histories and physicals may be exempted from conjoint admissions requirements but must make arrangements with a member of the active medical staff for responsibility for the patient's overall medical care.
2. A member of the medical staff will be responsible for the medical care and treatment of each patient in the hospital, for the prompt completion and accuracy of the medical record, for necessary special instructions and for transmitting reports of the condition of the patient to the referring practitioner and to relatives of the patient. Whenever these responsibilities are transferred to another staff member, documentation by the respective practitioner covering the transfer of responsibility, as well as the acceptance of responsibility, will be entered in the medical record.
3. Except in an emergency, no patient will be admitted to the hospital until a provisional diagnosis or valid reason for admission has been recorded. In the case of an emergency, such statement will be recorded as soon as possible. Provisional diagnoses will be recorded on admission orders.
4. An individual initially applying for specialty or subspecialty privileges is encouraged to be a Diplomate of his American Specialty Board. However, the granting of such privileges will not be based solely upon such board certification status.

5. Each physician will cooperate with the functions of the various Hospital and Medical Staff Committees.
6. Patients will be discharged only on order of the attending practitioner or his designee. Should a patient leave the hospital against the advice of the attending practitioner, or without proper discharge, a notation of the incident will be made in the patient's medical record.
7. In the event of a hospital death, the deceased will be pronounced dead by the attending practitioner or his designee within a reasonable time. The body will not be released until an entry has been made and signed in the medical record of the deceased by a member of the medical staff. Policies with respect to release of bodies will conform to law.
8. AUTOPSIES: It will be the duty of all staff members to attempt to secure meaningful autopsies whenever possible. Autopsies should be considered for all uncomplicated deaths in particular circumstances as listed in these rules and regulations and the Administration Autopsy Policy when:
 - 2/20/01 Autopsy may help explain unknown or unanticipated complications;
 - Cause of death is not known with certainty based on the clinical findings;
 - Autopsy may help to allay concerns of the family and/or the public regarding the cause of death;
 - Unexplained or unexpected death occurred during or following any medical or surgical diagnostic procedure or therapy;
 - Death occurred following an injury sustained while hospitalized;
 - Obstetrical death;
 - Pediatric or neonatal death;
 - Suspected illness may have bearing on survivors or recipients of transplant organs.
- 2/20/01 An autopsy may be performed only with a written consent, signed in accordance with state law. All autopsies will be performed by the hospital pathologist, or by a practitioner delegated this responsibility. The medical Staff and attending practitioner shall be notified when an autopsy is being performed pursuant to the Administration Autopsy Policy.

9. EMTALA: All patients presenting themselves for emergency medical care at Grand Strand Regional Medical Center shall receive a medical screening examination within the capacity and capability of the medical center. The treatment and transfer of patients shall not be predicated upon arbitrary, capricious, or unreasonable discrimination based upon race, religion, national origin, age, sex, physical condition, payor class, or economic status. No patient shall be transferred or referred to another healthcare provider without an appropriate medical screening examination being performed by a qualified physician member of the medical staff.

- (a) In the event of a potential need to transfer the patient, the patient shall be:

- (1) evaluated by a physician who is on duty in the Emergency Department at the time the patient presents, or
- (2) if patient is felt to be in need of a specialty consultation by the Emergency Department physician, a specialty consult will be obtained by utilizing the on call roster. Specialists are required to respond within 60 minutes.

- (b) On-call physicians who refuse or fail to respond, if requested, within 60 minutes to personally examine a patient, will be subject to automatic referral to the appropriate Department Chairperson.

B. GENERAL PATIENT CARE

1. A general consent form, signed by or on behalf of every patient admitted to the hospital, must be obtained at the time of admission. The admitting officer should notify the attending practitioner whenever such consent has not been obtained. When so notified, it will be, except in emergency situations, the practitioner's obligation to obtain proper consent before the patient is treated in the hospital.

8/13/02 All orders for treatment shall be in writing. A verbal order shall be considered to be in writing if given to a registered nurse, licensed practical nurse I and license practical nurse II, pharmacist, registered physical therapist, rehabilitation therapist, respiratory therapist, dietitian, or a properly credentialed allied health professional functioning within his/her scope of

responsibility and signed by the responsible practitioner.

3. All orders dictated over the telephone shall be signed by the appropriately authorized person to whom dictated with the name of the practitioner per his or her own name. The nursing service should flag those verbal and telephone orders which require signature by the practitioner to remind him of this responsibility.

(a) Orders for RESTRAINTS AND DO NOT RESUSCITATE ORDERS SHALL BE SIGNED BY THE ORDERING PHYSICIAN WITHIN TWENTY-FOUR (24) HOURS.

(b) Orders for "Do Not Resuscitate" must be written within the guidelines of the Do No Resuscitate Policy.

(c) The practitioner's orders must be written clearly, legibly, and completely. Orders which are illegible or improperly written will not be carried out until rewritten or understood by the nurse.

(d) All orders will automatically be canceled when a patient goes to surgery or is transferred into or out of a special care unit. The attending physician must rewrite all orders.

(e) Orders for patient restraints must be time limited and may not be written as "PRN." Please see Policy for Patient Restraints.

(f) Standard orders shall only concern the work of physicians doing the same procedures. Such standard orders must be approved by the appropriate service, and written or printed on the standard doctors order form. It is to be authenticated with the current date and the attending physicians' original signature. The physician shall delete such parts as he does not desire.

(g) Pre-printed order has to be signed and dated by the attending physician.

4. All previous orders are canceled when patients go to surgery.

5. The attending physician or his designee should make rounds at least daily.

6. Consultation

- (a) Consultant. Any qualified practitioner can be called for consultation within his/her area of expertise. A consultant must be well qualified to give an opinion in the field in which his/her opinion is sought. The status of the consultant is determined by the medical staff on the basis of an individual's training, experience and competence at this or any other accredited medical institute.

A consultant may be called in when a qualified practitioner involved in the care of a patient feels additional expertise is required for effective patient care or when the needs of the patient exceed the delineated privileges of the attending physician.

- (b) Essentials of a Consultation. A satisfactory consultation includes examination of the patient and the medical record. A written opinion signed by the consultant must be included in the medical record. When operative procedures are involved, the consultation note, except in emergency, will be recorded prior to the procedure.
- (c) Responsibility for Requesting Consultations. The patient's physician is responsible for requesting consultations when indicated. It is the duty of the hospital staff, through its chiefs of service and executive committee, to make certain that members of the staff do not fail in the matter of calling consultations as needed.

10/10/00 A consultant is required when the medical management of the patient exceeds the clinical privileges of the attending physician.

- (d) Emergency Consultation. An emergency consultation will require a verbal communication between the requesting and consulting physicians. When a member of the staff requests an emergency consultation, the staff member who has been requested in consultation should respond and offer appropriate assistance.
- (e) If a nurse has any reason to doubt or question the

care provided to any patient, or believes that appropriate consultation is needed and has not been obtained, she may call this to the attention of her superior, who in turn may refer the matter to the director of nursing service. If warranted, the director of nursing service may bring the matter to the attention of the chief of the service in which the practitioner has clinical privileges. Where circumstances are such as to justify such action, the chief of the service himself may request a consultation.

7. 2/20/01 PSYCHIATRIC OR SUBSTANCE-ABUSE SERVICES
Because this hospital does not primarily provide psychiatric or substance-abuse services, the medical staff's role in the care of appropriate referral of patients who are emotionally ill, who become emotionally ill while in the hospital, or who suffer the results of alcoholism or drug abuse as defined in an administrative written plan.

8. PRESCRIBE/ORDER MEDICATIONS

The Grand Strand Regional Medical Center Medical Staff clinical privileging process includes medication prescription ordering as a granted privilege when appropriate to the practitioner's license.

- I. All physicians (M.D., D.O.,) and qualified oral surgeons will be granted medication ordering privileges to all classes of drugs with the following restrictions:

(a) any limitations place by DEA or DHEC restricting the ordering of any schedules of controlled substances;

(b) any limitations placed on physicians regarding a credentialing and/or recredentialing process;

- II. All dentist and podiatrists will be granted medication ordering privileges limited to those classes of drugs appropriate to their practice, with restrictions as outlined in A and B above. The drugs appropriate to their practice include: pain medication, antibiotics topical anesthetics, and steroids.

III. All CRNA's, nurse practitioners and physicians assistants will be granted medication ordering privileges limited to those classes of drugs appropriate to their practice, with restrictions as outlined in A and B. The drugs appropriate to their practice will be defined by the Pharmacy and Therapeutics Committee.

C. MEDICAL RECORDS

1. The attending practitioner will be responsible for the preparation of a complete and legible medical record. This shall include the following:
 - a) Admission history and physical that documents the patient's admitting complaint, personal history, family history, history and present illness, physical exam and plan of therapy.
 - b) consultation reports
 - c) Results of tests
 - d) Progress notes
 - e) Operative reports
 - f) Anesthesia record
 - g) Pathological findings
 - h) Discharge summary which documents the reason for admission, results of tests, summary of hospitalization, condition at discharge, follow-up recommended, discharge medications, and activity at discharge.
 - i) Autopsy results when indicated
2. The history and physical will be completed by the admitting physician within 24 hours of admission and prior to any invasive procedure. In an emergency situation when there is insufficient time prior to the procedure to record a history and physical, the pre-procedure form must be completed. If a history and physical has been completed by a physician staff member or qualified oral or maxillofacial surgeon staff member within seven days prior to admission, a durable, legible copy may be used in the patient's medical record provided any changes that have occurred are recorded in the medical record at the time of admission. The physical exam will include pertinent findings resulting from an assessment of the patient.

C.2(a) 04/03/01 INVASIVE PROCEDURES REQUIRING HISTORY AND PHYSICAL

AABBI
ANGIOGRAM
AORTOGRAM
ARTERIOGRAM
AVSHUNT, DELOT, INSERT, ETC/XR AND SDS
BIOPSIES
BLOOD PATCHES/SDS
BRONCHOSCOPY
EGD
ERCP
ENDOSCOPY
HEART CATH

Procedures requiring History and Physical Examination

OBSERVATION	Short Form Dictation	Handwritten
OUTPATIENT SURGERY	Short Form Dictation	Handwritten
ENDOSCOPY	Short Form Dictation	Handwritten
INPATIENT	Diction	
	Handwritten	
INPATIENT READMISSION	Interval note	Dictation
	Handwritten	
(within 30 days)		

INTERVENTIONAL RADIOLOGIC PROCEDURES REQUIRING ADMISSION

Short form Handwritten

OBSTETRICS (The H&P's from past offices visits are to be attached to the chart with the completed H&P)

C. SECTION	Dictation	Handwritten
TUBAL LEGATION	Dictation	Handwritten

3. Pertinent progress notes will be recorded at the time of observation sufficient to permit continuity of care with adequate documentation of significant clinical problems, evaluation and treatment of progress. Progress notes will be recorded at least daily.
4. 10/10/00 Operative reports must be recorded immediately after surgery and will include a detailed account of the findings at surgery and the details of the surgical procedure. A written operative progress note must be entered in the record immediately after surgery. The operative progress note must document the following:

04/03/01

- a) the name of primary surgeon and assistants;
- b) findings;
- c) technical procedures used;
- d) specimens removed;
- e) Pre operative diagnosis;
- f) post procedure diagnosis and
- g) Estimated blood loss

5. Verbal Orders 04/03/01 12/10/02

C.5(a) All orders for medication and treatment shall be authenticated according to the hospital policy. All medical records shall contain the orders for medication and treatment written in ink and signed and dated by the prescribing physician or by his/her designee. Signatures of other health care professionals who document in the medical record can be identified by signatures kept on file in the Director of Medical Staff Services' Office and Human Resources Department. If it is necessary to make a correction in the medical record, a single line which does not obliterate the entry should be made through the original entry and the corrected item added. This correction should be initialed and dated by the physician. If the correction is more complex than this, a cover sheet should be made outlining the details of the correction. This must be dated and signed.

✓C.5(b) 12/10/02 Telephone/Verbal orders present multiple risks for error, and should be used infrequently. Telephone / Verbal orders are to be verified by "read back" procedures, where all information regarding the order is read back to the prescriber including patient identification and critical patient data. Telephone/Verbal orders shall be properly recorded in the medical record and signed and dated by the prescriber or his/her designee within 48 hours. It is recognized that in some instances, the ordering physician may not be able to authenticate his or her telephone/verbal order (e.g., the ordering physician gives a verbal order which is written and transcribed, and then is "off duty" for the weekend or an extended period of time). In such cases it is acceptable for a covering physician to co-sign the verbal order of the ordering physician. The signature indicates that the covering physician assumes responsibility for his/her colleague's order as being complete, accurate and final as

addressed in the hospital's policy. Entries in the medical record by Allied Health Professionals are authenticated by a medical staff member as defined in the "Protocol for Practice" of the Allied Health Professional.

C.5(c) 12/10/02 A verbal order shall be considered to be in writing if given to a registered nurse, licensed practical nurse I and license practical nurse II, pharmacist, registered physical therapist, rehabilitation therapists, respiratory therapist, dietitian, or a properly credentialed allied health professional functioning within his/her scope of responsibility.

C.5(d) 12/10/02 The telephone / verbal order shall be taken by personnel qualified by hospital medical staff rules and shall include the date, time and name of persons who gave the order, and the signature of the person taking the order.

6. A final diagnosis will be recorded in the medical record at the time of discharge of the patient. When this is not possible because essential reports have not been received at the time of discharge, the diagnosis must be documented as soon as this information is available.

7. A discharge summary will be recorded on all patients except for normal obstetrical deliveries, normal newborn infants and certain selected patients with problems of a minor nature. These exceptions will be identified by the Medical Executive Committee, and, for these, a final summation note will be sufficient. In all records, the discharge summary will be adequate to justify the admission diagnosis, and explain the significant findings and procedures. A discharge summary must also contain the disposition of the patient, recommendations regarding activity, diet, medications and other pertinent instructions.

If the discharge summary cannot be recorded at the time of discharge, a final discharge progress note must be written in the medical record, to include the final diagnosis if this is not recorded on the face sheet. 6/10/03 For stays 48 hours or less, a final progress note may serve as the discharge summary providing it contains the required components.

8. 6/10/03 The medical record will be available in the HIM Department for completion one day after discharge of the patient. The record is considered complete when:

its contents reflect the patient's condition on arrival, and in-hospital progress and condition at discharge.

1. its contents reflect the patient's condition on arrival, diagnosis, test results, therapy, condition, and in-hospital progress and condition at discharge;
2. its contents are assembled and authenticated
3. and all final diagnoses and complications are recorded.

A medical record is considered to be delinquent when it has not been completed for any reason within thirty (30) calendar days following a patient's discharge. When a Medical Staff member or individual with clinical privileges has failed to complete a medical record and the record becomes delinquent, following notification his/her clinical privileges shall be automatically suspended. The suspension shall continue until all of the individual's delinquent records are completed.

Physicians on the suspension list will also forfeit privileges for scheduling inpatient and outpatient surgery, endoscopy and cardiopulmonary procedures. A physician cannot accept transfer of a patient when he/she is currently on the suspension list. Physicians who are on call must maintain their responsibilities to cover the Emergency Department but will be able to admit patients on an emergency basis only. Suspension of care will not apply to a physician's care of patients already under his/her care as inpatients.

Reinstatement of privileges shall be automatic upon completion of the delinquent records and notification to the respective areas by the Health Information Manager or designee. The Health Information Management shall be responsible for analyzing medical records for the purpose of administering this rule.

Three (3) such suspensions within a 12-month period and/or remaining on the suspension list over seven (7) days will result in automatic suspensions of hospital privileges for two (2) weeks. Reinstatement of hospital privileges will occur only upon notification to the physician by the Health Information Manager or designee. The Health Information Management Department shall be responsible for analyzing medical records for the purpose of administering this rule.

9. The Medical Record Department, under the direction of the Medical Record Committee will be responsible for analyzing medical records for the purpose of administering these rules and regulations.
10. Access to medical records will be afforded to members of the medical staff for study and research. All such projects must be approved by the Medical Executive Committee before records can be studied. Subject to approval of the CEO and GSRMC former members of the medical staff will be permitted access to information from the medical records of their patients covering periods during which they attended the patient in the hospital. The confidentiality of the medical record should be maintained at all times when records are being reviewed.

Members of the medical staff will refrain from unauthorized perusal of medical records of patients who are not under their care unless such perusal is authorized by virtue of medical staff function research study.

11. Medical records may be removed from the jurisdiction of the hospital only in accordance with a court order. Subpoena or statute. Unauthorized removal of medical records from the hospital's jurisdiction is grounds for suspension of a practitioner for a period to be determined by the Medical Executive Committee.

D. RULES OF THE DEPARTMENT OF SURGERY

1. Operative permits are required in all cases. Patients of legal age and of sound mind will sign their own permit. In cases of minors, the parents or legal guardian will sign the permit. Married minors under 18 years of age may sign their own permit.
2. A signed surgical consent will be obtained prior to the operative procedure except in those situations wherein the patient's life is in jeopardy and suitable signatures cannot be obtained due to the condition of the patient. In emergencies involving a minor or unconscious patient in which consent for surgery cannot be immediately obtained from parents, guardian or next of kin, these circumstances should be fully explained on the patient's medical record. A consultation in such instances may be desirable before the emergency operative procedure is undertaken if time permits.
10/10/00 The surgeon has to be on campus before a patient receives general anesthesia.

3. In elective surgical cases, a legible history and physical must be documented on the patient's medical record prior to the induction of anesthesia. If the history and physical is not documented, surgery will be delayed until there is a History and Physical on the chart and may be canceled if no history and physical can be obtained. The person responsible for making the decision to delay the case will be the Nursing Supervisor in the O.R.
4. In the case of a serious emergency, a comprehensive note regarding the patient's preoperative condition will be placed on the chart as soon as possible.
5. 10/10/00 A member of the anesthesia team will maintain a complete anesthesia record to include evidence of pre-anesthetic evaluation, a re-evaluation immediately prior to induction and post-anesthetic follow-up of the patient's condition.
6. All tissues and artifacts removed at the operation will be sent to a pathologist who is credentialed at this facility and who will make such examination as he may consider necessary to arrive at a tissue diagnosis. His authenticated report will be made a part of the patient's medical record. The exceptions to sending to a pathologist all specimens removed during a surgical procedure will be established by medical staff policy. The recommendation of the Joint Commission as outlined in the current Hospital Manual of Accreditation, will be followed.
7. A patient admitted for dental, oral surgery, or podiatric care is a dual responsibility involving the dentist, oral surgeon, or podiatrist and a physician member of the medical staff. 04/03/01 The admitting practitioner has the responsibility to identify the conjoint admitter within the record.

(a) Admitting practitioner's responsibilities:

- (1) A detailed dental, oral surgical or podiatric history justifying hospital admission.
04/03/01 The name of the admitting physician will be noted in the History and Physical.
- (2) A detailed description of the examination of the pertinent anatomy and a preoperative diagnosis.

- (3) A complete operative report, describing the findings and technique.
- (4) Progress notes which are pertinent to the dental or podiatric condition will be documented.
- (5) Clinical resume (or summary statement).
- (6) The discharge of the patient will be with the concurrence of the responsible physician.

(b) Physician's responsibilities

- (1) Medical history and physical examination pertinent to the patient's general health prior to anesthesia and surgery.
- (2) Supervision of the patient's general health status while hospitalized.

- (c) The discharge of the patient will be on written order of the dentist or podiatrist.

8. Oral surgeons, who are exempt from the conjoint admissions requirement mentioned above, must arrange for a physician member of the medical staff to be responsible for the general health status of the patient while hospitalized.
9. Rules for conduct of the operating suite will be formulated and posted. These rules will guide the day-to-day operation of the suite.
10. Those practitioners desiring surgical privileges and assignment in the Department of Surgery must meet the following criteria:

- (a) Those applicants who seek specialty designation in their application shall be certified or eligible for certification in the specialty for which application to the staff has made. This requirement is waived for those practitioners who are members of the Medical Staff in good standing on 2/10/98. Certification for physicians must be by an American Specialty Board recognized by the American Board of Medical Specialties 10/9/01 or their equivalent. Certification for oral and maxillofacial surgeons shall be by the American Board of Oral and Maxillofacial Surgeons.

However, this requirement may be waived for a period of (5) years for board eligible physicians who have completed training. Failure to maintain board certification after being appointed to the Medical Staff shall result in the loss of Medical Staff membership unless the practitioner demonstrates, to the satisfaction of the Board, competency equivalent to that required for board certification. Non-renewal of medical staff membership and clinical privileges because of failure to obtain board certification does not give the practitioner fair hearing rights.

- (b) The M.E.C. may recommend to the Board under unusual and exceptional circumstances certain well qualified physicians who may not meet all qualifications for staff membership.

E. RULES OF THE DEPARTMENT OF MEDICINE

1. Those new applicants applying for privileges in the Department of Medicine, specifically in the fields of general practice and emergency medicine, must have, in addition to one year of satisfactory postgraduate training following medical school training, 2 years of satisfactory formal training in an approved program OR three years of satisfactory practice in the area of desired privileges. The Department of Medicine, at a valid departmental meeting, may grant an exception to this standard by a majority vote.
2. Those new applicants who seek specialty designation in their application shall be certified or eligible for certification in the specialty for which application to the staff has been made. This requirement is waived for those practitioners who are members of the Medical Staff in good standing on 2/10/98.

Certification for physicians must be by an American specialty Board recognized by the American Board of Medical Specialties 10/09/01 or their equivalent. Certification for oral and maxillofacial surgeons shall be by the American Board of Oral and Maxillofacial surgeons.

However, this requirement may be waived for a period of (5) years for board eligible physicians who have completed training. Failure to maintain board certification after being appointed to the Medical Staff shall result in the loss of Medical Staff membership unless the practitioner demonstrates, to the satisfaction of the Board, competency

equivalent to that required for board certification.

3. The M.E.C. may recommend to the Board under unusual and exceptional circumstances certain well-qualified physicians who may not meet all qualifications for staff membership.
4. Those new applicants who desire to perform invasive procedures must demonstrate to the Credentials Committee that they have had adequate training and experience to perform said invasive procedures.

F. RULES REGARDING THE OBSTETRICAL SUITE

1. Rules governing the conduct of the obstetrical suite will be formulated, posted, and adhered to.
2. 2/20/01 Medical Screening
A registered nurse with demonstrated competency in obstetrics nursing may perform a medical screening examination in the Labor and Delivery Unit as per approved protocol. These personnel must also be functioning within the scope of their license and in compliance with state law and applicable state nurse and medical practice acts.

G. EMERGENCY SERVICES

1. The medical staff will provide coverage in the emergency services area. This will be in accordance with the hospital's basic plan for the delivery of such services. A monthly call schedule will be posted by all clinical services.
2. The policies and procedures for the emergency area will be defined in a procedure manual relating specifically to this outpatient facility. The policies and procedures will be reviewed and approved at least annual by the Chief of Staff and the Board of Trustees.

3. When a practitioner reaches an age specified below and has served on the active staff of GSRMC for the corresponding number of years according to the table for that age, he may be allowed to voluntarily discontinue emergency room call for unassigned patients. Time served at Ocean View Memorial Hospital will count as service to GSRMC.

<u>AGE</u>	<u>YEARS SERVICE</u>
55	15
56	14
57	13
58	12
59	11
60	10
61	9
62	8
63	7
64	6
65	5

All other members of the active staff must serve. All practitioner's applying for active staff privileges, regardless of age, will be required to serve a minimum of five years on emergency room call. 4/11/2000 The practitioners call responsibility shall be offered equally to any willing practitioners in the same specialty.

10/12/99 The call responsibility transfer will be in writing by the accepting physician until further notice. This does not apply to occasional days the provider will cover for members in their own call group. Should the accepting physician decide that he/she, in the future does not want to take on this call responsibility, it will again be the responsibility of the original active staff member to assume that call or transfer it to another willing provider in the same specialty.

4. An appropriate medical record will be kept for every patient receiving emergency service and will be incorporated in the patient's hospital record, if admitted. The record will include:

- (a) Adequate patient identification
- (b) Information concerning the time of the patient's arrival, means of arrival, by whom transported, and time of discharge
- (c) Pertinent history of the injury or illness including details relative to first aid or emergency care given the patient prior to his arrival at the hospital
- (d) Description of significant clinical, laboratory and roentgenologic findings
- (e) Diagnosis
- (f) Treatment given
- (g) Condition of the patient on discharge or transfer
- h) Final disposition, including instructions given to the patient and/or his family, relative to necessary follow-up care.

- 5. Each patient's medical record will be signed by the practitioner in attendance who is responsible for its clinical accuracy.

H. GENERAL RULES OF THE MEDICAL STAFF

- 1. A physician on the active staff will maintain a permanent office for the practice of medicine twelve months per year, unless exempted by the executive committee.
- 2. Each request for medical staff membership will be decided on a case by case basis taking into consideration the practitioner's capability to respond to an emergent request which is reasonably expected to be within one (1) hour and the ability to provide continuing care to his or her patients.
- 3. The executive committee alone decides if a physician lives "close enough to the hospital to provide continuous care to his hospitalized patients."
- 4. An individual applying, or reapplying, for active staff privileges may be required by the credentials committee or the executive committee to submit to a physical examination

**GRAND STRAND REGIONAL MEDICAL CENTER
POLICY AND PROCEDURE**

TITLE: TRIAGE

FORMULATED BY: EMERGENCY DEPARTMENT

CATEGORY: PATIENT CARE

APPROVED BY: EMERGENCY DEPARTMENT MEDICAL DIRECTOR
EMERGENCY DEPARTMENT NURSE MANAGER

EFFECTIVE DATE: JANUARY 2001

Original Date: April 1988
Replaces:

POLICY:

It is the policy of Grand Strand Regional Medical Center to provide emergency care to all patients in need. All patients presenting to the Emergency Department requesting emergency care will be afforded triage and medical screening service by a Registered Nurse. This will not be delayed to obtain demographic or financial information.

PURPOSE:

The purpose of triage is to determine appropriate treatment priorities.

PROCEDURE:

- I. **The triage nurse's responsibility is to:**
- A. Assess patients for the priority of care as they arrive
 - B. Assign the patient to the appropriate treatment area and notify the zone nurse of patient arrival.
 - C. Remain aware of arriving patients and patients waiting in the waiting room whose status may change and need more rapid treatment.
 - D. Evaluate the patient to see if he/she could wait to be triaged or if he/she need immediate attention
 - E. Perform triage interview and document:
 - 1. Patient complaint, vital signs, allergies, past medical history, medications, patient's family physician, weight and immunization status on pediatric patients, tetanus status when applicable, and other pertinent history.
 - 2. Ask about TB screens and allergies to Latex.
 - F. Administer medication when indicated by established protocols (antipyretics).
 - G. Designate priority of care (emergent, urgent, non-urgent)

- H. May direct family or patient to registration (after triage).
- I. Assist family members with questions and concerns about patients.
- J. Notify charge nurse for assistance when census dictates.
- K. Triage will be operational 24 hours/day.

II. Triage is incorporated into several classifications:

A. Emergent - Immediate Care, Life Threatening Conditions:

1. Airway and breathing difficulty or arrest
2. Cardiac arrest
3. Irregular pulse with symptoms
4. Status seizure
5. Uncontrolled bleeding or hemorrhage
6. Temperature > 103 degrees F in pediatric patients
7. Temperature > 104 degrees F in adult patients
8. Shock
9. Drug overdose with symptoms
10. Acute chest pain with dyspnea
11. Unconscious, unresponsive, altered LOC
12. Obvious multiple injuries or trauma
13. Acute allergic reaction
14. Testicular pain
15. Third degree burns to large area
16. CVA / TIA with neurologic deficit
17. Active labor
18. Foreign, chemical substance or trauma to the eye
19. Complicated childbirth
20. Chest or abdominal trauma
21. Femur fractures

B. Urgent - Major Injury or Illness but Stable:

1. First or second degree burns
2. Severe pain
3. Chest pain, sharp non-cardiac
4. Obvious fractures
5. Persistent nausea with vomiting and diarrhea
6. Temperature > 102 degrees F
7. Headaches
8. Open wounds
9. Patients with cardiac history, regardless of complaint
10. Cancer patients presenting with fever
11. Upper respiratory complaints with productive cough and SOB

C. Non-Urgent - Minor Injury or Illness and Ambulatory

1. Cough, non-productive
2. Minor burns
3. Sprains and strains
4. Minor complaints of pain and pain for over 36 hours
5. Minor lacerations with bleeding controlled
6. Suture removals

7. Rechecks
8. Medication refills
9. Chronic back pain without neurologic deficit

III. Qualifications of the Triage Nurse:

- A. Licensed Registered Nurse in the state of South Carolina.
- B. ACLS preferred.
- C. Six months experience in the Emergency Department at Grand Strand Regional Medical Center preferred.
- D. Demonstrated ability to accurately elicit chief complaint, prioritize care needs, assign patients to appropriate area to receive immediate intervention/treatment as needed.

**GRAND STRAND REGIONAL MEDICAL CENTER
POLICY AND PROCEDURE**

TITLE: DISCHARGE INSTRUCTIONS

FORMULATED BY: EMERGENCY DEPARTMENT

CATEGORY: PATIENT CARE

APPROVED BY: EMERGENCY DEPARTMENT MEDICAL DIRECTOR
EMERGENCY DEPARTMENT NURSE MANAGER

APPLIES TO: EMERGENCY DEPARTMENT

EFFECTIVE DATE: JANUARY 2001

POLICY:

Each patient and/or significant other discharged from this department, will express an understanding of the treatment incurred while a patient in the ED, medications with side effects, diagnosis, follow-up care, the name (s) or physician (s) who treated them, referrals to other physicians or facilities, the name and phone number of this facility. The written instructions will be EPIC discharge instructions.

PURPOSE:

To ensure patients/significant others leaving the ED have an understanding of the care they received, prescribed medications and follow-up care.

PROCEDURE:

- I. Patient and/or significant other will verbalize and/or demonstrate understanding of discharge instructions, medications, and follow-up care.
- II. Patient and/or significant other will receive EPIC written instructions appropriate to their care.
- III. ED nurse or physician will witness patient/significant other signature on EPIC instructions.
- IV. In the absence of prescribed EPIC instructions, the nurse will choose the appropriate instructions from the system.
- V. The ED nurse will document on the patient care record that instructions were explained and a written copy given to the patient and/or significant other.

GRAND STRAND REGIONAL MEDICAL CENTER
POLICY AND PROCEDURE

TITLE: Discharge Criteria
FORMULATED BY: Emergency Department
CATEGORY: Patient Care
APPROVED BY: Emergency Department Medical Director
Emergency Department Nurse Manager
APPLIES TO: Emergency Department
EFFECTIVE DATE: January 2001

POLICY:

Patients, who do not meet criteria for admission or are deemed stable for discharge by the physician, will be discharged from the ED. Each discharged patient will be given Epic instructions regarding:

- Diagnosis and the care for that problem
- Medication and their side effects
- Referral to their family physician with their phone number
- Referral to an on call physician if the patient doesn't have a family physician with their phone number
- Any additional comments i.e., return if any problems or condition gets worse

PURPOSE:

To meet Joint Commission Requirements.

LAW OFFICES
MCCUTCHEEN BLANTON JOHNSON & BARNETTE, LLP

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THOMAS S. WHALEY
(1888-1988)

JAMES E. BRIDGES, JR.
(1888-1988)

June 10, 2004

Behavioral Health Care of Cape Fear Valley Health System Outpatient Services
Attn: Records Department
1830 Owen Drive
Fayetteville, NC 28304

In Re: *Kelly Fay*
Our File No.: 0-781

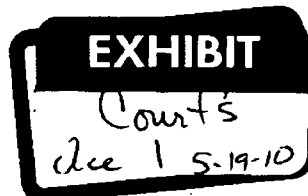
Dear Records Custodian:

Please be advised that we represent Sean D. Fay, as Personal Representative of the Estate of Kelly L. Fay. Enclosed please find a HIPPA medical authorization as well as the Certificate of Appointment appointing Sean D. Fay as Personal Representative for the Estate of Kelly L. Fay. If you would kindly forward a complete certified copy of Mr and Mrs. Fay counseling records along with an invoice reflecting payment for same, it would be greatly appreciated. If you have any further questions, please do not hesitate to contact my office.

With kindest regards, I remain,

Sincerely yours,
Lori D. Torbett
Lori D. Torbett
Paralegal to Ruskin C. Foster

/sdt
Enclosures



PI 464

425189

McCutchen Blanton Johnson & Barnette, L.L.P.
P.O. Drawer 11209
1414 Lady Street
Columbia, South Carolina 29211-1209
(803) 799-9791
(803) 253-6084-Fax

HIPAA AUTHORIZATION FORM

Note: This is NOT a form to be simply adopted and used without further review. It is not endorsed by anyone and is not to be construed as legal advice. It does not necessarily reflect every component that should or should not be in a specific providers authorization form, in light of its own circumstances. It is not necessarily in compliance with what is additionally required under any particular providers state law. Each facility should consult with its legal counsel regarding finalizing an authorization form.

I hereby authorize use or disclosure of protected health information about me as described below

1. The following specific person or class of persons or facility is authorized to make the requested use or disclosure:
McCutchen Blanton Johnson & Barnette
Behavioral Health Care of Cape Fear Valley Health

2. The following person or class of persons may receive disclosure of protected health information about me:

His/her/its name is: Kelly L. Fay

His/her/its address is: 3582 Evergreen Way, Myrtle Beach, SC 29577

3. The specific information that should be disclosed is: A complete copy of all medical records, physicians' notes, discussions with physicians and/or medical providers, nurses' notes, hospital records, progress reports, prescriptions, invoices, statements and bills for all services previously provided to Kelly L. Fay.

4. I understand that the information used or disclosed may be subject to re-disclosure by the person or class of persons or facility receiving it, and would then no longer be protected by federal privacy regulations.

5. I may revoke this authorization by notifying Behavioral Health Care in writing of my desire to revoke it. However, I understand that any action already taken in reliance on this authorization cannot be reversed, and my revocation will not affect those actions. I understand that the medical provider to whom this authorization is furnished may not condition its treatment of me on whether or not I sign the authorization.

6. This authorization expires on _____, 2003, OR upon occurrence of the following event that relates to me or to the purpose of the intended use or disclosure of information about me: For Litigation Purposes

THIS FORM MUST BE FULLY COMPLETED BEFORE SIGNING.

Signature of Individual
(The person about whom the information relates)

Date of Individual's Signature

DOB: 2/25/76 SS#: 387-22-2325
Date of Birth or Social Security Number

- OR, if applicable -

Sean D. Fay 10-4-03 Personal Representative
Signature of Guardian or Date of Guardians/Personal Description of Guardians/Personal
Representative of Patient's Estate Representative's Signature Representative's Authority
to Act for the Individual

A copy of this completed, signed and dated form must be given to the Individual or person signing on the Individuals behalf.

PI 465

STATE OF SOUTH CAROLINA
COUNTY OF HORRY

PROBATE COURT

IN THE MATTER OF KELLY LYNN FAY

ASE NUMBER 2003ES2600208

CERTIFICATE OF APPOINTMENT

This is to certify that
SEAN D FAY

is the duly qualified

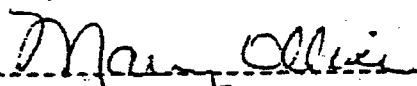
PERSONAL REPRESENTATIVE

in the above matter and that this appointment, having
been executed on the 12th day of FEBRUARY , 2003, is
now in full force and effect, including authorization
to receive all monies, income, principal, interest &
dividends of and belonging to said estate.

RESTRICTIONS:

Executed this 12th day of FEBRUARY , 2003.

Do not accept a copy of this
certificate without the raised
seal of the Probate Court.



MARY OLLIVER, ADMINISTRATIVE ASST
Horry County Probate Court

PI 466

Form #141pc(1/91)

☐ 15m ☐ 30m ☐ 60m Other _____ ☐ Medication Management ☐ Individual ☐ Family _____ Members ☐ Telephone ☐ Group ☐ Consult

PRESENTING PROBLEM/SESSION SUMMARY:

*Therapist discharge pt because he has
not returned call (5/23/00) and
asked for more session.*

MENTAL STATUS (Circle Applicable Response)

APPEARANCE: neat/clean unkempt overweight under-nourished other: _____

ATTENTION/CONCENTRATION: normal other: _____

SPEECH: normal other: _____

MOOD & AFFECT: normal depressed flat labile anxious agitated euphoric other: _____

THOUGHT PROCESSES: normal looseness poverty of thought flight of ideas thought blocking obsessions
compulsions other: _____

PERCEPTIONS: undistorted hallucinations-auditory visual tactile olfactory other: _____

ORIENTATION: person place time situation other: _____

MEMORY: intact impaired-recent remote other: _____

JUDGEMENT&INSIGHT: good limited poor other: _____

SUICIDAL/HOMICIDAL RISK: no yes - ideation plan recent attempt past attempts self mutilating assaultive

SUBSTANCE ABUSE/USE: _____

DIAGNOSTIC IMPRESSION: _____

AXIS I: _____

AXIS III: _____

AXIS IV: _____

AXIS II: _____

AXIS V: CURRENT GAF: _____ LAST YEAR GAF: _____

PLAN/FOLLOW UP: _____

SIGNATURE/TITLE: *Al Panter LHC, LMSW* DATE: *7/24/00*

PROGRESS NOTE



Behavioral Health Care
of Cape Fear Valley Health System™

Patient Name: *Kelly Fay*
Medical Record #: *42 518T*

PI 468

Bordeaux Center

NT NAME: Kelly FAY
SE DATE: 5/23/01

MEDICAL RECORD #: 42 52 89

15m 25m 30m 40m 60m Other ☐ Medication Management ☐ Individual ☐ Family ☒ Members ☐ Telephone ☐ Group ☐ Consult

MENTAL STATUS

RANGE: neat clean unkempt overweight under nourished Other: _____

TION/CONCENTRATION: normal Other: _____

H: normal Other: _____

& AFFECT: normal depressed flat labile anxious agitated euphoric Other: _____

THT PROCESSES: normal looseness poverty of thought flight of ideas thought blocking obsessions
Compulsions Other: _____

PTIONS: undistorted hallucinations - auditory visual tactile olfactory

TATION: person place time situation

RY: intact impaired: recent remote

IENT & INSIGHT: good limited poor

IAL/HOMICIDAL RISK: no yes: ideation plan recent attempt past attempts self mutilating assaultive

ANCE ABUSE/USE: _____

ENDING PROBLEM/SESSION SUMMARY/PLAN:

Thought left means a pt. with
Ourselves making reports proper.

IOSTIC IMPRESSION:

AXIS III:

PI 469

AXIS IV:

II:

AXIS V: CURRENT GAF:

LAST YEAR GAF:

OW UP:

ATURE/TITLE:

Alvin's CAC, 1/1/01

DATE:

5/23/01

PROGRESS NOTE

Therapist Progress Note

DATE: 15" 30" 60" 90" OTHER___ IND COUPLE FAMILY___ MEMBERS

1/4/02

Therapist left message on cell
answering machine re progress + asked her
to call back.

Al Vester CPC, LMSW

FOLLOW UP:

SIGNATURE:

DATE: 15" 30" 60" 90" OTHER___ IND COUPLE FAMILY___ MEMBERS

P1470

FOLLOW UP:

SIGNATURE:

 **Behavioral Health Care**
of Cape Fear Valley Health System
Melrose Center • Boulevard Center • Lenoirburg Center

Patient Name: Kelly Fay

Chart #: 425189

Therapist Progress Note

DATE: 15" 30" 60" 90" OTHER IND COUPLE FAMILY MEMBERS

Date: 2/23/00 60 Min Fam Client and Spouse

P: Depression: Client sleep is good, appetite good, energy level is good and interest in usual activities is normal. Client more angry and uncomfortable at work where spouse's girl friend works.

I: Therapist used cognitive therapy to help client and spouse increase calmness at work.

E: Client decided to write a letter sharing her feelings to send to the other woman. Client will present to therapist next week. Client also worked on changing her self talk to replace angry hurt feelings with calmness. Both agreed to reach out to children of other woman because of their strong bond before affair.

Task: Write letter.

Follow UP: Wed 2/23/00 5pm Al Peuster LPC LMFT

Al Peuster LPC LMFT

FOLLOW UP:

SIGNATURE:

DATE: 2/23/00 15" 30" 60" 90" OTHER IND COUPLE FAMILY MEMBERS

Client called & cancelled.

Al Peuster LPC, LMFT

P1471

FOLLOW UP:

SIGNATURE:

Behavioral Health Care
of Cape Fear Valley Health System
Melrose Center • Bordeaux Center • Laurinburg Center

Patient Name:

Kelly Fay

Chart #:

425189

Therapist Progress Note

DATE: 1/12/00 15" 30" ~~60"~~ 90" OTHER___ IND COUPLE FAMILY___ MEMBERS

P. dx in Depression: crying, sleep, mood, appetite normal. Client has anger at husband for affair, but trust S. Spouse on computer 7 hrs + at work 7.

I. Therapist used brief therapy to help client + spouse mental reconciliation

E. Client was able to ask spouse question but client's spouse refused to answer question about affair except to give final. Spouse agreed to spend more time to client + client agreed not to "keep thinking about it."

FOLLOW UP: Will call

SIGNATURE: *[Signature]* LPC, LMFT

DATE: 15" 30" 60" 90" OTHER___ IND COUPLE FAMILY___ MEMBERS

FOLLOW UP:

SIGNATURE:

PI 472

 **Behavioral Health Care**
of Cape Fear Valley Health System
Mebane Center • Bordeaux Center • Lenoir County Center

Patient Name: Kelly FAU

Chart #: 425189

MEDICAL RECORD

Behavioral Health Care of Cape Fear Valley Health System, Inc. Fayetteville, N.C.

Bordeaux Center

PATIENT NAME: FAY, KELLY L.
DATE OF EVALUATION: 12/29/1999

MEDICAL RECORD #: 42-51-89
AGE: 23

REFERRAL: Rose Calhoun.

IDENTIFYING INFORMATION: White female, married for five years. *she is* Lives with her husband here in Fayetteville, North Carolina.

CHIEF COMPLAINT: The patient states that she has been devastated and experiencing crying spells, upon finding out that her husband had an affair with a "friend" which all of them work together and live within two blocks of each other.

HISTORY OF PRESENT ILLNESS: The patient states that her present *symptoms* *ca 1/1/00* have begun since finding out that her husband had an affair that has been going on for approximately six months and which he told her about a week before Christmas. The patient states that she has been having crying spells on a regular basis, has great difficulty concentrating at work. She experiences headaches, nausea, diarrhea and worries. The patient worries about the welfare of her marriage.

PAST HISTORY: The patient reports that in July of 1998, she saw Dr. Kommu because she was experiencing irritability, which she stated began with her job at Cape Fear in March of 1999. The patient was placed on Prozac 20 mg once a day. The patient states that this has made a drastic difference in her life and that her outbursts and irritability have ceased. No other prior psychological history is reported.

FAMILY/SOCIAL HISTORY: The patient is the oldest child. The patient has a sister one year younger and a brother two years younger. The patient states that her father and mother divorced when she was 6 years old. She says that she can remember very little about her dad and her mother, as far as how they handled conflict or showed affection. The patient states that her mother was remarried when she was 8 years old. She says that her stepdad "is wonderful" and he and her biological dad are "good buddies" now. The patient states that her mother has been an alcoholic all of her life, but that the alcoholism increased drastically when the patient was 16 years old. The mother continues to drink, but tries to hide, but will call the patient inebriated. The patient reports that her grandparents on her father's side both were alcoholics and the grandfather on her mother's side was an alcoholic. In addition, the patient's mother was overweight from childhood and not until approximately 4 or 5 years ago, did she loose her weight. The patient states "my mom is beautiful now."

The patient states that her mother and stepfather were not affectionate to each other, nor to her. Her mother occasionally, but her dad was "a blue collar worker" and more reserved. The patient states that her stepdad handles conflict by being quiet, where as her mother becomes very boisterous, will make a scene and be obnoxious.

The patient states that she rarely was disciplined because she and her siblings seemed to respect their parents and did not want to do anything to bother them, and especially did not want to make their mother come to school and make a scene. The patient states that she and her siblings would be embarrassed if her mother would come to school.

The patient states that she began working along with her sister when she was 14 years old and had to do this because her mother and stepdad were very "stingy" with the money. The patient states that she and her sister, however, became very hurt when they gave their younger brother many things.

The patient reports that she believes her mother drinks because her mother had an affair in the first part of the marriage with her biological father, that she wanted to live on the wild side for awhile and chose not to back to the

NEW PATIENT EVALUATION

PI 473

MEDICAL RECORD

Behavioral Health Care of Cape Fear Valley Health System, Inc. Fayetteville, N.C.
Bordeaux Center

FAY, KELLY L.

Page 2

patient's biological father. The patient believes that her mother regrets having made that decision, even though she has a good relationship with her present husband.

The patient reports that she has "a lot of positive memories." One was at 14 years old was awarded a volleyball trophy. She remembers happy days in childhood. She states that she was a leader and other kids came to play with her a lot. Also, family vacations are a positive memory. Negative memories are one, when her aunt, her mother's sister, was killed by a drunk driver when she was 6 years old, this was the same year that her mother and father divorced. The patient believes that her aunt, who died at 23, was robbed of her life. Second negative memory is when her grandfather experienced a heart attack at Christmas upon she, the patient, unwrapping a Christmas present from her mother, which turned out to be a book that she already had in her possession. The patient states that her mother slapped her in the face and shortly after, the grandfather had a heart attack. The grandfather lived through it. The third negative memory was her parent's divorce. She said that her father suffered depression during that time.

Upon thinking about her positive and negative memories and events in her life, the patient realized that she has made the following decisions, one that she would not drink. Two, that she would be a hard worker. She says that both her father and biological father are hard workers. Also, she decided that she would have a good heart towards people and not be stingy.

The patient graduated from high school, went to college for one year. The patient states that this was a very lonely experience for her. She said that she had a roommate who was "straight from hell." The patient mothered her, but the roommate did not want to be mothered. The patient states that she married her husband the next year, moved to Fayetteville to attend Methodist College, received her Associate Degree and she and her husband both have "good jobs" at Cape Fear Hospital. The patient states that the first time there were problems in the marriage was this summer when her husband said "I want to leave." The patient stated that her husband said that things were just not the way they used to be. In order to help with the situation, because the patient was aware that she was irritable, she went to receive help from Dr. Kommu.

ACTIVE MEDICAL PROBLEMS: None.

ALLERGIES: NONE.

HABITS: None.

FAMILY PHYSICIAN: Dr. Kommu.

CURRENT MEDICATIONS:

1. Prozac 20 mg once per day.
2. Desogen birth control pill once a day.

OTHER RELEVANT PAST MEDICAL HISTORY: None.

MENTAL STATUS EXAMINATION

APPEARANCE: The patient appears as an energetic, attractive 23-year-old female.

NEW PATIENT EVALUATION

PI 474

MEDICAL RECORD

Behavioral Health Care of Cape Fear Valley Health System, Inc. Fayetteville, N.C.
Bordeaux Center

FAY, KELLY L

Page 3

POSTURE: The patient sits erect.

DRESS/GROOMING: The patient is neatly dressed and groomed.

MOVEMENTS/MANNERISMS: Nothing unusual observed.

SPEECH: The patient speaks in normal rate, tone and volume.

MOOD: Anxious, angry.

AFFECT: Appropriate.

THOUGHT PROCESSES: The patient's thought processes are normal with no signs of impaired consciousness, intelligence or abstract thinking.

THOUGHT CONTENT: The patient worries about her marriage and about the affair that has occurred.

PERCEPTIONS: No illusions or hallucinations.

ORIENTATION: The patient is fully oriented.

MEMORY: No memory problems observed or reported.

ATTENTION/CONCENTRATION: The patient has difficulty focusing.

GENERAL FUND OF INFORMATION: Average.

INTELLIGENCE: Average.

INSIGHT: Intact.

JUDGMENT: Intact.

DIAGNOSIS:

AXIS I: Code 309.0. Adjustment disorder with depression.

AXIS II: No diagnosis.

AXIS III: No diagnosis.

AXIS IV: Marital infidelity.

AXIS V:

CURRENT GAF: 60

LAST YEAR'S GAF: 80

NEW PATIENT EVALUATION

PI 475

MEDICAL RECORD

Behavioral Health Care of Cape Fear Valley Health System, Inc. Fayetteville, N.C.
Bordeaux Center

FAY, KELLY L

Page 4

TREATMENT PLAN

LAB: N/A.

MEDICATIONS: Per continued consultation with Dr. Kommu.

THERAPY: Individual/family therapy one time a week. Goals of therapy will be:

1. To assist the patient in maintaining a positive, content, relaxed mood.
2. To increase the patient's communication and problem solving skills.

FOLLOW UP: Wednesday, January 12, 2000 at 6 p.m.


ALFRED PEUSTER, LPC, LMFT

AP/ah
d: 12/30/1999 t: 12/31/1999 11:38 A
Document #: 133421

NEW PATIENT EVALUATION

PI 476

ROA_1074

Could you ask the
Judge to provide us
with the exact
legal definition of
"proximate cause"

EXHIBIT

Courts

Dec 4

5-23-10

Michael Walden

We have a question regarding Question 5, which deals with attributing percentages, etc.

There are two (2) spaces for inscribing percentages, one (1) for the Plaintiff and one (1) for the Defendants. The language of the question, though, is "what percentage is attributable to each of the Defendants" with only one space to put a figure, doesn't it mean (needs) both Defendants? Advise, please.

EXHIBIT

6
Dec 5-28-10

Michael Walden

PLAINTIFF, AND IT IS IMPOSSIBLE TO DETERMINE THE PROPORTION EACH CONTRIBUTED TO THE INJURY, NO PERSON BE RESPONSIBLE FOR THE WHOLE INJURY, EVEN IF NO PERSON'S ACT ALONE MIGHT NOT HAVE CAUSED THE INJURY OR THE SAME DAMAGE MIGHT HAVE RESULTED FROM THE ACT OF THE OTHER TORTFEASORS.

IF YOU SHOULD FIND FROM THE EVIDENCE THAT MORE OF THE DEFENDANTS WERE NEGLIGENT THAN FEWER, THE NEGLIGENCE OF EACH SUCH DEFENDANT WAS A PROPORTION OF THE INJURY CLAIMED BY THE PLAINTIFF, THEN YOU SHOULD RETURN A VERDICT IN A SINGLE SUM FOR SUCH DAMAGES AS YOU DETERMINE TO BE DUE AGAINST ALL THE DEFENDANTS WHO FIND LIABLE FOR SUCH DAMAGES.

We are at a point where
we can "agree" on something
in the next 20 minutes or
so. We have some ways to
go and think starting
anew in the morning
might be best. Is that
okay?

EXHIBIT

for 5-27-10

Michael Walden.

PROXIMATE CAUSE

FINALLY, THE PLAINTIFF MUST PROVE THAT THE DEFENDANT'S NEGLIGENCE PROXIMATELY CAUSED THE PLAINTIFF'S DAMAGES.

PROXIMATE CAUSE IS SOMETHING THAT PRODUCES A NATURAL CHAIN OF EVENTS THAT, IN THE END, BRINGS ABOUT THE INJURY. IT IS THE DIRECT CAUSE OF THE INJURY.

TO PROVE THAT THE DEFENDANT'S NEGLIGENCE PROXIMATELY CAUSED THE PLAINTIFF'S INJURY, THE PLAINTIFF MUST FIRST PROVE CAUSATION IN FACT. THIS IS PROVEN BY SHOWING THAT THE INJURY WOULD NOT HAVE OCCURRED BUT FOR THE DEFENDANT'S NEGLIGENCE.

THE PLAINTIFF MUST ALSO PROVE LEGAL CAUSE. LEGAL CAUSE IS PROVEN BY SHOWING THAT THE INJURY WAS FORESEEABLE. THIS MEANS THAT THE INJURY OCCURRED AS A NATURAL AND PROBABLE CONSEQUENCE OF THE DEFENDANT'S NEGLIGENCE. THE PLAINTIFF MUST PROVE THAT SOME INJURY FROM THE DEFENDANT'S NEGLIGENCE WAS FORESEEABLE, BUT DOES NOT HAVE TO PROVE THAT THE PARTICULAR INJURY THAT OCCURRED WAS FORESEEABLE. HOWEVER, THE DEFENDANT

CANNOT BE HELD RESPONSIBLE FOR SOMETHING WHICH COULD NOT BE EXPECTED TO HAPPEN.

SOMETIMES A DEFENDANT'S NEGLIGENCE WILL COMBINE WITH OTHER FORCES, SUCH AS ACTS OF NATURE, TO BRING ABOUT A RESULT. THE LAW DOES NOT REQUIRE THAT A DEFENDANT'S NEGLIGENCE BE THE ONLY CAUSE OR THE SOLE CAUSE OF THE INJURY. A DEFENDANT MUST COMPENSATE THE PLAINTIFF IF ONE OR MORE OF HIS NEGLIGENT ACTS OR OMISSIONS WAS AN EFFICIENT CAUSE OF THE INJURY AND COMBINED WITH OTHER EFFICIENT CAUSES IN SUCH A WAY THAT HAD THERE BEEN NO NEGLIGENT ACTS OR OMISSIONS, THE INJURY EITHER WOULD NOT HAVE RESULTED OR WOULD NOT HAVE BEEN AS SEVERE.

PROXIMATE CAUSE DOES NOT MEAN THE ONLY CAUSE OR THE SOLE CAUSE OF A CONDITION. THE DEFENDANT'S ACT CAN BE A PROXIMATE CAUSE OF THE PLAINTIFF'S INJURY IF IT WAS AT LEAST ONE OF THE DIRECT, CONCURRING CAUSES OF THE INJURY.

IF THE CONCURRENT OR SUCCESSIVE NEGLIGENT ACTS OR OMISSIONS OF TWO OR MORE PERSONS OR ENTITIES, ALTHOUGH ACTING INDEPENDENTLY OF EACH OTHER, ARE, IN COMBINATION, THE DIRECT AND PROXIMATE CAUSE OF A SINGLE INJURY TO THE

June 18, 2007

SeanFay.com

About Me

Sean's Daily Drivel Archives

Sunday, January 27, 2002

Family

Kelly update ±

Career

It's 7:20 p.m. Sunday night and she's feeling better after today's scare. She's been able to sleep and drink some and that has really helped. We'll see how it goes overnight.

Hobbies

Sean posted this on 01/27/02 at 19:25:53

1 Comment (Judy & Calvin Bergeron, you?)

Photos

Poor Kelly... ±

Saturday morning I was awoken by my wife who was in major pain. We quickly concluded the pain was similar to a kidney stone she has last year. So we packed up and headed out to the Emergency Room just a few minutes down the road. In record time, we check and saw the doctor. On a side note, Kelly and I worked for Cape Fear Valley Health System for three years. And in our experience it took on average, 3 hours before you would see a doctor and 6 hours before you were out. Well, we saw a doctor within 2 minutes and were out in 3 hours. So that was a big shock.

After an x-ray and a cat scan, it was determined that Kelly had a very large stone, one that would probably require Lithotripsy. The Urologist being the great, all helpful doctor he is, said she would have to wait until Monday (read: lazy bastard). They packed her up and shipped her home with a nice, shinny prescription where in my hell started.

Kelly was tired, getting sick and running a high fever. This morning she woke me screaming that she was shaking uncontrollably. And was she ever...major fever, then major hot flash, then major fever again. End result is we don't know what happened but she's finally resting. It's possible she did pass the stone, I sure hope so. She looks like she's in so much pain but on the road to recovery. I'll be sure to thank the Urologist for nothing. Bastard...

(P.S. It was a 5 millimeter stone. One of the largest the ER doc has seen. And Kelly is only 25! And yes, she drinks lots of water.)

Site Links

Today's
Ramblings
Past Ramblings

Cool Blogs

Gretchen
Will Weaton

Web Cam



XML

Sean posted this on 01/27/02 at 13:15:45

No comments

Site Updates +

Okay, okay...so I couldn't go to bed, sue me! I have the template where I'm happy and I'm going to leave it where it is for the most part. I'll add the links from the site to here and poof...we're live.

On a side note, I will be updating the web site. A lot of information needs to be updated. I'll try to update some tomorrow and over the next two weeks. My job information is months old. Currently, I'm working for a large golf/hotel chain thingy... Here are the web sites I designed: Legends Golf and Sands Resorts. Both are live and Sands Resorts is the big ecommerce site of the two and I'm pretty proud of the business it's doing.

Sean posted this on 01/27/02 at 04:22:33

1 Comment (Chad, you?)

My opening blog.... +

For some reason I felt compelled to write about my daily actives. Okay..well, sort of a lie. I saw everyone else doing it so I wanted too. I think Gretchen is mainly the one to blame. I enjoy reading her daily blog and perhaps blogging is her way to cope with the pressures of life. And, well, I need someone to shift blame to when I'm running behind on something and I'm too busy blogging. Thanks Gretchen, you're a real trooper!

I've got a lot more to write but it's late, I can't get the template just right and so the hell with it for now. I'll return tomorrow with everything just so and tell you about my exciting weekend...oh...bet you can't wait!

Sean posted this on 01/27/02 at 03:55:39

No comments

SeanFay.com

June 18, 2007

[About Me](#)[Journal](#)[Photos](#)

Thursday, February 28, 2002

Thank you, Thank you!

I want to thank everyone who took the time to stop and write Kelly birthday wishes. It's been really touching to read all of your comments and I can't thank you enough. I know she'd be embarrassed reading all the comments and hearing how loved she was by all.

She was a very special person. I'm just so happy that she was able to touch so many lives like she did in such a short time.

I love you Kell!

Sean posted [this](#) on 02/28/02 at 01:38:07.

[No comments](#) from the peanut gallery!

Monday, February 25, 2002

Birthday Wishes

Kelly wasn't someone who needed a lot of material things in life but she did like getting birthday wishes. So if you would like to post some [Birthday Wishes to Kelly](#), just click the link. I'm sure she'll love reading them in heaven. :-)

Sean posted [this](#) on 02/25/02 at 11:09:41.

[No comments](#) from the peanut gallery!

Kelly in the news

A little while back I said that the Fayetteville Observer was going to do a story on Kelly. Well they did and it was great! It was a real tribute to the kind of person she was and I'm SO proud of her. Hopefully soon I'll be able to scan and post it online.



My current mood?

Site Links

[Current Ramblings](#)[Past Ramblings](#)[Other Links](#)

While browsing around the Net, I found another article that Kelly was in. It was by the Charleston Gazette and featured information about staying in Myrtle Beach. Kelly is quoted heavily in the piece and well...it really shows her intelligence about the hotel biz! Sadly though, it was printed after her death and she never got a chance to see.

Just another feather in her cap and another reason for me to proud of her!

Sean posted this on 02/25/02 at 01:55:34.

No comments from the peanut gallery!

What Happened?

On Friday, January 25th, Kelly was a healthy, happy 25 year old looking forward our Orlando trip the following weekend. On Saturday morning, however, she woke up in pain. We went to the emergency room right away. The doctor did an x-ray and told us that she had a 2 or 3 millimeter kidney stone. After he believed it was a stone they tested her urine. The results were good apparently...perhaps too good. I think they were looking for more bacteria or blood in the urine and didn't find it. So the doctor wanted a cat scan just to be certain it was a kidney stone. After the cat scan, he came in and said, "Good news, it's a kidney stone!" He seemed excited that it was a stone and nothing else. Then came the bad news, it was a 5 millimeter stone, one of the largest he has ever seen. He said he was going to call the urologist to see what to do. He figured they would try to control the pain and send Kelly home with some pain killers until the urologist could see her on Monday.

He came back and said that they both agreed because of her age and good health that she could wait until Monday, January 28th. He continued to say that it was important we went to see the Urologist or the stone could cause kidney issues. He said I would need to call around 8:30 a.m. on Monday to make the appointment. More than likely he said, Kelly would need lithotripsy.

When we got home Kelly laid down and I got the prescription for her. Over the next 24 hours, she took 4 pills. She was allowed to take up to 8 per 24 hours but we went on the low side to avoid any issues.

Around 10:30 a.m. Sunday morning Kelly woke me

up (I was up till 5:30 a.m. watching over her) screaming. She had really bad chills. I covered her with 5 blankets and sat with her to warm her up. In about 15 minutes or so, the chills stopped and she was burning up. So off go the blankets. Around noon she had the chills again and I did the same thing. That's when we decided to go back to the doctor.

I should mention that all day Saturday she had a fever for 101.2 to 101.6...never any higher. Now that's a fever but nothing alarming. So Kelly being Kelly, had to take a shower. After she got out, I got dressed and washed up. When I got back in the living room, Kelly said that she felt better. She thought that she shaking from the chills might have broken up the stone a tad and that she might have passed the stone into her bladder from her urethra tube. If so, that generally relieves a lot of pain. Kelly had different pain now, her lower back and stomach area...muscle pain from the shakes. And a slight headache but overall, she was feeling a lot better and not getting sick.

Earlier that Sunday morning, she also decided to stop taking the pain medicine because it wasn't helping stop the pain and just making her sick. Around the time she told me she was feeling better on Sunday, I called the ER and asked to speak to a doctor but they instead handed me off to a nurse. The nurse told me that she should drink lots of water, take the pain medicine for her pain, get rest and if she felt she needs to see the doctor, to come on in. With Kelly felt better, neither of us thought she needed the doctor and that it could wait until Monday. As far as we knew, she had a kidney stone. Everyone plays those off as no big deal...so that's what we thought.

I took her temperature several times that day (Sunday), 101.2 to 101.6 again..nothing really different. Kelly was finally able to drink and eat without getting sick and as I said, she looked and acted better. She was even moving around more.

Monday morning (January 28th), Kelly got up and took a shower. I got up after her and began to get ready for work. At 8:30 a.m. I called the urologist's office to schedule an appointment for that morning. They couldn't get me in until 3:00 p.m. because the urologist didn't get in until 2:30 p.m. With that done, I kissed her goodbye at 9:30 a.m. as she was about to nap on the couch and told her I love her and I'll see her around 2:00 p.m. That was the last conversation I had with Kelly.

She was taken the emergency room...unconscious

and passed away later that same night from Clinical Septous (spelling). It's a major body infection I believe that's spread via the blood. It's very serious but you can recover from it. Kelly tried and tried...but wasn't able to. It shut down her liver, kidney...and well...she passed on to heaven to be with Lexus, our dog.

There are other details but I would prefer not to share them. I relive a lot of this daily and I'm sure you'll understand my reasons for not sharing more.

How Kelly got the infection is the big question. I have some theories but I'll leave that up to my attorney. He's a former practicing physician who works a full time a lawyer. If something went wrong, he'll find out what.

Sean posted this on 02/25/02 at 01:04:46.

1 members of the peanut gallery have spoken!

Happy Birthday Kelly

Happy Birthday sweetie, today is your 26th birthday. My gift to you is my love for the rest of my life and the promise that we'll see each other again soon.

I miss and love you always...your husband.

Sean posted this on 02/25/02 at 00:47:27.

16 members of the peanut gallery have spoken!

Friday, February 22, 2002

Prayers

People ask me, "Is there anything I/we can do for you?" and generally I respond, "No, I'm doing okay but thank you."

But now I've thought of something, however, I really feel bad for asking. Here it goes... Would you mind saying a prayer for Kelly and I? We really could use it. Like I said before, I don't know what's keeping me strong or giving me the strength to continue on. I hate asking for you to say a prayer for us but we really need them. I, for one, could use all I can get.

My heart hurts so bad and I'm so lonely. I need something, anything to keep me going and the prayers have helped tremendously. Please keep praying for us.

Thank you from the bottom of my heart. - Sean

Sean posted this on 02/22/02 at 01:21:49.

5 members of the peanut gallery have spoken!

I'm really lonely....

I just got done looking at some messages that Kelly sent me via ICQ. Man...she was amazing. Not only was she a great wife but a great friend. We had so much fun together, we just clicked like two peas in pod. I miss her so much...

At times I really don't want to go on. I just go...do whatever it is I'm supposed to do. I don't really know how I'm making it. At times I'm really strong, other times really weak. It's like a blur, I still can't believe it. She didn't deserve this, not someone with the heart of an angel.

Each day that goes by is one day closer I get to see my beautiful Kelly again. I miss you Kelly and I'll love you always. Until we see each other again...goodnight my love

Sean posted this on 02/22/02 at 01:02:43.

2 members of the peanut gallery have spoken!

Wednesday, February 20, 2002

Hampton Inn

Last night was the Potluck dinner at the Hampton Inn. I had been invited by the staff a couple of weeks ago and was looking forward to it.

As I pulled into the hotel parking garage, I was really nervous. I wanted to go and see the staff but I didn't want to stir up any upsetting emotions. When I walked in, all the guests where eating. A lot of them came up and greeted me and I felt a lot better. I ate and laughed for an hour and half with the guests and

well...that was pretty special.

I also talked to Charlotte, Jill and Tom, who all work at the Hampton. I went from having them call at the house almost daily and hearing about their daily lives from Kelly to nothing... Personally, I don't like that because I like these people! I care about these people! And I miss them! Thankfully Jill said they won't let that happen and I don't plan on it either. I'll stop by and bug them from time to time, plus with Jennifer headed that way I'm sure they'll stay in my lives. I couldn't be happier with that. :-D

Sean posted this on 02/20/02 at 10:36:37.

2 members of the peanut gallery have spoken!

Tuesday, February 19, 2002

More random thoughts...

Last Night

I went to bed at 1:30 a.m. as promised but I couldn't fall asleep until 3:00. At least I'm trying! I read two chapters in the book Jennifer gave me, *A Painted House* by John Grisham. I've read all his books except for his three most recent, "Skipping Christmas", "The Summons" and "A Painted House". The Summons is his most recent release and it gets back to the legal genre he is known for. I'm chopping at the bit to read it!

What happened?

A lot of people still don't know what happened. I plan on explaining a lot this Sunday in a post. Just please bear with me. I'm handling the anger fine for the most part. I try not to think about stuff that will set me off. So please don't ask, "Why didn't they do this?" or "Why didn't you do that?". I have a lot of guilt associated with everything and questions that I don't have the answers to really frustrate and anger me. I still can't read over any of the medical reports...too upsetting. The biggest thing that I have problems with is being lonely. It's not that I need company, I just need her. I miss her tremendously. But each day, is a day closer to seeing her again. :-)

Sean posted this on 02/19/02 at 10:17:57.

1 members of the peanut gallery have spoken!

Just some thoughts...

Various thoughts in tonight's writings...

I'm going to head to bed at 1:30 a.m. today. Not too shabby for me. I'll probably lay there and watch Olympic coverage until I dose off. I'm trying really hard to get into a normal groove and that's getting close.

I cleaned the house some tonight and tomorrow night I hope to really work on my office, it's a mess. Chad and Laura stopped by for a while and we watched Ally McBeal. We all ate some of the pecan pie that Blake made for them. Yes...Blake cooks and it was really good.

I brushed Beemer and clipped his nails tonight. He was really testy but the job needed to get done. I also took a lint brush and brushed all the furniture in the house. Boy did I pick up a lot of hair...sheesh. I could make a wig from it.

Hmm...what else...??? Oh yeah, tomorrow night I'll be visiting the Hampton Inn for their Pot Luck dinner. They were kind enough to invite me and I'm looking forward to seeing everyone.

Signs from Kelly

1. Patriots winning the Super Bowl. Clearly the underdogs going in and that was Kelly's style. She was a huge football fan and I think she knew I would be watching. :-)
2. Kelly Clark winning the first Gold medal for the US in the Winter Olympics. :-)
3. My face tingling at 1:30 a.m. on Valentine's Day when I was crying...Kelly kissing me. (Okay..this is totally a sign!!!) :-D
4. A dream I had a couple of nights ago. Kelly came back to life in the dream and keep telling she's okay and she's fine. :-)

Can't wait for more!

Good night all! Love ya Kelly and Lexus!

Sean posted this on 02/19/02 at 01:28:36.

No comments from the peanut gallery!

Monday, February 18, 2002

Bedtime for Bonzo

It's 2:15 a.m. and I'm off to bed! That's a lot better than my 3:30 a.m. bedtime. Slowly but surely I'm working it down. Six and half hours sleep is perfect for me. Eventually I want to get to bed between midnight and 1:00 and wake up around seven.

I finished most of my chores like cleaning the fish tank. That is a big project but I'm happy to say it's completed!

For those of you who have been worried about me, thank you very much! Rest assured I'm doing well. Why you ask? Because I had a great teacher, Kelly! She taught me more than I knew and I'm starting to realize that. Keeping the house clean, doing the little things around the house, paying bills, staying organized, taking care of Beemer, etc... I'm not 100% but I'm getting there. I learned from the best and I'm aiming to make her damn proud of me!

Thanks Kelly, you're the greatest! :-D

Sean posted [this](#) on 02/18/02 at 02:16:58.

[No comments](#) from the peanut gallery!

I'm back home again

I got back from Hope Mills around 8:30 tonight, and that's a little later than I wanted. Beemer was happy to see me and I was really happy to see him. He followed me around like a puppy. Kind of ironic considering he's a cat. :-)

It was really cold in Hope Mills today and the wind was blowing wicked hard. It was a little warmer in Myrtle Beach, thank the lord. The weather changes so fast it seems. Just yesterday it was nice and sunny out and I even went golfing with Blake and another two-some (I played poorly...as usual).

However, I'll have a chance to improve my scores this weekend because Kelly's step dad Tom is coming to visit for the weekend. We are planning on going golfing once or twice while he is here. Tom's a really fun guy and it will be nice to hang out with him for a few days. I honestly hope the family I had before Kelly's passing is the same family I'll continue to have in the future. It's obviously really hard losing Kelly but losing everyone else who was important in my life...well...that's about as low I could possibly get. So far they have all been really great and

supportive and I don't foresee any change to that! :-)

I feel tremendously bad for them and very responsible. What if I did this...what if I did that? I failed them at protecting their daughter, sister, niece, cousin... I know they don't look at it that way but I do. I'm a failure in my eyes. I failed to protect the thing that meant the most to me, Kelly. I should have done more.

I just hope Kelly can forgive me.

Sean posted [this](#) on 02/18/02 at 00:57:45.

[1 members](#) of the peanut gallery have spoken!

Saturday, February 16, 2002

Hello from Hope Mills

It's 2:13 a.m. and do you know where you're at? I'm at Blake and Jennifer's house, upstairs. They are downstairs sleeping away. What if I need to talk to someone? Jenn is normally one of my first contacts. Do I go wake her up? Do I call the house from my cell phone? Dam dilemmas! :-)

I'm actually in an ill mood and I don't know why. I've been a real sourpuss lately. I don't think I'm getting upset with my friends or family, it's not that. I'm just plain irritable at times. Not yelling, screaming or anything like that...just ill. I think for the most part I'm hiding it well. I told Blake in the car tonight that I could feel it coming on...a mood shift. Maybe I need Prozac or perhaps some nice quality sleep. Tonight I'm on the couch, so perhaps it will be just sleep and not the quality/quantity that I need.

I'm also a little homesick. I miss [Beemer](#). I wonder what Beemer is doing right now? I know he is missing his mommy. He waits by the door on the love seat night after night for her to come home. When she would pull in, he would start meowing like crazy. Now when I open the door he gets excited like it's her coming in the door. How do I tell him she's not coming back? Will he get over it too?

Speaking of thinking Kelly is coming home, every time the phone rings at home (my special ring), I think it's Kelly calling. Well...I did. I think I'm getting over that part. But the last time I was here in Fayetteville and the phone rang late, I thought it was Kelly calling to check on me. Except...Kelly isn't here

anymore. No, I take that back. She's always with me now no matter where I go. Maybe not in body but in spirit.

I think I'll sign off now and go downstairs. Maybe I'll get to bed before my 3:30 a.m. bedtime! I'm feeling better already, the funky mood is wearing off. She always could cheer me up! Good night Kelly...I love you babe. :-)

Sean posted this on 02/16/02 at 02:20:54.

2 members of the peanut gallery have spoken!

Friday, February 15, 2002

Thank you

Just a big thank you to all of our family and friends and those who don't even know us, who have been so supportive over the past 2 1/2 weeks. Your thoughts, your prayers and your strength are what pulls me through these tough times.

There will be many times in the future where I'll need a shoulder to lean/cry on and I know you'll be there for me. Thank you again for everything...I love you all

Sean

Sean posted this on 02/15/02 at 20:05:14.

No comments from the peanut gallery!

Thursday, February 14, 2002

Tingling experience

Last night as I posted my last blog, I was crying. I got up to go downstairs and crying the whole way. I noticed that when I got up, my face was tingling. It tingled all the way down the steps to the kitchen.

At first I was freaked out that something was wrong because that hasn't happened before. But the more I

thought about it, the more I think it was Kelly. I swear I could feel her touching my face.

Sean posted this on 02/14/02 at 10:54:17.

5 members of the peanut gallery have spoken!

Valentine's Day

It's 1:30 a.m. on February 14th...I wish some days could just be skipped over. Earlier on tonight (13th) I bought a Valentine's Day card for Kelly. I'm writing a love note to her and later today (14th), I'll open the card and read it to her. I know she's watching over me and hopefully she won't see the card until I read it to her. I'm not sure if they Internet access in heaven so hopefully she's reading over my shoulder know. :-)
)

Even though I'm joking, my heart hurts really badly. I want to cry, I miss her so much it hurts...I joke and smile to cover my pain. Kelly was my love, my dreams, my world... It's starting to hit me, my life after Kelly, without Kelly and I don't like it. I don't want it this way... I'd do anything just for one more year, one more month, one more day...one hour.

Kelly..please come back to me. I need you...I love you. Happy Valentine's Day my love.

Sean posted this on 02/14/02 at 01:32:36.

3 members of the peanut gallery have spoken!

Wednesday, February 13, 2002

The Fay Home Gym

Sports Authority's web site is back up so I thought I'd show you the home gym I want. Keep in mind that the fitness station is a corner unit and everything

should fit nicely.

- [Universal Fitness Nine Station Double Stack Corner Gym](#)
- [Pro Form LX360 Treadmill w/ Racetrack Console](#)
- [Pro Form 700 Elliptical Trainer](#)

Whatcha think?

[Sean](#) posted [this](#) on 02/13/02 at 16:45:47.

[No comments](#) from the peanut gallery!

Quite an honor!

I'm happy to say that Amneris Solano, a reporter with the [Fayetteville Observer](#), is going to do a story on Kelly this weekend in the Saturday Extra!

The Saturday Extra is a special section in the Fayetteville Observer that is devoted to the citizens in a specific region of the county that the paper is delivered in. Kelly's story will be published in the Hope Mills Saturday Extra. Kelly would be extremely honored to hear the story. She did A LOT in our community like setting up our [community watch](#), publishing newsletters, organizing the first ever community safety day, helping organize a community garage and even getting a new town ordinance established about community watch signs.

I was very proud of Kelly and everything she did. She really put her heart into it and I can't wait to read the story. It's a real tribute to Kelly's dedication to her community.

I'd like to say a special thank you for those people who contacted the paper about the story. I can't tell you how happy this makes me. I'm just beaming with joy for Kelly.

[Sean](#) posted [this](#) on 02/13/02 at 10:04:56.

[No comments](#) from the peanut gallery!

Is it late or early?

It's late....or perhaps it's early. It's 3:17 a.m. and I can't sleep. My prescription ran out yesterday. It worked very well. It would knock me out to la-la land without any problems. Now I just lay there and wonder. It can't be good for my mind or my body. Rest is important for me to heal. Anyone have any suggestions?

I decided earlier this week that I will be putting in a home gym in the spare room upstairs. I told Kelly a while back that I always wanted to do that and after she saw what I meant, she agreed that it was a good idea. I think now it would be really good thing to wear me out at night and keep me from being destructive. I'm going to get an all in one weight bench set, an elliptical machine and a treadmill. I'm also moving the TV from my bedroom and I'm going to place it on the wall with a mount. I plan to spend a lot of time up there working out my frustrations. I'll post pictures of the units I'm getting once Sports Authority comes back online.

I'm back off downstairs to try to go back to sleep. Wish me luck.

Sean posted this on 02/13/02 at 03:27:29.

No comments from the peanut gallery!

Tuesday, February 12, 2002

Back to work...

I went back to work yesterday. I figured because I accomplished a lot of personal business last week, that I would need something constructive to do or I would start being destructive. Well, today at work I realized I'm lonely. Really lonely. Yes, I have friends and family that call and hang out with me but I'm lonely for my wife. To hold her, hold her hand, kiss her, tease her, laugh with her, just to be with her...

My friends and family are the greatest and love me dearly but I need the love that only a partner, lover, spouse can give. Make sense? I hope I don't upset any of them, it's not them, it's me. I just miss Kelly a lot. With Valentine's Day coming up, I should be panicking because I didn't buy anything yet, not going through this. This mini-holiday is really going to suck.

Sean posted this on 02/12/02 at 10:47:28.

1 members of the peanut gallery have spoken!

Sunday, February 10, 2002

Two weeks tomorrow...

It will be two weeks tomorrow that Kelly passed away and I'm feeling stronger than ever. My friends and family have been awesome with their support. At times, the love they have shown me is overwhelming. I can never repay them for all they have done.

I wonder why I'm feeling so strong and at times I feel guilty because of it. Does it mean I love Kelly any less? Does it mean I'm over the loss of my wife? The answer is **NO** on both accounts. I love Kelly more than ever and I'm certainly **NOT** over the loss of her. My strength comes from my friends, my family and my faith. I will see Kelly again and that calms me. She has talked to God and touched his hand. She has met our savior and she knows all the answers to life. She only has joy and happiness in her life now. How could I not be stronger from that? The Lord took Lexus from us in October to prepare me for when he took Kelly. He has a plan and she was needed in heaven more than she was needed here on earth. As good a person, as great a worker as she was, it's no wonder God needed her on his team. :-D

That's my strength, my motivation.

Kelly I miss you, I love you and I'll see you in heaven.

Sean posted this on 02/10/02 at 20:57:29.

1 members of the peanut gallery have spoken!

Friday, February 08, 2002

A Friend is a Treasure

*A friend is someone we turn to,
when our spirits need a lift.
A friend is someone we treasure,
for our friendship is a gift.
A friend is someone who fills our lives,
with beauty, joy and grace.
And make the world we live in,
a better and happier place.*

- Author Unknown

A small tribute from me to all of our friends who have been so supportive and by my side since Kelly's passing. My friends amaze me daily...

Sean posted [this](#) on 02/08/02 at 10:45:10.

[No comments](#) from the peanut gallery!

I'm angry

I'm angry because my wife can't say she loves me
I'm angry because I can't tell my wife I love her
I'm angry because I can't hold her
I'm angry because she can't hold me
I'm angry because I don't have someone to come home too
I'm angry because I only got 6 years with Kelly...I wanted 50
I'm angry because she's gone because was the best person in the world
I'm angry because I miss her
I'm angry because I love her

Sean posted [this](#) on 02/08/02 at 02:25:17.

[No comments](#) from the peanut gallery!

Thursday, February 07, 2002

My beloved wife....

My beloved wife Kelly passed away on January 28, 2002 at the tender age of 25. Kelly was my best friend, my wife, my everything.... Words can't describe how great a person she was or how much she meant to me. At her three memorial services, there were over 500 people who attended in 3 states. For someone so young, to touch so many lives is a real tribute to Kelly and to how Kelly's parents (Sandy, Tom and Ray) raised her. She was the most unselfish and kind person I know. Always going out her way for someone else, no matter what. In the 8 years I knew her, the 6 years years we were married, I was truly a blessed person.

For all the family and friends who have called, written or stopped by to check on me, I can not thank you

enough. Kelly would be amazed at the outpouring of support. Your thoughts and prayers are helping myself and our families through this tragic time. I will never forget Kelly and she'll always remain my loving wife.

As the saying goes, "It is better to have loved and lost than to have never loved at all". I couldn't agree more.

A few people have asked if there is a memorial fund. Yes, Chad and Laura set one up for me. Any and all donations are very much appreciated.

First Union
Surfside Beach Financial Center
2361 Dick Pond Road
Surfside Beach, SC 29575
(843) 215-6167
Fund Number: 1010045654086

Thank you again for all your support...I love you all.

Sean posted this on 02/07/02 at 18:24:09.

13 members of the peanut gallery have spoken!

STATE OF SOUTH CAROLINA)
)
COUNTY OF HORRY)

IN THE COURT OF COMMON PLEAS
2008-CP-26-9047
2008-CP-26-9368

Sean D. Fay, as Personal Representative)
for the Estate of Kelly L. Fay, Deceased,)
)
Plaintiff,)

v.)

Grand Strand Regional Medical Center,)
LLC d/b/a South Strand Ambulatory Care)
Center, Jane Doe, an unidentified nurse)
employed with Grand Strand Regional)
Medical Center, LLC, Stephen W. Law,)
DO, Carolinahealth Specialists, Dr. Richard)
Young, MD, and Grand Strand Urology,)
LLP,)
)
Defendants.)

DEFENDANT GRAND STRAND
REGIONAL MEDICAL CENTER'S
MOTION FOR NEW TRIAL

HORRY COUNTY
10 JUN -7 PM 2:08
MELANIE HARRIS-WARD
CLERK OF COURT

The defendant, Grand Strand Regional Medical Center d/b/a South Strand Ambulatory Care Center, hereby moves pursuant to Rules 50 and 59 of the South Carolina Rules of Civil Procedure for judgment notwithstanding the verdict, a new trial absolute, or in the alternative, a new trial *nisi remittitur*. The grounds for these motions are set forth herein.

JUDGMENT NOTWITHSTANDING THE VERDICT (JNOV)

The defendant, Grand Strand Regional Medical Center d/b/a South Strand Ambulatory Care Center, renews its motion for directed verdict or for judgment notwithstanding the verdict on the grounds that there is no reliable testimony sufficient to support the plaintiff's claim that any breach of the standard of care by this defendant proximately caused the plaintiff's injury and damage. The basis for this motion is that the plaintiff's experts offered conflicting

testimony regarding whether or not the alleged breaches of the standard of care proximately caused the plaintiff's injury. This inconsistency in the testimony of the plaintiff's experts reveals the inherent unreliability of the plaintiff's theory of causation. Therefore, the plaintiff has failed to present reliable testimony to support a claim that any alleged breach of the standard of care by this defendant caused the plaintiff's damages. Thus, the evidence was insufficient as a matter of law that any breach of the standard of care by Grand Strand Regional Medical Center proximately caused the plaintiff's death and judgment should be entered in favor of this defendant.

Furthermore, the only reasonable inference that can be drawn from the evidence is that the real cause of the plaintiff's injury was the plaintiff's failure to return to the emergency room or seek medical care elsewhere when his wife's condition seriously deteriorated after leaving the emergency room on the morning of January 26, 2002.

In addition, the only reasonable inference that can be drawn from the evidence is that the plaintiff's claim is barred as a matter of law because the plaintiff was at least 51% at fault in failing to bring his wife back to the emergency room, or in failing to seek medical care elsewhere when his wife's condition seriously deteriorated after he left the emergency room on January 26, 2002.

NEW TRIAL ABSOLUTE

If the Court were to deny Grand Strand Regional Medical Center's Motion for Judgment Notwithstanding the Verdict, then Grand Strand moves for a new trial absolute for the following reasons:

- (1) The Court erred in excluding evidence of the plaintiff's pre-marital affair.

(2) The Court erred in excluding evidence of the plaintiff's remarriage after the death of the plaintiff's decedent.

(3) The Court erred in limiting the testimony of the plaintiff's decedent's mother, stepfather, and brother.

(4) The Court erred in charging the jury that a hospital has an absolute duty to provide competent medical care in its emergency room and this duty cannot be delegated. This charge is improper in that it essentially makes a hospital an insurer of the care provided in its emergency room. This charge was inapplicable and gave the jury the impression that the hospital is a guarantor of the care provided in its emergency room.

(5) The amount of the verdict in this case is so excessive that it was clearly actuated by passion, caprice, and prejudice. Thus it is this Court's duty to set aside this verdict absolutely.

(6) The jury verdict is so excessive that it must have been influenced by matters outside the evidence or is so excessive that the jury must have been unable to follow the Court's instructions or charges in rendering its verdict.

(7) The Court should also grant a new trial because the only reasonable inference that can be drawn from all of the evidence is that the negligence of the plaintiff is 50% and is greater than any negligence on the part of the defendant, Grand Strand Medical Center, or Dr. Law.

(8) The Court should grant a new trial absolute because the jury verdict was the result of an improper quotient verdict.

(9) The Court, sitting as a thirteenth juror, should conclude that the evidence and facts do not justify the verdict in this case and should grant a new trial absolute.

NEW TRIAL NISI REMITTITUR

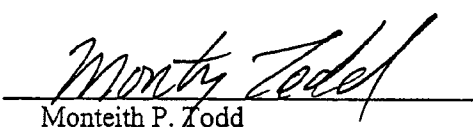
If the Court chooses not to grant JNOV to Grand Strand and chooses no to grant a new trial absolute, then this court should grant a new trial *nisi remittitur*. This defendant is entitled to a new trial *nisi remittitur* for the reasons set forth herein previously. In South Carolina, the trial judge "has the power, and with it the responsibility" of reducing a damage award that is "unduly liberal" or "merely excessive." Easler v. Hejaz Temple of Greenville, 829 S.E.2d 753, 758 (S.C. 1985) See also Becker v. Wal-Mart Stores, Inc., 529 S.E.2d 758, 762 (S.C. Ct. App. 2000) (upholding the trial court's decision to reduce an award of \$1.75 million to \$525,000 for a plaintiff's partially paralyzed foot because the jury award was "merely excessive" and "unduly liberal.") In this case, the jury verdict is unduly liberal and excessive and should be reduced by this court. This is especially true because the Court, unlike the jury, has information regarding the plaintiff's pre-marital affair and subsequent remarriage. Furthermore, the verdict is well in excess of the plaintiff's economic losses set forth by the plaintiff's expert and should be reduced by this court.

CONCLUSION

The Court should, therefore, grant judgment notwithstanding the verdict to the defendant, or in the alternative, should grant this defendant a new trial absolute, or at a minimum a new trial *nisi remittitur*.

SOWELL GRAY STEPP & LAFFITTE, L.L.C.

By: _____


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Care Center

Columbia, South Carolina

June 7, 2010

5597/15-11
To file

STATE OF SOUTH CAROLINA) IN THE COURT OF COMMON PLEAS
COUNTY OF HORRY) FIFTEENTH JUDICIAL CIRCUIT
C/A NO.: 2008-CP-26-9047 and
2008-CP-26-9368

Sean D. Fay, as Personal)
Representative for the Estate)
of Kelly L. Fay, Deceased,)
Plaintiff,)

vs.)

Grand Strand Regional Medical)
Center, LLC d/b/a South Strand)
Ambulatory Care Center, Jane)
Doe, an unidentified nurse)
employed with Grand Strand)
Regional Medical Center, LLC,)
Stephen W. Law, D.O., Carolina)
Health Specialists, Dr. Richard)
Young, M.D., and Grand Strand)
Urology, LLP,)
Defendants.)

**DEFENDANT STEPHEN W. LAW, D.O.'S MOTION FOR JUDGMENT
NOTWITHSTANDING THE VERDICT, OR, IN THE ALTERNATIVE, MOTION
FOR NEW TRIAL, OR, IN THE ALTERNATIVE, MOTION TO ALTER, AMEND
AND VACATE THE VERDICT, OR FOR REMITTITUR, OR, IN THE
ALTERNATIVE FOR THE JUDGMENT TO BE ENROLLED USING THE
PERCENTAGE OF COMBINED NEGLIGENCE THAT THE JURY
CONCLUDED CAUSED THE PLAINTIFF'S INJURIES**

PLEASE TAKE NOTICE that, pursuant to Rule 50 of the South Carolina Rules of Civil Procedure, Defendant Stephen W. Law, D.O. (hereinafter "Dr. Law"), respectfully requests that the Court enter judgment for Dr. Law notwithstanding the verdict. In the alternative, Dr. Law respectfully requests, pursuant to Rule 59(a) of the South Carolina Rules of Civil Procedure, that the Court grant him a new trial or, in the alternative, that the Court alter or amend the

judgment and vacate or remit the amount of the jury's compensatory damage award.

STATEMENT OF FACTS

Kelly Fay was a 25-year-old, married, female who presented to the emergency room of South Strand Ambulatory Care Center, Myrtle Beach, South Carolina, at 8:00 A.M., on Saturday, January, 26, 2002, complaining of a sudden onset of right flank pain that began, depending on whose records you use, either 30 minutes or 1 and ½ hours prior to arrival. Mrs. Fay was accompanied by her husband, the Plaintiff Sean Fay. According to the medical records from South Strand Ambulatory Care Center, Mrs. Fay complained to emergency room physician Dr. Stephen Law of mild nausea, but she denied vomiting, fevers, chills, dysuria, hematuria, or menstrual irregularities.

Dr. Law examined the patient and noted that she did not have a fever (98.1°) and her vital signs were stable. Dr. Law's examination of the patient's abdomen revealed moderate-to-severe flank tenderness on the right side. The patient had a normal urinalysis with no blood, white blood cells, nitrites, or bacteria in the urine. Dr. Law ordered a KUB x-ray (flat plate of the abdomen that examines the kidneys, ureters, and bladder) which revealed a moderate-sized stone in the region of the right ureteropelvic junction (the kidney end of the ureter). A CT Scan of the abdomen revealed a 0.5 cm diameter stone within the proximal ureter that was lying at or close to the level of the ureteropelvic junction, with mild hydronephrosis. Radiologist Dr. John Chomyn noted that there was

minimal pyelosinus extravasation of urine on the CT Scan and that the ureter had a normal caliber.

Prior to discharge, Dr. Law discussed this case with Dr. Richard Young, on-call urologist, who requested to see the patient on Monday since the patient's pain was under control. Dr. Law then set forth in his dictated note:

"I did explain to the patient, however, that if her pain becomes out of control or if she has increasing nausea, vomiting, any fevers or chills, that she is to return to the emergency department immediately."

Kelly Fay left the hospital with good pain control and without any clinical signs of infection.

Mr. Fay has testified that on Sunday morning, January 27, 2002, Kelly Fay woke him up because "she was having chills – extreme chills – just real bad shivering . . . she got sick once or twice." Mr. Fay has further testified that Sunday evening, probably like 10:00 P.M., she had brief chills. Also, Mr. Fay has testified that basically all weekend his wife ran a fever of between 101.3 and 101.6.

On Monday, January 28, 2002, at approximately 8:30 A.M., Mr. Fay called Dr. Young's office for an appointment. He was advised to report to Dr. Young's office at 3:00 P.M. Mr. Fay then left for work and has testified that he called home probably 3 times that morning to check on his wife but the telephone was not answered.

Also, on Monday, January 28, 2002, at 1:59 P.M., EMS received a call from the patient's husband. When EMS arrived at their home, they found Mrs. Fay lying on the floor, very hot to the touch, cyanotic, with shallow, rapid

respirations and vomit in her mouth. They noted that she had been incontinent of urine and feces. According to the EMS records, the patient's husband reported to EMS paramedics that his wife had been febrile the night before at 101°. Sean Fay also reported to EMS that when he came home from work he found his wife lying on the floor unresponsive making gurgling noises.

EMS transported the patient to Grand Strand Regional Medical Center where the patient's urine and blood cultures revealed evidence of proteus mirabilis bacteria. Her temperature when she arrived in the emergency room was noted to be 107° rectally. The ER records indicate that the Plaintiff, patient's husband, reported to emergency room physician Dr. Chi that the patient had done well since she left the emergency room on Saturday, with the exception of having a mild temperature elevation along with some fever and chills. After arriving at the hospital, the patient went into cardiac arrest and was pronounced dead at 10:00 P.M. An autopsy revealed that the patient died as a result of overwhelming clinical sepsis due to proteus species bacteria.

ARGUMENT

This Court Should Enter Judgment for Dr. Law Notwithstanding the Verdict

Pursuant to Rule 50(b) of the *South Carolina Rules of Civil Procedure*, the Court should set aside the verdict in this case and enter judgment for Dr. Law notwithstanding the verdict ("JNOV"). A court should grant a JNOV when the evidence presented at trial is insufficient to support the jury's verdict. See *Rogers v. Norfolk Southern Corp.*, 343 S.C. 52, 59, 538 S.E.2d 664, 668 (Ct. App. 2001), *aff'd as modified*, 356 S.C. 85, 588 S.E.2d 87 (2003). In other

words, a motion for JNOV should be granted where no reasonable jury could have reached the verdict being challenged. See *id.* (reversing trial court's denial of JNOV because the only reasonable inference that would be drawn from the evidence in the record was that there was no negligence).¹

Here, the evidence presented at trial is insufficient to support the jury's verdict either on liability or damages. Indeed, because the weight of the evidence is so overwhelmingly against Plaintiff, it was not possible for a reasonable jury to assess liability against Dr. Law.

The only reasonable inference to be drawn from the evidence is that Dr. Law honored all accepted standards of care for an emergency physician and did not harm the Plaintiff or Plaintiff's decedent in any way.

The evidence shows:

- Dr. Law saw Kelly Fay on the morning of January 26, 2002, at South Strand Ambulatory Care Center emergency department within minutes of her presentation;
- Dr. Law performed an appropriate physical examination;
- Dr. Law ordered appropriate, reasonable and responsible tests;
- Dr. Law relieved the decedent's pain;
- Dr. Law made the correct diagnosis;
- Dr. Law issued appropriate and responsible discharge instructions:

"I did explain to the patient, however, that if her pain becomes

¹ See also *Catawba Ins. Co. v. Smith*, 336 S.C. 33, 38-39, 518 S.E.2d 291, 293-94 (Ct. App. 1999) (reversing trial court's denial of JNOV because there was "insufficient evidence of implied consent for the trial court to have submitted the issue to the jury"); *Gastineau v. Murphy*, 331 S.C. 565, 569, 503 S.E.2d 712, 714 (1998) (reversing trial court's denial of JNOV because, based on the evidence introduced at trial, no reasonable jury could have come to the conclusion reached by the jury). In ruling on motions for JNOV, the trial court must consider the evidence and the inferences that reasonably can be drawn therefrom in the light most favorable to the non-moving party. *Gastineau*, 331 S.C. at 568, 503 S.E.2d at 713.

out of control or if she has increasing nausea, vomiting, any fevers or chills, that she is to return to the emergency department immediately."

Dr. Law dictated this note on January 26, 2002, at 11:38:20 A.M. and Kelly Fay was discharged at 12:00 Noon on January 26, 2002. There was no evidence attacking the integrity and credibility of Dr. Law's discharge typewritten note.

Further, the only reasonable inference that can be drawn from the evidence is that the decedent's physical condition deteriorated over the weekend and the proximate cause of the decedent's death was the failure of the Plaintiff to follow Dr. Law's discharge instructions to take the decedent immediately back to the emergency department. Even Plaintiff's expert, Charles Stratton, M.D., testified that if the decedent had been taken back to the emergency department by 10:00 A.M. on January 28, 2002 (date of death) then Kelly Fay would have survived.

Therefore, the only reasonable inference to be drawn from the evidence is that the Plaintiff was either solely responsible for the decedent's death or at a minimum at least 51% at fault.

In the Alternative, This Court Should Order a New Trial

In the event that the Court does not grant a JNOV with respect to all of Plaintiff's claims, this Court should order a new trial. Pursuant to Rule 59 of the *South Carolina Rules of Civil Procedure*, the trial court can grant a new trial on the ground that the verdict is excessive. See *Krepps v. Ausen*, 324 S.C. 597, 607, 479 S.E.2d 290, 295 (Ct. App. 1996). When a party moves for a new trial based on a challenge that the verdict is excessive, the trial court must distinguish

between awards that are merely unduly liberal and awards that are actuated by passion, caprice or prejudice. See *id.* The trial court must set aside a verdict and grant a new trial absolute when it is shockingly disproportionate to the injuries suffered and thus indicates that passion, caprice, prejudice, partiality, corruption, or other considerations not reflected by the evidence affected the amount awarded. See *Sanders v. Prince*, 304 S.C. 236, 238-39, 403 S.E.2d 640, 642 (1991) (reversing trial court's denial of a new trial because jury verdict was so grossly excessive as to indicate passion, prejudice, or other improper motive); *Small v. Springs Indus. Inc.*, 292 S.C. 481, 487, 357 S.E.2d 452, 455 (1987) (it is the duty of the court to remand for a new trial where jury's verdict was excessive and based upon improper considerations not found in the evidence). The failure of the trial court to grant a new trial absolute in this situation amounts to an abuse of discretion. See *Krepps*, 324 S.C. at 607, 479 S.E.2d at 295.²

The reasons requiring a new trial absolute are as follows:

- (1) The Court erred in excluding evidence of the Plaintiff's marital affair.

² Separately, under the "thirteenth juror" doctrine, a trial judge may grant a new trial absolute when he finds the evidence does not justify the verdict. See *Folkens v. Hunt*, 300 S.C. 251, 254, 387 S.E.2d 265, 267 (1990) (affirming trial court's order granting a new trial under the thirteenth juror doctrine); *McEntire v. Mooregard Exterminating Svcs., Inc.*, 353 S.C. 629, 631, 578 S.E.2d 746, 747 (Ct. App. 2003) (same); *Sorin Equipment Co., Inc. v. Firm, Inc.*, 323 S.C. 359, 363-64, 474 S.E.2d 819, 822 (Ct. App. 1996) (same). The trial judge, sitting as the thirteenth juror charged with the duty of seeing that justice is done, has the authority to grant new trials when he is convinced that a new trial is necessitated on the basis of the facts in the case. See, e.g., *id.* Essentially, as the thirteenth juror, the trial judge can hang the jury by refusing to agree to the jury's otherwise unanimous verdict. See *Norton v. Norfolk Southern Ry. Co.*, 350 S.C. 473, 478, 567 S.E.2d 851, 854 (2002).

(2) The Court erred in excluding evidence of the Plaintiff's remarriage after the death of the Plaintiff's decedent.

(3) The Court erred in limiting the testimony of the Plaintiff's decedent's mother, stepfather, and brother.

(4) The amount of the verdict in this case is so excessive that it was clearly actuated by passion, caprice, and prejudice. Thus, it is this Court's duty to set aside this verdict absolutely.

(5) The jury verdict is so excessive that it must have been influenced by matters outside the evidence or is so excessive that the jury must have been unable to follow the Court's instructions or charges in rendering its verdict.

(6) The Court should also grant a new trial because the only reasonable inference that can be drawn from all of the evidence is that the negligence of the plaintiff is 50% and is greater than any negligence on the part of the Defendant Dr. Law.

(7) The Court, sitting as a thirteenth juror, should conclude that the evidence and facts do not justify the verdict in this case and should grant a new trial absolute.

NEW TRIAL NISI REMITTITUR

If the Court chooses not to grant JNOV to Dr. Law and chooses not to grant a new trial absolute, then this court should grant a new trial *nisi remittitur*. This Defendant is entitled to a new trial *nisi remittitur* for the reasons set forth herein previously. In South Carolina, the trial judge "has the power, and with it the responsibility" of reducing a damage award that is "unduly liberal" or "merely

excessive." *Easler v. Hejaz Temple of Greenville*, 829 S.E.2d 753, 758 (S.C. 1985) See also *Becker v. Wal-Mart Stores, Inc.*, 529 S.E.2d 758, 762 (S.C. Ct. App. 2000) (upholding the trial court's decision to reduce an award of \$1.75 million to \$525,000 for a plaintiff's partially paralyzed foot because the jury award was "merely excessive" and "unduly liberal.") In this case, the jury verdict is unduly liberal and excessive and should be reduced by this court. This is especially true because the Court, unlike the jury, has information regarding the Plaintiff's marital affair and subsequent remarriage. Furthermore, the verdict is well in excess of the Plaintiff's economic losses set forth by the Plaintiff's expert and should be reduced by this court.

ENROLLMENT OF JUDGMENT

Should the Court fail to grant the Motion for Judgment Notwithstanding the Verdict, or in the alternative, the Motion for New Trial, or in the alternative, the Motion to Alter, Amend and Vacate the Verdict, or for Remittitur, then Dr. Law requests the judgment be enrolled using the percentage of combined negligence that the jury concluded proximately caused the Plaintiff's injuries:

Plaintiff 4%

Defendant Dr. Law 6%

Defendant Grand Strand 90%

CONCLUSION

For the foregoing reasons, Dr. Law respectfully requests that the Court enter judgment for him notwithstanding the verdict. In the alternative, Dr. Law respectfully requests that the Court grant him a new trial or, in the alternative,

that the Court alter or amend the judgment and vacate or remit the amount of the jury's compensatory awards. In the alternative, Dr. Law respectfully requests that the Court enter judgment in the percentages as set forth above. **Finally, Dr. Law requests oral argument on these Motions.**

Respectfully submitted,

BY: _____

J. BOONE AIKEN, III

Aiken, Bridges, Elliott, Tyler & Saleeby, P.A.

SC Bar # 307

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**ATTORNEYS FOR THE DEFENDANT,
STEPHEN W. LAW, D.O.**

Florence, South Carolina

June 7, 2010

(22108)

STATE OF SOUTH CAROLINA
COUNTY OF HORRY

IN THE COURT OF COMMON PLEAS

Sean D. Fay, as Personal Representative
for the Estate of Kelly L. Fay, deceased,

Plaintiff,

v.

Grand Strand Regional Medical
Center, LLC, d/b/a South Strand
Ambulatory Care Center,
Stephen W. Law, D.O., and
Richard Young, M.D.,

Defendants.

Civil Action Nos. 2008-CP-26-9047
2008-CP-26-9368

**NOTICE OF MOTION AND
MOTION TO ALTER OR AMEND
JUDGMENT AND/OR MOTION
FOR RECONSIDERATION**

TO: THE HONORABLE J. MICHAEL BAXLEY

RUSKIN C. FOSTER, ESQUIRE, COUNSEL FOR PLAINTIFF

MONTEITH P. TODD, ESQUIRE, RANDOLPH L. LEE, ESQUIRE, COUNSEL FOR
DEFENDANT GRAND STRAND REGIONAL MEDICAL CENTER, LLC

YOU WILL PLEASE TAKE NOTICE that the undersigned attorneys for the Defendant Stephen W. Law, D.O., will move before the Honorable J. Michael Baxley at such time and place as may be set by the Court, for an Order, pursuant to Rule 59(e), *SCRCP*, altering, amending, and/or reconsidering the Order Denying Defendant Law's Post Trial Motions, filed June 24, 2010. Counsel for the Defendant Law received written notice of entry of the Order on July 12, 2010.

The Defendant Law's motion is based upon the following grounds:

1. The Order Denying Defendant Law's Post Trial Motions has not addressed each of the grounds for relief as set forth in the Defendant Law's Post-Trial Motions. The Court failed

to address the basis for the Defendant Law's JNOV Motion. Specifically, the Court has not addressed Dr. Law's position that the only reasonable inference to be drawn from the evidence is that Dr. Law complied with all accepted standards of care for an emergency physician and did not cause harm to the Plaintiff or his decedent. The Court has also not addressed Dr. Law's position that the only reasonable inference that can be drawn from the evidence is that the proximate cause of the decedent's death was the failure of the Plaintiff to follow the discharge instructions to take the decedent back to the emergency department. Likewise, the Court has not addressed Dr. Law's position that the only reasonable inference to be drawn from the evidence is that the Plaintiff was either solely responsible for the decedent's death or was more than fifty percent at fault as a matter of law. The Court is respectfully requested to alter or amend its current Order to specifically address the Defendant Law's JNOV Motion.

2. In its Order Denying Defendant Law's Post Trial Motions, the Court has addressed only portions of the Defendant Law's Motion for New Trial, specifically the exclusion of evidence of the Plaintiff's extramarital affair and subsequent remarriage and the limiting of the testimony of the decedent's mother, stepfather and brother. The Court has not addressed the excessiveness of the verdict or the Defendant's request for relief under the Thirteenth Juror Doctrine. The Court is respectfully requested to alter or amend its current Order to specifically address these grounds for a new trial.

3. In its Order Denying Defendant Law's Post Trial Motions, the Court has not addressed the Defendant Law's Motion for New Trial Nisi Remittitur. The Court has also not addressed Dr. Law's request that the judgment be enrolled using the percentage of fault as found by the jury and specifically that the judgment against Dr. Law be enrolled as six percent (6%) of

the damages awarded by the jury. The Court is respectfully requested to alter or amend its current Order to specifically address these motions.

The Defendant's motion is based upon the pleadings filed in this case; the trial record; the Order Denying Defendant Law's Post Trial Motions, filed June 24, 2010; the Defendant Law's Post-Trial Motions; the rules of court; and such other matters as may be properly presented to the Court at the time of the hearing.

Respectfully submitted,

BY:


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Florence, South Carolina

July 21, 2010

(22108)

COUNTY OF HORRY

Sean D. Fay, as Personal Representative of
the Estate of Kelly L. Fay, deceased,

Plaintiff,

vs.

Grand Strand Regional Medical Center,
LLC, d/b/a South Strand Ambulatory Care
Center, Jane Doe and unidentified nurse
employed with Grand Strand Regional
Medical Center, LLC, Stephen W. Law,
D.O., Carolina Health Specialists, Dr.
Richard Young, M.D. and Grand Strand
Urology, LLP

Defendants.

Civil Action No.: 08-CP-26-9047
08-CP-26-9368**PLAINTIFF'S MEMORANDUM IN
OPPOSITION TO DEFENDANT DR.
STEPHEN LAW'S MOTION FOR JNOV,
NEW TRIAL, REMITTITUR, ETC.**

Plaintiff in the above-referenced action, by and through the undersigned counsel, hereby respectfully submits this memorandum in opposition to Defendant Dr. Law's Motion for New Trial. The grounds for this memorandum are discussed more thoroughly below. The Plaintiff prays this Court deny the Defendant's Motion for New Trial.

**I. DEFENDANT'S MOTION FOR JUDGMENT NOTWITHSTANDING THE
VERDICT SHOULD BE DENIED.****Standard of Review**

When ruling on motions for judgment notwithstanding the verdict, the trial court must view the evidence and its reasonable inferences in the light most favorable to the party opposing the motions. Hessenthaler v. Tri-County Sister Help, Inc., 365 S.C. 101, 616 S.E.2d 694 (2005). The trial court must deny the motions when the evidence yields more than one inference or its

inference is in doubt. Id. On review, a court will reverse the trial court's ruling only when there is no evidence to support it. Id. The Plaintiff offered sufficient expert testimony to create a reasonable inference that the Defendant breach of the standard of care proximately caused the Plaintiff's injuries and damages. Also, the Court properly submitted the issue of comparative negligence to the jury for consideration.

a. Plaintiff presented reliable testimony to support a claim that the Defendant's breach of the standard of care proximately caused the Plaintiff's damages.

Defendant's assertion that there was no evidence attacking the integrity and credibility of Dr. Law's discharge typewritten note is disingenuous and a blatant disregard of the evidence presented at trial. Plaintiff testified ad nauseum that Dr. Law failed to explain to either he or Decedent that they were to return immediately if Decedent experienced fever or chills. Defendant ignores an entire segment of testimony by Plaintiff in its inaccurate assertion that there was no evidence contradicting Dr. Law's note. Defendant Dr. Law testified that he was ultimately responsible for the care of the patient, the conduct of the nurses, and the decision to discharge Decedent. Dr. Michael Siroky, Plaintiff's expert urologist, testified that Decedent should have been admitted to the hospital on January 26, 2002, and that Plaintiff and Decedent should never have been placed in the position by Defendants to decide when and if to return to the emergency room.

The Plaintiff's medical experts, three physicians and a registered nurse, offered testimony providing that the Defendant breached the standard of care and/or such breach of the standard of care proximately caused the Decedent's death and the Plaintiff's injuries and damage. Defendant's own employee and registered nurse, Grace New, admitted in her testimony that she breached the standard of care. Dr. Law admitted he failed to follow standard kidney protocol. The admission or exclusion of expert testimony is a matter within the sound discretion of the trial

court, whose decision will not be disturbed on appeal absent an abuse of discretion. Means v. Gates, 348 S.C. 161, 166, 558 S.E.2d 921, 923 (S.C. Ct. App. 2001). The qualification of an expert witness and the admissibility of his opinion are matters resting largely within the discretion of the trial judge. Manning v. City of Columbia, 297 S.C. 451, 377 S.E.2d 335 (1989).

Where the expert's testimony is based upon facts sufficient to form the basis for an opinion, the trier of fact determines its probative value. Berkeley Elec. Coop v. South Carolina Pub. Serv. Comm'n, 304 S.C. 15, 402 S.E.2d 674 (1991). Plaintiff's experts' opinions on the breach of the standard of care and causation was bottomed and premised on trial testimony, deposition testimony, medical records, as well as their education, knowledge, training and experience. If there was any conflict in the expert testimony, it would be the jury's duty to weigh conflicting evidence. Jones v. Grissett, 258 S.C. 22, 186 S.E.2d 829 (1972). Moreover, Defendant did not make any objections during trial upon qualification of each of Plaintiff's experts nor did Defendant make a proffer of testimony for the trial court to determine the admissibility of such expert testimony. As a result, Defendant failed to preserve this issue for review.

b. The issue of comparative negligence was properly submitted to the jury.

Plaintiff's experts testified that the Defendants had a greater duty than Plaintiff Sean Fay regarding the treatment and care of Decedent Kelly Fay. A determination of the degrees of negligence attributable to the plaintiff and the defendant presents a question of fact for the jury to decide. Snively v. AMISUB of S.C., Inc., 379 S.C. 386, 665 S.E.2d 222 (S.C. Ct. App. 2008). Plaintiff Sean Fay testified that he did not have medical training and was not instructed that a kidney stone combined with a fever or infection is a urological emergency. The Defendants testified that Plaintiff Sean Fay was never instructed that a kidney stone and a fever or infection

was an emergency and that Decedent Kelly Fay could die from such a combination. Defendants also testified that the discharge instructions provided to the Plaintiff and Decedent were confusing and improper. The issue of comparative negligence was properly submitted to the jury and the jury specifically itemized percentages of negligence for each Defendant. Accordingly, Defendant's Motion for JNOV should be denied.

II. DEFENDANT'S MOTION FOR A NEW TRIAL ABSOLUTE SHOULD BE DENIED.

Standard of Review

The grant or denial of new trial motions rests within the discretion of the trial judge and his decision will not be disturbed on appeal unless his findings are wholly unsupported by the evidence or the conclusions reached are controlled by error of law. Vinson v. Hartley, 324 S.C. 389, 477 S.E.2d 715 (S.C. Ct. App. 1996). The admission of evidence is a matter left to the discretion of the trial judge and, absent clear abuse, will not be disturbed on appeal. Carlyle v. Tuomey Hosp., 305 S.C. 187; Hofer v. St. Clair, 298 S.C. 503, 381 S.E.2d 736 (1989).

a. The Court properly excluded the evidence of the Plaintiff's extra-marital affair.

Evidence of Plaintiff's extra-marital affair was properly excluded as irrelevant and highly prejudicial. Evidence, to be admissible, must be relevant. SCRE 402. Evidence is relevant if it has a "tendency to make the existence of any fact that is of consequence to the determination of the action more probable or less probable than it would be without the evidence." SCRE 401. Even if relevant, under South Carolina Rule of Evidence 403, a trial court may exclude otherwise relevant evidence if "its probative value is substantially outweighed by the danger of unfair prejudice, confusion of the issue, or misleading the jury, or by considerations of undue delay, waste of time, or needless presentation of cumulative evidence." Evidence of Plaintiff's extra-

marital affair was properly excluded as irrelevant to the issues in this case as any probative value of the evidence would have been substantially outweighed by the danger of unfair prejudice to the Plaintiff.

In Wooten v. Amspacher, 279 S.C. 325, 307 S.E.2d 232 (1983), the Supreme Court held that the fact that the husband and wife were actually separated at the time of his death was not relevant to any damages of the surviving spouse. It follows that a single affair which was terminated prior to the Decedent's death would have been equally irrelevant to any damages sustained by Plaintiff in this matter. Plaintiff's affair ended more than 2 years before Decedent Kelly Fay's death. Plaintiff terminated the affair and disclosed the malfeasance to Decedent in December of 1999. Shortly thereafter, Plaintiff and Decedent commenced marriage counseling in an effort to save and rejuvenate their marriage, which occurred. This was the Plaintiff's only extra-marital affair during his marriage with Decedent. As there is no remaining question of Plaintiff's infidelity at the time of Decedent's death, the evidence of the affair was immaterial, irrelevant, and properly excluded.

In Brossette v. Swift Transp., Co., 2008 U.S. Dist. LEXIS 112928 (W.D. La. Oct. 29, 2008), the court excluded any evidence of an extra-marital affair by the surviving spouse, holding that the potential probative value of such evidence was slight. The Brossette court also excluded evidence that the surviving spouse dated following the death of her spouse. Ordinarily, evidence of marital infidelity would be inadmissible on grounds that it lacks relevance and amounts to a smear upon the [witness's] character. Smith v. Com., 904 S.W.2d 220, 220 (Ky. 1995). The inflammatory nature of this evidence far outweighs any probative value it may have. See, e.g., Barnett v. Com., 763 S.W.2d 119 (Ky. 1988); Barnett v. State, 733 S.W.2d 342 (Tex. App. 1987). Admission of this evidence would have violated the general principle disallowing

character evidence absent delineated circumstances. South Carolina Rule of Evidence 404.

“The term character refers to a generalized description of a person’s disposition or a general trait such as honesty, temperance or peacefulness.” State v. Nelson, 331 S.C. 1, 7, 501 S.E.2d 716, 719 (1998).

Following Plaintiff’s termination and disclosure of the affair, the marriage remained vibrant until Decedent’s death in 2002. Plaintiff testified that the marriage was “fantastic” and that he and Decedent were as close as they had ever been at the time of Decedent Kelly Fay’s death. See, Sean Fay Depo. pp. 24-28. The Defendant cannot establish marital discord between Plaintiff and Decedent at the time of death because it is not true. Moreover, there is no evidence of an incompatible or non-supportive marital relationship that would mitigate an award for grief, sorrow, loss of companionship, or economic loss. The evidence of Plaintiff’s extra-marital affair was properly excluded as irrelevant to the issues in this case as any probative value of the evidence would have been substantially outweighed by the danger of unfair prejudice to the Plaintiff.

b. The Court properly excluded the evidence of the Plaintiff’s remarriage after the death of Plaintiff’s Decedent.

The Supreme Court of South Carolina has held repeatedly for nearly forty years that evidence concerning the surviving spouse’s subsequent remarriage after the death is not admissible in a wrongful death action where the issue is the widow’s or widower’s damages. See, e.g., Moultrie v. Medical University of South Carolina, 280 S.C. 159, 311 S.E.2d 730 (1984); Wooten v. Amspacher, 279 S.C. 325, 307 S.E.2d 232 (1983); Smith v. Wells, 258 S.C. 316, 188 S.E.2d 470 (1972). This evidence is likewise inadmissible in a survival action. See, Moultrie and Wooten. It is axiomatic that any other romantic relationship following Kelly Fay’s death is inadmissible, regardless of whether the relationship was consummated by marriage.

Plaintiff's remarriage did not affect the damages recoverable for the wrongful death of Kelly Fay, and that evidence of the fact of remarriage or romantic relationships subsequent to Kelly Fay's death are inadmissible. Smith, 258 S.C. 316, 188 S.E.2d 470. This is in accord with the rule adopted by the majority of American jurisdictions which have considered the questions. Id. 258 S.C. 316 at 321, 188 S.E.2d at 472 (citing 87 A.L.R. (2d) 252, 22. Am. Jur. (2d), Death Section 164, 25A C.J.S. Death § 114, pg. 961).

Any testimony of the post-death romantic relationships and remarriage would have involved an inquiry into the relative merits of the two wives, which could only be determined by a comparison of their prospective earnings, contributions, services, society, and companionship. Plaintiff's subsequent romantic relationships and remarriage was occasioned by the wrongful death of Decedent Kelly Fay, and the probable effect of the remarriage upon such elements of damage as grief and sorrow, wounded feelings, and mental shock would have involved an inquiry into all of the surrounding facts and circumstances which may have hastened the choosing of another mate. Such testimony was too speculative to form any valid standard by which to determine the damages sustained by the Plaintiff.

The highly speculative inquiry into the prospective value of the second marriage would not have contributed to the certainty of the ultimate determination of the damages, and would only have served to inject considerations which would have confused the issues. Such evidence of post-death romantic relationships and remarriage would have been incompetent and would have presented an issue not germane to the real question involved in this case, and therefore would have been calculated to mislead and confuse the jury, and as such would have been prejudicial to the rights of the Plaintiff. The evidence of Plaintiff's remarriage was properly

excluded as irrelevant to the issues in this case as any probative value of the evidence would have been substantially outweighed by the danger of unfair prejudice to the Plaintiff.

c. The Court properly limited the testimony of Decedent Kelly Fay's mother, stepfather, and brother.

The Court properly limited the testimony of Decedent Kelly Fay's family regarding their support of this lawsuit or matters outside of the personal knowledge of the family. South Carolina Rule of Evidence 602 prohibits a witness from testifying to matters unless evidence is introduced sufficient to demonstrate the witness has personal knowledge. The testimony of the family members regarding their support of this lawsuit, what they felt Plaintiff Sean Fay should have done under the circumstances, and whether they believe Defendants are liable for Decedent's death is inadmissible and was properly limited.

In addition, the prejudicial effect of the family members' testimony regarding their lack of support for the lawsuit was likely to sway and confuse the jurors. Evidence, to be admissible, must be relevant. SCRE 402. Evidence is relevant if it has a "tendency to make the existence of any fact that is of consequence to the determination of the action more probable or less probable than it would be without the evidence." SCRE 401. Even if relevant, under South Carolina Rule of Evidence 403, a trial court may exclude otherwise relevant evidence if "its probative value is substantially outweighed by the danger of unfair prejudice, confusion of the issue, or misleading the jury, or by considerations of undue delay, waste of time, or needless presentation of cumulative evidence."

Even assuming, *arguendo*, that there is some modicum of relevancy to this evidence, its probative value was outweighed by its prejudicial effect. The family members' beliefs as to the merits of the lawsuit and what they would have done if their loved one was in a similar situation was irrelevant and highly prejudicial. Such evidence would have been incompetent and would

have presented an issue not germane to the real question involved in this case, and therefore would have been calculated to mislead and confuse the jury, and as such would have been prejudicial to the rights of the Plaintiff.

Notwithstanding the irrelevance of the family members' testimony concerning their lack of support for the lawsuit, the members of the family are not competent to testify whether the Defendants are responsible for Kelly Fay's death and whether Plaintiff Sean Fay's actions were appropriate under the circumstances. Expert testimony is required to establish proximate cause in a medical malpractice case if outside the common knowledge or experience of laypersons. See, Bramlette v. Charter-Medical-Columbia, 302 S.C. 68, 393 S.E.2d 914 (1990). Opinion testimony from a lay witness is admissible if it is: (a) rationally based on the perception of the witness, (b) helpful to the determination of a fact in issue, and (c) does not require special knowledge, skill, experience, or training. Rule 701, SCRE. Opinion testimony would be clearly improper given the complexity of the subject matter of this lawsuit.

The family members were in Wisconsin during the span of time in which the Decedent visited the emergency room and later died of septic shock. Consequently, the family members' testimony is not rationally based on the perception of the Decedent at the time of her treatment and death. Most significantly, any testimony about the Defendants' liability and merits of the lawsuit would have required special knowledge, skill, experience, or training. None of the family members have any special knowledge, skill, experience, training or education in a particular field, profession or occupation so as to be qualified as an expert and render an opinion on the merits of this lawsuit. The family members lacked personal knowledge and were not qualified to render testimony on the standard of care and the Defendants' failure to conform to the required standard.

Whether this lawsuit is meritorious required testimony that was outside the ambit of common knowledge or experience of laypersons and would have invaded the province of the jury. Furthermore, the family members' testimony about the reasonableness of Sean's actions would have required speculation and was irrelevant to this lawsuit. Such evidence would have been incompetent and would have presented an issue not germane to the real question involved in this case, and therefore would have been calculated to mislead and confuse the jury, and as such would have been prejudicial to the rights of the Plaintiff.

d. The verdict in this case was not excessive and should not be disturbed.

The verdict in this case was far from excessive and was not actuated by passion, caprice, and prejudice. The award of actual and punitive damages remains within the discretion of the jury, as reviewed by the trial judge. Miller v. City of W. Columbia, 322 S.C. 224, 471 S.E.2d 683 (1996). When considering whether or not the verdict is excessive, if there is substantial evidence to sustain the verdict, it will not be disturbed. Id. The appellate court will intervene only where the verdict is so grossly excessive and the amount awarded is so shockingly disproportionate to the injuries to indicate that it was the result of caprice, passion, prejudice, or other considerations not found in the evidence. Easler v. Hejaz Temple A.A.O.N.M.S of Greenville, 285 S.C. 348, 329 S.E.2d 753 (1985). Considering the age of the Decedent, the circumstances of her death, the economic damages, and the breach of a basic medical standard, there is substantial evidence to sustain the verdict.

South Carolina courts have upheld numerous multi-million dollar verdicts awarded in medical malpractice actions containing actions for wrongful death and survival. See, e.g., Hawkins v. Pathology Associates, P.A., 330 S.C. 92, 498 S.E.2d 395 (S.C. Ct. App. 1998) (\$1.1 million in wrongful death claim and \$3.5 million in the survival action affirmed); Welch v.

Epstein, 342 S.C. 279, 536 S.E.2d 408 (S.C. Ct. App. 2000) (\$3 million in wrongful death claim and \$3.9 million in punitive damages affirmed); Haselden v. Davis, 341 S.C. 486, 534 S.E.2d 295 (S.C. Ct. App. 2000) (\$1,082,103.71 in wrongful death claim and \$1 million in survival action affirmed); Scott v. Porter, 340 S.C. 158, 530 S.E.2d 389 (Ct. App. 2000) (\$1.5 million in wrongful death claim, \$600,000 in survival claim, and \$3 million in punitive damages affirmed); Burroughs v. Worsham, 352 S.C. 382, 574 S.E.2d 215 (Ct. App. 2002) (\$3.5 million in wrongful death claim and \$3.5 million in survival action affirmed); Taylor v. Medenica, 324 S.C. 200, 479 S.E.2d 35 (1996) (\$4 million in actual damages and \$10 million in punitive damages affirmed).

Dr. Oliver G. Wood, the forensic economist retained by Plaintiff, testified that the economic loss resulting from Decedent's death was in excess of \$1,700,000.00. There was overwhelming evidence in this matter, including testimony by Defendant Grand Strand employees, that the Defendants violated their own internal hospital policy by failing to secure basic vital signs from the Decedent prior to her discharge that could have prevented her death. See, Caldwell v. K-Mart Corp., 306 S.C. 27, 410 S.E.2d 21 (Ct. App. 1991). Moreover, Plaintiff provided evidence that Defendant Dr. Law failed to order requisite tests to rule out infection and also failed to see that Decedent's temperature was taken before she was discharged while admitting that a fever and a kidney stone is a true urologic emergency. Additionally, Plaintiff presented evidence that Defendants may have engaged in the spoliation of medical records. Lastly, Plaintiff also provided evidence detailing the horror of Decedent's final hours and the sorrow, grief, and loss of companionship experienced by Plaintiff following the loss of his wife. As a result of the economic loss, circumstances surrounding the Decedent's death, and the breaches of basic standards of care, the verdict should be sustained.

- e. **Viewing the evidence and inferences in the light most favorable to Plaintiff, the issue of comparative negligence was properly submitted to the jury.**

~~The issue of comparative negligence was properly submitted to the jury for consideration~~

of Plaintiff's actions. Plaintiff's experts testified that the Defendants had a greater duty than Plaintiff Sean Fay regarding the treatment and care of Decedent Kelly Fay. A determination of the degrees of negligence attributable to the plaintiff and the defendant presents a question of fact for the jury to decide. Snavely v. AMISUB of S.C., Inc., 379 S.C. 386, 665 S.E.2d 222 (S.C. Ct. App. 2008). Plaintiff Sean Fay testified that he did not have medical training and was not instructed that a kidney stone combined with a fever is a urologic emergency. Plaintiff also testified that Defendant Dr. Law never instructed Decedent or Plaintiff that Decedent should return to the emergency room if she experienced any fever or chills. The Defendants testified that Plaintiff Sean Fay was never instructed that a kidney stone and a fever was an emergency and that Decedent Kelly Fay could die from such a combination. As a result, the issue of comparative negligence was properly submitted to the jury. Accordingly, viewing the evidence and inferences in the light most favorable to Plaintiff, the issue of comparative negligence was properly submitted to and decided by the jury.

f. The Court, sitting as a thirteenth juror, should deny Defendant Dr. Law's motion for a new trial absolute.

In South Carolina, a trial judge may grant a new trial following a jury verdict under the Thirteenth Juror Doctrine. See, Lane v. Gilbert Constr. Co., 383 S.C. 590, 681 S.E.2d 879 (2009). The doctrine "entitles the judge to sit, in essence, as the thirteenth juror when he finds 'the evidence does not justify the verdict,' and then to grant a new trial based solely 'upon the facts.'" Norton v. Norfolk Southern Railway Co., 350 S.C. 473, 478, 567 S.E.2d 851, 854 (2002) (citing Folkens v. Hunt, 300 S.C. 251, 387 S.E.2d 265 (1990)). Based upon the facts in this case, the testimony provided by Plaintiff and Plaintiff's medical experts, the medical records, the

Defendants' own trial admissions, Defendant Grand Strand's internal policies and procedures, the evidence and facts more than justify the verdict against Defendants.

The Defendants' records, the veracity of which was stipulated to by the parties, clearly evidence that Defendant Grand Strand violated its own policy on vital signs. In light of the fact that the Defendants admitted that a fever and kidney stone is a urological emergency, the Defendants' failure to ensure that appropriate vital signs were administered or otherwise rule out an infection in Decedent and that Decedent's temperature was taken sufficiently warrant evidence to sustain the verdict. Plaintiff and Decedent did not know that a kidney stone combined with a fever was a urological emergency that could entail infection and ultimately death. Defendants admitted that neither Plaintiff nor Decedent were informed of the dire consequences of having a kidney stone and a fever. Defendants also admitted that Decedent's temperature was taken only once over the course of her 4 hour stay at the emergency room in contravention to Defendant Grand Strand's internal hospital policy. See, Caldwell v. K-Mart Corp., 306 S.C. 27, 410 S.E.2d 21 (Ct. App. 1991).

Grace New, the treating registered nurse employed by the Defendant, admitted that she breached the standard of care in not taking appropriate vital signs. Defendant Dr. Law provided that it was standard protocol to order a specific litany of tests when treating a kidney stone and then admitted that he failed to order these tests. Plaintiff's experts and Defendants themselves admitted that the discharge instructions provided to Plaintiff were confusing and inadequate. Mary Beth Doolittle, the discharge nurse employed by Defendant, admitted that she would inform a patient to come to the emergency room if she was called and provided the information that Plaintiff testified over the phone the Sunday prior to Decedent's death.

Taking into consideration the Plaintiff's testimony, Plaintiff's experts' testimony, Defendants' admissions, the medical records, and the internal policies and procedure on vital signs and other tests which should have been administered, there was sufficient evidence presented during the trial to justify the verdict.

III. DEFENDANT'S MOTION FOR A NEW TRIAL *NISI REMITTITUR* SHOULD BE DENIED.

The verdict in this case was not excessive considering the Plaintiff's economic loss, the horrific manner in which the Decedent died, and the Plaintiff's damages arising out of the abrupt loss of his twenty-five year old wife. A motion for new trial *nisi remittitur* asks the trial court to reduce the verdict because the verdict is merely excessive. See O'Neal v. Bowles, 314 S.C. 525, 431 S.E.2d 555 (1996). The jury verdict in this case was neither unduly liberal nor excessive and should not be reduced. The evidence during trial detailed the dreadful conditions in which the Plaintiff found the Decedent the day of her death. Further, the economic damages alone surpassed \$1,700,000.00. A \$3 million verdict for the wrongful death and survival action arising out of the death of a twenty-five year old healthy individual that died a horrid death is not excessive.

As aforementioned, courts in this State have upheld verdicts in wrongful death/survival actions that far exceeded the verdict in this case. In Knoke v. South Carolina Dept's of Parks, Rec. & Tourism, 324 S.C. 136, 478 S.E.2d 256 (1996), the South Carolina Supreme Court found that a \$3,000,000 verdict was not excessive in a wrongful death claim that was absent of economic damages entirely (finding that a verdict containing damages for mental shock and suffering, wounded feelings, grief, sorrow, loss of society and companionship, could not be determined by any fixed measure and was not grossly excessive).

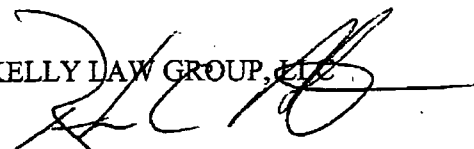
Plaintiff provided evidence of the Decedent's last hours – in which Decedent was found gagging, seizing, and incontinent. Plaintiff suffered the grief, anguish, sorrow and loss of companionship following the death of his spouse. Dr. Oliver G. Wood testified that the economic loss arising out of Decedent's death approached nearly two million dollars. Defendant's citation to Becker v. Wal-Mart Stores, Inc., 529 S.E.2d 758 (S.C. Ct. App. 2000) only bolsters an affirmation of the verdict in this case. An award of \$525,000 for a partially paralyzed foot pales in light of the tragic and gruesome death experienced by Decedent Kelly Fay. In its motion for new trial *nisi remittitur*, the Defendant fails to afford credence for non-economic losses, a notion that should offend the sensibility of this Court.

CONCLUSION

As a result of the aforesaid, the Plaintiff therefore prays this Honorable Court deny Defendant Dr. Law's motion for judgment notwithstanding the verdict, new trial absolute, or new trial *nisi remittitur*.

Respectfully Submitted,

MIKE KELLY LAW GROUP, LLC

BY: 

Ruskin C. Foster
Brad D. Hewett
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803/726-0123
Attorney for Plaintiff

Columbia, South Carolina
June 14, 2010

STATE OF SOUTH CAROLINA
COUNTY OF HORRY

IN THE COURT OF COMMON PLEAS
2008-CP-26-9047
2008-CP-26-9368

Sean D. Fay, as Personal Representative
for the Estate of Kelly L. Fay, Deceased,

Plaintiff,

-vs-

Grand Strand Regional Medical Center,
LLC d/b/a South Strand Ambulatory
Care Center, Jane Doe, an unidentified
nurse employed with Grand Strand
Regional Medical Center, LLC, Stephen
W. Law, D.O., Carolinahealth
Specialists, Dr. Richard Young, M.D.,
and Grand Strand Urology, LLP,

Defendants.

NOTICE OF MOTION AND MOTION
FOR SUMMARY JUDGMENT ON
BEHALF OF DR. RICHARD YOUNG
AND GRAND STRAND UROLOGY,
LLP

FILED
HORRY COUNTY
2010 MAY 12 AM 11:26
MELANIE HUGGINS-WARD
CLERK OF COURT

TO: RUSKIN C. FOSTER, ESQUIRE, ATTORNEY FOR PLAINTIFF:

YOU WILL PLEASE TAKE NOTICE that the undersigned, as attorney for the Defendants Dr. Richard Young and Grand Strand Urology, LLP, will move before the Judge of the Court of Common Pleas, on May 17, 2010, at 10:00 o'clock in the forenoon, or as soon thereafter as counsel may be heard, for an Order granting summary judgment on the grounds that there is no genuine issue of material fact, and these Defendants are entitled to judgment as a matter of law because there was no physician/patient relationship between Dr. Young and the decedent.

Said Motion will be based upon the pleadings, affidavits, memoranda, depositions, and any other evidence that may be received by the Court hereinafter to be served.

[Signature on page following]

Regina L. Magee

Lydia Lewis Magee
Marian Williams Scalise
Richardson, Plowden & Robinson, P.A.
P.O. Box 3646
Myrtle Beach, SC 29578
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5-12, 2010.
Myrtle Beach, South Carolina

Attorneys for Defendants Richard Young, M.D. and Grand
Strand Urology, LLP

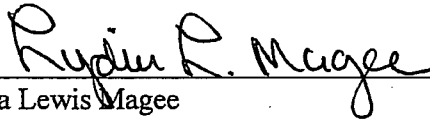
RULE 11 CERTIFICATION

The attorney below hereby certify that either:

- A. She has communicated, orally or in writing, with opposing counsel and has attempted in good faith to resolve the matter contained in the Motion; or
- B. Such consultation would serve no useful purpose, or could not be timely held; or
- C. Due to the nature of the Motion, there is no duty to consult opposing counsel in that this is a Motion:

- _____ a. To Dismiss
- XX b. For Summary Judgment
- _____ c. For New Trial
- _____ d. For Judgment NOV

FILED
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2010 MAY 12 AM 11:26
JUDICIAL DISTRICT OF CLAY COUNTY



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5-12, 2010.
Myrtle Beach, South Carolina

Attorneys for Defendants Richard Young, M.D. and Grand
Strand Urology, LLP

STATE OF SOUTH CAROLINA)
COUNTY OF HORRY)

IN THE COURT OF COMMON PLEAS
C/A 04-CP-26-480 (SURVIVAL ACTION)
C/A 04-CP-26-481 (WRONGFUL DEATH)

Sean D. Fay, as Personal Representative)
for the Estate of Kelly L. Fay, Deceased,)
Plaintiff,)

-vs-

Grand Strand Regional Medical Center,)
LLC d/b/a South Strand Ambulatory)
Care Center, Jane Doe, an unidentified)
nurse employed with Grand Strand)
Regional Medical Center, LLC, Stephen)
W. Law, D.O., Carolina Health)
Specialists, Dr. Richard Young, M.D.,)
and Grand Strand Urology, LLP,)
Defendants.)

**MEMORANDUM IN SUPPORT OF
RICHARD YOUNG, M.D.'S AND
GRAND STRAND UROLOGY, L.L.P.'S
MOTION FOR SUMMARY
JUDGMENT**

The Defendants, Richard Young M.D. and Grand Strand Urology, L.L.P., move for summary judgment pursuant to Rule 56 of the South Carolina Rules of Civil Procedure and Rules 702 and 403 of the South Carolina Rules of Evidence, on the ground that there exists no genuine issue of material fact that a doctor-patient relationship existed between the decedent and these Defendants to impose a duty.

FACTS

Kelly Fay was a 25-year-old, married, female who presented to the emergency room of South Strand Ambulatory Care Center at 8:00 a.m. on Saturday, January 26, 2002, complaining of a sudden onset of right flank pain that began approximately 1-1/2 hours prior to arrival. Ms. Fay was accompanied by her husband, the Plaintiff Sean Fay. According to the medical records from South Strand Ambulatory Care Center, Ms. Fay complained of mild nausea, but had no

vomiting, and denied fevers, chills, dysuria, hematuria, or menstrual irregularities.

Emergency room physician Dr. Steven Law examined the patient and noted that she did not have a fever (98.1°) and had stable vital signs. Dr. Law's examination of the patient's abdomen revealed moderate-to-severe flank tenderness on the right side; however, the abdomen was soft, non-tender, and non-distended without rebound, rigidity, or guarding, and he noted active bowel sounds. The patient had a normal urinalysis with no blood or bacteria in the urine. Dr. Law ordered a kidney, urethra, bladder (KUB) x-ray which revealed a moderate-sized stone in the region of the right ureteropelvic junction (the kidney end of the ureter). A CT-Scan of the abdomen revealed a .5 cm diameter stone within the proximal ureter that was lying at or close to the level of the ureteropelvic junction.

After receiving these test results and deciding that the patient was safe to discharge with urologic follow-up, Dr. Law telephoned on-call urologist Dr. Richard Young. Dr. Law testified that generally whenever he calls a doctor from the emergency department he reports the patient's presentation, symptoms, relief to pain medications, any lab findings, and disposition. [Exhibit A; Depo. of Dr. Law; pg. 84, ln. 10-18] After Dr. Law discussed the patient's clinical symptoms with Dr. Young, he told Dr. Young that he was going to discharge the patient with pain medication. Dr. Law did not ask Dr. Young to come in to evaluate the patient, Dr. Law did not ask Dr. Young if she needed to be admitted, and Dr. Law did not ask Dr. Young his opinion regarding the patient. [Exhibit A; Depo. of Dr. Law; pg. 97, ln. 20-23; Exhibit B; Depo. of Dr. Young; pg. 58, ln. 3-15; pg. 71, ln. 22-25; pg. 102, ln. 5-11] Dr. Law testified that he asked Dr. Young when he would be available to see the patient, and he indicated that she could be seen the following Monday. [Exhibit A; Depo. of Dr. Law, pg. 89, ln. 3-5; pg. 158, ln. 4-7; Exhibit B.; Depo. of Dr. Young; pg. 51, ln. 19-25]

Dr. Young testified that he received a phone call from Dr. Law advising him that "he had a patient in the emergency room with a stone that he saw on the CT scan, and that [Dr. Law] thought the pain was well controlled and [Dr. Law] was going to send them home and that . . . [Dr. Law] thought she'd be okay to go home but . . . [Dr. Law] thought that she would probably need follow-up." [Exhibit B; Depo. of Dr. Young; pg. 39, ln. 4-12] At no time did Dr. Young see the patient or make a treatment decision regarding the care she received in the hospital emergency room. Dr. Young merely agreed with Dr. Law's evaluation and treatment and Dr. Law's decision to discharge the patient. [Exhibit A; Depo. of Dr. Law, pg. 85, ln. 10-25; pg. 86, ln. 1-3; pg. 87, ln. 20-25]

Dr. Law testified that when he discharged the patient, in addition to telling her to drink plenty of water, he told Ms. Fay that if her pain became out of control or if she had increasing nausea, vomiting, or any fevers or chills, that she was to return to the emergency department immediately. [Exhibit A; Depo. of Dr. Law; pg. 132-133, ln. 22-25, ln. 1-2] The typed instructions that she took home with her also recited that she should call or go to the emergency room right away if she developed fever, more intense pain, or repeated vomiting. The instructions further stated, "If you do not continue to improve or if your condition worsens, please call your doctor or the emergency department right away so you can be examined." The patient's discharge instructions indicate that the patient was supposed to call Dr. Young's office at 8:30 a.m. on Monday, January 28, 2002.

On Monday, January 28, 2002 at 1:59 p.m., EMS received a call from the patient's husband. When EMS arrived at their home, they found Ms. Fay lying on the floor, very hot to the touch, and cyanotic with shallow rapid respirations and vomit in her mouth. They noted that she had been incontinent of urine and feces. According to the EMS records, the patient's

husband reported to EMS paramedics that his wife had been febrile the night before at 101°. He also reported to EMS that when he came home from work he found his wife lying on the floor unresponsive making gurgling noises.

EMS transported the patient to Grand Strand Regional Medical Center where the patient's urine and blood cultures revealed evidence of proteus mirabilis bacteria. Her temperature when she arrived in the emergency room was noted to be 107° rectally. The ER records indicate that the Plaintiff, patient's husband, reported to emergency room physician Dr. Chi that the patient had done well since she left the emergency room on Saturday, with the exception of having a mild temperature elevation along with some fever and chills. After arriving at the hospital, the patient went into cardiac arrest and was pronounced dead at 10:00 p.m.

An autopsy revealed that the patient died as a result of overwhelming clinical sepsis due to proteus species bacteria. The Plaintiff filed this lawsuit against the Defendants on January 27, 2004 alleging wrongful death and survival causes of action.

STANDARD OF REVIEW

Summary judgment is appropriate where there is no genuine issue of material fact and the moving party is entitled to judgment as a matter of law. Baird v. Charleston County, 333 S.C. 519, 529, 511 S.E.2d 69, 74 (1999). In determining whether any triable issues of fact exist, the trial court must view the evidence and all reasonable inferences that may be drawn from the evidence in the light most favorable to the non-moving party. Manning v. Quinn, 294 S.C. 383, 365 S.E.2d 24 (1988).

Although the burden is on the party seeking summary judgment, the non-moving party must make a showing sufficient to establish the existence of an element on which it will bear the

ultimate burden of proof at trial; otherwise, the failure of proof concerning an essential element of the case necessarily renders all other facts immaterial. Celotex Corp. v. Catrett, 477 U.S. 317, 322 (1986) (emphasis added). A party cannot rest on the mere allegations in his complaint. Nor can a party escape summary judgment on the mere hope that something will develop later at trial, or by remaining silent and later claiming additional facts supporting the cause of action. Hammond v. Scott, 268 S.C. 137, 232 S.E.2d 336 (1977).

DISCUSSION

I. Plaintiff Has Failed to Establish a Physician-Patient Relationship Between Kelly Fay and Dr. Young To Impose A Duty As a Matter of Law, and Defendants Dr. Young and Grand Strand Urology, L.L.P Are Entitled to Summary Judgment.

The establishment of a doctor/patient relationship is a prerequisite to a claim of medical malpractice. "The relationship is a consensual one wherein the patient knowingly seeks the assistance of a physician and the physician knowingly accepts him as a patient." Roberts v. Hunter, 310 S.C. 364, 426 S.E.2d 797 (1993) (citations omitted) (emphasis added). "It is well-settled law that when a physician-patient relationship exists, the physician owes the patient a duty to exercise reasonable care." When the physician neither offers nor intends to treat, care for, or otherwise benefit the patient, in contrast to the situation in which the physician assumes the role of the treating physician, no doctor-patient relationship is formed. Tumblin v. Ball-Incon Glass Packaging Corp., 324 S.C. 359, 478 S.E.2d 81, 85 (Ct. App. 1996). Where the physician has not intended to treat, offered to treat, or otherwise benefit the patient, the Appellate Courts of this state have held that the dismissal of action is proper in the absence of any physician-patient relationship. See Tumblin at 365-66;

A. Under South Carolina law a physician-patient relationship is not established by an informal consultation.

In Roberts v. Hunter, 310 S.C. 364, 426 S.E.2d 797 (1993), the South Carolina Supreme Court examined the novel issue of whether a doctor/patient relationship may exist when the patient has not been examined or treated by that physician. In Roberts, a neurologist was with other patients in the hospital when he was contacted by an ER physician to examine a patient who was complaining of pain in his neck and shoulder after falling from a scaffold. The neurologist agreed to come to the ER to examine the patient; however, the patient left the hospital before the neurologist had an opportunity to examine him. The patient returned to the hospital approximately 2½ hours later with right-sided paralysis as a result of stroke. The patient then sued the neurologist for medical malpractice, claiming that a doctor-patient relationship existed with him such that he had a duty to immediately come to the emergency room and his failure to do so resulted in the patient's subsequent stroke. The South Carolina Supreme Court disagreed and found no doctor-patient relationship existed.

In holding that no doctor-patient relationship existed, the Roberts' court agreed with other jurisdictions and found that: "a treating physician's informal consultation with another physician did not give rise to a relationship: There has been no showing that the respondent consulting physician had any contact with the patient, saw any records relating to the case, or even knew the patient's name." Id., citing Hill by Burston v. Kokosky, 186 Mich.App. 300, 463 N.W.2d 265 (1990); see also Childers v. Frye, 201 N.C. 42, 158 S.E.2d 744, 746 (N.C. 1931), (holding a doctor may agree to examine a patient for purposes of determining to undertake care without establishing a doctor-patient relationship). Because the neurologist never examined the patient or reviewed his file, circumstances of the case mandated holding that no doctor-patient relationship existed. Roberts, 310 S.C. at 367, 426 S.E.2d at 799; see also, Ellis by Ellis v. Niles, 324 S.C. 223, 479 S.E.2d 47 (1996) (holding Plaintiff had failed to establish the existence of a

duty owed to patient by surgeon who told treating physician "to proceed" with course of treatment but never undertook to personally treat the patient).

In this case, Dr. Young never saw or evaluated the patient; he provided no treatment or care to the patient; he never spoke with the patient; and never saw the patient's lab results, radiology films, or chart. Although Dr. Young testified that he did not remember the specifics of the conversation he had with Dr. Law over two years earlier, he recalled that Dr. Law told him that he had a patient with a kidney stone seen on CT scan in the emergency room, that the patient's pain was well-controlled, that Dr. Law was going to send the patient home, that he did not see any sign of fever and he thought that the stone was five to six millimeters in size and Dr. Law thought she would need follow-up. [Exhibit B; Depo, of Dr. Young; pg. 39, ln. 4-12] Dr. Law testified that he did not ask Dr. Young to come in and see the patient that day; and although Dr. Law also could not recall the specifics of the conversation, he testified that he was calling Dr. Young so Dr. Young would know that he was asking Kelly Fay to follow-up with Dr. Young on Monday since her pain was under control on Saturday. [Exhibit A; Depo, of Dr. Law; pg. 90, ln. 14-21] Significantly, Dr. Law testified that when he called Dr. Young he had already determined that Kelly Fay had a kidney stone, that there was no evidence of infection, that's he did not have a fever, her pain was controlled, and he had already made the decision that she could be discharged. [Exhibit A; Depo, of Dr. Law; pg. 188, ln. 19-25; pg. 189, ln. 1-9]

Additionally, Dr. Law, not Dr. Young, actually diagnosed the patient, and Dr. Young recalled that Dr. Law was "pretty certain of his diagnosis." [Exhibit B; Depo, of Dr. Young; 41, ln. 6-9] Dr. Law testified that he did not believe he would have asked Dr. Young if he thought Kelly Fay needed to be admitted. [Exhibit A; Depo, of Dr. Law; pg. 97, ln. 20-23] Dr. Young testified that Dr. Law was merely calling him because Dr. Law thought that the patient would

need follow-up. [Exhibit B; Depo, of Dr. Young; pg. 41, ln. 1-3] When Dr. Law called him, Dr. Young did not think that Dr. Law was asking his opinion about whether or not she had a kidney stone or anything else. Dr. Young believed that the primary purpose of the phone call from Dr. Law was to arrange for follow-up care. [Exhibit B; Depo, of Dr. Young; pg. 58, ln. 6-15] In fact, Dr. Young testified that he did not recall one way or the other if he agreed or disagreed with Dr. Law's decision to send the patient home, and Dr. Law did not ask his opinion about that decision. [Exhibit B; Depo, of Dr. Young; pg. 71, n. 19-25] Therefore, according to the actual conversation which took place between Dr. Law and Dr. Young, under South Carolina case law, taking the evidence in the light most favorable to the Plaintiff as the non-moving party, there can be no genuine issue of material fact about the existence of a physician-patient relationship because Dr. Young never saw, treated, diagnosed, advised, offered any opinion, or directed the care of the patient in his phone call with Dr. Law. Thus, no doctor-patient relationship existed between the decedent and Dr. Young. See Roberts.

Despite what the clear facts of the case show, Plaintiff's expert urologist Dr. Mike Siroky, attempts to testify that a physician-patient relationship exists merely because Dr. Young answered the phone when Dr. Law called. However, whether a physician owes a duty to a patient is a question of law, not a question of medicine. The Illinois Court of Appeals recognized that experts may try to circumvent the rule of law in their testimony on this issue and succinctly stated, "The proffered opinion of Plaintiff's expert transcends the bounds of his competence and intrudes on the exclusive province of the Court. Plaintiffs may not, in the guise of offering expert medical opinion, arrogate themselves a judicial function and obviate a ruling on the existence of or extent of a legal duty which might be owed by a physician to a patient." Reynolds v. Decatur Memorial Hospital, 660 N.E.2d 235, 239 (Ill. Ct. App. 1996). Thus,

Plaintiff's expert testimony cannot create a genuine issue of material fact, as the facts are to be evaluated on their own merit, and then the law applied to those facts based on the current legal standard for when a physician patient relationship exists as defined by the legal authorities and case law, and NOT by what a medical expert defines a physician-patient relationship to be.

B. An Affirmative Act is Necessary to Establish a Physician-Patient Relationship With a Physician.

While it is clear that the Roberts case supports a complete failure of the establishment of a physician-patient relationship by Dr. Law's telephone call to Dr. Young in the instant case, other jurisdictions have examined nearly identical circumstances surrounding how a physician-patient relationship is established, or more importantly is not established, with an on-call or consulting physician. Most significantly, Texas courts have held that the mere fact that a doctor is on-call does not, in itself, create a physician-patient relationship or impose any duty on the doctor to treat the patient. See St. John v. Pope, 901 S.W.2d. 420, 424 (Tex. 1995). "If, as in this case, no prior relationship exists between physician and patient, an on-call physician may assume a duty to the patient if he takes some affirmative action to treat the patient." Reynosa v. Huff, 21 S.W.3d 510, 513 (Tex. App.-San Antonio 2000). A physician who is on-call and is consulted by an emergency room doctor renders medical services by evaluating the information provided and making a medical decision. See Wheeler v. Yettie Kersting Mem'l Hosp., 866 S.W.2d 32, 37-40 (Tex. App.-Houston 1993).

Oja v. Kin

In the Michigan case of Oja v. Kin, 581 N.W.2d 739 (Mich. Ct. App. 1998), the personal representative of a patient's estate brought a medical malpractice action against an on-call physician, Dr. Kin, who was telephoned by the emergency room resident about a gunshot wound patient. When telephoned, the on-call physician Dr. Kin told the emergency medicine resident

that he was not feeling well and would not come to the emergency room. The lower court granted summary judgment to the on-call physician Dr. Kin, and the Michigan Court of Appeals upheld the grant of summary judgment finding that there was no physician-patient relationship because the on-call physician did not take any action supporting a finding of implied consent to a physician-patient relationship.

On appeal, the Plaintiff argued that there existed a genuine issue of material fact about whether a physician-patient relationship existed. This was an issue of first-impression in Michigan regarding whether a telephone conversation between an attending physician and an on-call consulting physician created a physician-patient relationship between the on-call doctor and a patient whom he does not know, has not spoken with, and has not previously treated. After reviewing the jurisprudence of Michigan and looking at cases from other jurisdictions, the Michigan Court of Appeals found that a physician's on-call status alone is insufficient to warrant a finding that the physician impliedly consented to a physician-patient relationship. *Id.* 581 N.W.2d 739, at 742-43.

The Michigan Court of Appeals further found that a physician-patient relationship can only be found between an on-call doctor and a patient when a physician has done something, such as participate in the patient's diagnosis and treatment, which supports the implication that he consented to the doctor-patient relationship. *Id.* 581 N.W.2d 739, at 743. The Court went even further and held that while such participation is necessary for a physician-patient relationship in the context of an on-call physician, that the "participation by itself" still does not establish a physician-patient relationship. *See id.* Because the on-call physician Dr. Kin never gave any advice to the emergency resident during each of the three phone calls that the resident made to him, the Court agreed that Dr. Kin never took any action which would support a finding

of implied consent, and that under those circumstances there could be no genuine issue of material fact regarding the existence of a physician-patient relationship.

Irvin v. Smith

In Irvin v. Smith, 31 P.3d 934 (Kan. 2001), the Kansas Supreme Court examined the question of when and how a physician-patient relationship is created and what elements were necessary to establish a duty which would preclude summary judgment. In Irvin, the patient was born with hydrocephalus and had surgical placement of a shunt. When the patient was twelve-years-old, she began experiencing flu-like symptoms and seizures and eventually was examined by numerous physicians at several different facilities to determine whether her shunt was working properly. Her pediatric intensivist ordered that the patient be transferred to a hospital and made a telephone call to obtain a neurological consult from Dr. Gilmartin, a child neurologist, because he thought that Dr. Gilmartin was the best consultant to use to help evaluate the patient. The physicians discussed the case and it was agreed that Dr. Gilmartin would see the patient the next morning and would assist the pediatric intensivist in performing a shuntogram. However, prior to any tests or procedures being performed, the patient's condition worsened and she deteriorated to a point where she became critical. Dr. Gilmartin never performed the shuntogram.

A medical malpractice lawsuit was brought against Dr. Gilmartin and several other physicians. The trial court granted summary judgment to Dr. Gilmartin after finding that no physician-patient relationship existed. In affirming the grant of summary judgment to Dr. Gilmartin, the Kansas Supreme Court recognized that although "[a] physician's indirect contact with a patient . . . does not preclude the finding of a physician-patient relationship. . . . **A physician who gives an informal opinion at the request of a treating physician, does not**

owe a duty to the patient because no physician-patient relationship is created.” *Id.* at 120 (emphasis added). The Kansas Supreme Court explained that: “the doctor must take some affirmative action with regard to treatment of a patient in order for the relationship to be established.” *Id.* (emphasis added). The Kansas Supreme Court found that the sole involvement of Gilmartin was as a private practitioner who had been asked to carry out a consultation the following day and that, by itself, did not create a physician-patient relationship.

Although no reported South Carolina case has addressed the issue of whether an affirmative act is necessary to create a physician-patient relationship, and/or what would constitute an affirmative act sufficient to establish a physician-patient relationship, it cannot be ignored that the Kansas Supreme Court’s requirements for the existence of a physician-patient relationship substantially mirror South Carolina’s requirements, *i.e.*, “A physician-patient relationship is consensual. Thus, where there is no on-going physician-patient relationship, the physician’s express or implied consent to advise or treat the patient is required for the relationship to come into being.” *Id.* at 121 (citation omitted).

Jackson v. Isaac

The State of Texas, similarly to Kansas, has also held that an affirmative act is necessary to create a physician-patient relationship. In Jackson v. Isaac, 76 S.W.3d 177 (Tex. App. 2002), the issue before the Texas Court of Appeals was “whether an agreement by a physician to see a new patient is sufficient to establish the physician-patient relationship for purposes of imposing a duty to act on the physician or whether the physician must take some affirmative action with regard to treatment of a new patient before the relationship is established.” *Id.* at 180. In Jackson, the patient went to see his family doctor and after listening to the patient’s complaints, the family doctor administered an EKG. Because the results of the EKG were abnormal, the

family doctor determined the patient should be seen by a cardiologist. The family doctor telephoned a cardiologist and reported that the patient had evidence of congestive heart failure and ischemia and advised the cardiologist that the patient needed to be seen “fairly soon like today.” The family doctor faxed the patient’s medical records to the cardiologist and the cardiologist wrote a note to himself that the patient “probably needed an echo and an office visit.” The family physician gave the patient the cardiologist’s phone number; however, later that day, someone from the cardiologist’s office called the patient and informed him that he had an appointment on Monday, one week later. The patient died on Sunday.

The essential question in Jackson was whether the steps in scheduling an appointment and echocardiogram were affirmative steps that established a duty on the part of the cardiologist. The cardiologist testified that based on the information given to him by the family physician, the only way to diagnose and treat the patient was to see him in person to evaluate him. It was because he needed more information to properly diagnose the patient that he had his office schedule the patient for an echocardiogram before he evaluated him.

Finding the Kansas case of Irvin v. Smith, persuasive, the Texas Court of Appeals held that, “A physician’s agreement to see a new patient should not by itself establish the physician-patient relationship. . . . [t]o hold that there was a physician-patient relationship imposing a duty on [the cardiologist] prior to the Monday appointment would significantly extend the duty of a physician where the physician has had no previous contact with a patient. This we decline to do.” Jackson, 76 S.W.3d at 183 (emphasis added). The Court found that the cardiologist simply agreed to see the patient if he came to his office on Monday. Id.

El Majzoub v. Appling

In another Texas case, El Majzoub v. Appling, 95 S.W.3d 432 (Tex. App. 2002), the

Texas Court of Appeals held that “[t]he on-call status of a physician does not automatically impose a duty. If there is no prior relationship between the physician and the patient, there must be some affirmative action on the part of the physician to treat the patient to create such a relationship.” *Id.*, at 436 (emphasis added) (citations omitted). In *El Majzoub*, patient went to the ER complaining of difficulty breathing and was examined by the ER physician who then telephoned the on-call otolaryngologist to report his findings and the patient’s symptoms. A telephone conversation took place wherein the otolaryngologist told the ER physician what he would normally do with a patient who presented to him with the same symptoms, advised the ER physician that “it probably would not hurt” to give additional medication to the patient and to observe the patient for a period of time after the additional treatment was given, and then asked the ER physician to call him back after the treatment was finished. Finally, the ER physician told the otolaryngologist he was going to refer the patient to him. The otolaryngologist told the ER physician that he would have the patient call to set up an appointment for that morning. However, the patient stopped breathing in the ER later that morning. The otolaryngologist was then called to assist the ER physician. When the otolaryngologist arrived at the hospital, he examined the patient for the very first time and transferred him to ICU where he died three days later.

The Plaintiff attempted to argue that the recommendations the otolaryngologist made to the ER physician over the telephone, his requests to be updated on the patient’s status, and his consent to see the patient in his office that morning were affirmative acts establishing the existence of a physician-patient relationship. The Texas appellate court rejected those arguments, relying on the reasoning of *Hill by Burston v. Kokosky*, cited with approval by the South Carolina Supreme Court in *Roberts*, which found:

Defendants' medical opinions were addressed directly to [treating physician] as a colleague, and not indirectly to plaintiffs as patients. **The opinions were not in the nature of prescribed course of treatment, but were recommendations to be accepted or rejected by the [treating physician] as he saw fit.** In short, the telephone conversations between the [treating physician] and defendants did not give rise to a physician patient relationship.....

Id. (emphasis in the original) (internal citations omitted).

Adams v. Harron

In the Fourth Circuit case of Adams v. Harron, 191 F.3d 447 (C.A.4 (W.Va. 1999)) (unpublished opinion), the Court of Appeals upheld the lower court's finding that there was no doctor-patient relationship between a retired steel company employee who responded to an offer from a law firm to have his chest x-rayed for asbestos litigation and the radiologists hired by the law firm to interpret his chest films, but who failed to diagnose and/or advise of the employee's lung cancer. In the Adams case, one radiologist failed to diagnose the lung cancer, and another radiologist noted that the retired employee may have cancer and advised the law firm to notify the retired employee and suggest that he see his family doctor. However, no one from the law firm ever notified the retired employee or called to tell him to follow-up with his family physician. In upholding the radiologists' grant of summary judgment on the basis that no physician-patient relationship existed, the Fourth Circuit Court of Appeals noted that neither radiologist ever saw the retired employee whose x-rays they were reviewing, and they had no medical information about him other than his name. The Court found that the radiologists were retained by the law firm only, and that as such, no physician-patient relationship existed, even when at least one physician actually made a diagnosis or at least suspected lung cancer, and then also made a recommendation that the patient follow-up with his own doctor.

II. Allowing the Plaintiff's Case to Reach a Jury Under the Facts of This Case Would Alter the Way Medicine Is Practiced In South Carolina and Would Constitute a Violation of Public Policy.

Finally, it must be recognized that the type of telephone conversation that took place between Dr. Law and Dr. Young was not one of asking for and then receiving advice on Kelly Fay's care and treatment; rather, this conversation was more akin to an administrative function between Dr. Law and Dr. Young, as Dr. Law was merely arranging follow-up care. Because it was the weekend, Dr. Young did not have a secretary; thus, in taking Dr. Law's call in this case, Dr. Young was simply acting as his own secretary in noting that Dr. Law would be asking Kelly Fay to follow-up with his office on Monday. Dr. Young did nothing more, and was not requested to do anything more or required to do anything more, than what his own secretary would have done had she received this phone call from Dr. Law.

However, even assuming without admitting that a more substantive conversation took place between Dr. Law and Dr. Young, these types of consultations take place on a frequent basis in the medical profession and are vital to the treatment of patients. See Irvin at 943 (describing this as a "legally ambiguous world of curbside consultation."). To discourage such conversations would not be in the public's best interests. Other jurisdictions have recognized that "[i]mposition of liability under these circumstances would not be prophylactic but instead counterproductive by stifling efforts at improving medical knowledge." Id., citing Rainer v. Grossman, 31 Cal.App.3d 539, 544 (1973); see also, Lopez v. Aziz, 852 S.W.2d 303, 306 (Tex. App. 1993); Hill by Burston v. Kokosky, 463 N.W.2d 265 (1990).

The ability of physicians to be able to freely discuss patients amongst themselves without fear of future reprisal for any thoughts they may have shared about a patient and communicated to the patient's treating physician can only facilitate and improve patient care. To impose liability on every physician who communicates with a patient's treating physician about the patient's care or condition would stifle the free exchange of knowledge amongst colleagues,

which is critical to the decision-making process of medical doctors when there may not be enough time or adequate resources for a treating physician to consult literature or refer to a textbook. In the case at bar, it would be even more illogical to impose a duty as a result of Dr. Young's conversation with Dr. Law, as Dr. Young did not provide any advice, input, direction, recommendation, or diagnosis for Kelly Fay's treatment.

Even if it could be construed in some way that Dr. Young offered advice to Dr. Law on Kelly Fay's care and treatment in the emergency department, the standard advocated by Plaintiff does not comport with public policy and would be illogical and counterproductive to the practice of medicine. The public policy behind this reasoning may be best illustrated by the Appellate Court of Illinois:

Plaintiffs suggest what needs to be done is to find a physician-patient relationship to result from every such conversation. The consequences of such a rule would be significant. It would have a chilling effect upon the practice of medicine. It would stifle communication, education, and professional association, all to the detriment of the patient. The likely effect in adopting plaintiffs' argument also would be that such informal conferences would no longer occur.

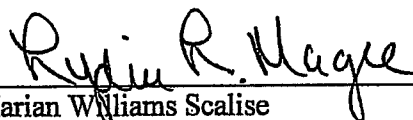
Oja v. Kin, 581 N.W.2d 739, 743 (citing Reynolds v. Decatur Memorial Hospital, 660 N.E.2d 235 (1996)). Thus, such an expansion of the physician-patient relationship as advocated by the Plaintiff in this case would not result in an improvement in medical care, but would in fact have the exact opposite effect, potentially resulting in more untoward events for patients, unnecessary tests, and delayed care or treatment. This would benefit neither those seeking medical attention nor the medical profession.

CONCLUSION

Both public policy and case law establish that Plaintiff has failed to satisfy his burden of creating a genuine issue of material fact that a physician-patient relationship existed between

Kelly Fay and Dr. Young. Therefore, for all the foregoing reasons, these Defendants request that this Court dismiss Plaintiff's Complaint against them on the basis that there was no physician-patient relationship between Plaintiff and these Defendants. Accordingly, summary judgment is appropriate.

Respectfully submitted,



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L.L.P.

May 16, 2010
Myrtle Beach, South Carolina

STATE OF SOUTH CAROLINA

IN THE COURT OF COMMON PLEAS

COUNTY OF HORRY

Sean D. Fay, as Personal Representative of
the Estate of Kelly L. Fay, deceased,

Plaintiff,

vs.

Grand Strand Regional Medical Center,
LLC, d/b/a South Strand Ambulatory Care
Center, Jane Doe and unidentified nurse
employed with Grand Strand Regional
Medical Center, LLC, Stephen W. Law,
D.O., Carolina Health Specialists, Dr.
Richard Young, M.D. and Grand Strand
Urology, LLP

Defendants.

Civil Action No.: 08-CP-26-9047
08-CP-26-9368

**PLAINTIFF'S MEMORANDUM IN
OPPOSITION TO DEFENDANTS'
MOTION FOR DIRECTED VERDICT**

Plaintiff in the above-referenced action, by and through the undersigned counsel, hereby respectfully submits this memorandum in opposition to Defendants' Motion for Directed Verdict. As discussed more thoroughly below, there are issues of fact in dispute between the parties regarding the Decedent's conscious pain and suffering before her death. In addition, where there are no issues of fact in dispute, the inferences to be drawn from the facts should be resolved by a jury. Therefore, the Plaintiff prays this Court deny the Defendants' Motion for Directed Verdict.

FACTUAL BACKGROUND

On Saturday, January 26, 2002, Decedent Kelly Fay ("Fay") presented at Grand Strand Regional Medical Center ("GSRMC") emergency room complaining of severe abdominal and back pain radiating around to her right periumbilical area as well as nausea, diarrhea and

vomiting. Fay's past medical history was significant for kidney stones. As a result of her past medical history and complaints, the emergency room osteopath ordered an abdominal x-ray which indicated that Fay had a large, irregularly shaped kidney stone measuring 8mm by 4mm. Subsequently, the emergency room osteopath ordered a CT scan of the abdomen without contrast, which showed the presence of a right hydronephrosis or dilation of the pelvis and calice associated with the stone.

The CT scan also showed that the stone was located within the proximal region of the ureter. Further, the same CT scan indicated pyelosinus extravasation of urine showing. Essentially, the CT scan showed a right kidney stone and dilation and extravasation of urine suggesting that the stone was obstructing. The emergency room osteopath was made aware of these findings by the radiologist prior to Fay's discharge. Subsequent to the above mentioned CT scan, a CT scan of Fay's pelvis was performed where, again, the radiologist diagnosed an obstructing kidney stone. Defendant Dr. Stephen W. Law was an emergency physician employed by GSRMC and ordered 30 milligrams of intravenous Toradol and 12.5 milligrams of intravenous Phenergan as well as 1 milligram of intravenous Dilaudid in the emergency department, which was administered by emergency department staff.

Defendant Dr. Richard Young was the on-call urologist at the time of Fay's presentation to GSRMC and was consulted by Defendant Dr. Law. After consulting with Dr. Law, Dr. Young agreed that Fay could be released and requested to see Fay on Monday, January 28, 2002. Fay was sent home without an infection having been ruled out and no antibiotics having been given or prescribed and was not admitted to the hospital for in-patient care and management even though she was febrile at the time of discharge.

Fay's temperature remained virtually the same the rest of the day on Saturday and Sunday. However, on Sunday, Fay began having chills which lasted roughly ten minutes. The chills resurfaced about an hour or so later and, as instructed by GSRMC, Plaintiff called the emergency department for advice. Plaintiff asked to speak to the doctor on duty and was transferred to a female nurse/employee instead. Plaintiff explained that Fay had been seen on Saturday, January 26th at the emergency room by Dr. Law for a kidney stone and that a follow up appointment was scheduled for Monday, January 28th with Dr. Young. Plaintiff informed the female nurse/employee of Fay's symptoms, including Fay's temperature. The female nurse/employee informed Plaintiff that Fay should drink lots of water, take the pain medication as needed, and follow-up with the urologist on Monday. The female nurse/employee concluded the conversation by telling Plaintiff that he should bring Fay to the hospital if Fay thought she needed to come in. Following the conversation with the nurse/employee on Sunday, Fay began to feel better and decided against going to the hospital.

Plaintiff returned from work on Monday to take Fay to Dr. Young for an appointment scheduled for 3:00 p.m. Upon arriving home, Plaintiff discovered Fay unconscious and on the couch. Fay was moaning, gagging and seizing with a white foamy substance coming out of her mouth. Additionally, Fay had soiled herself and Plaintiff immediately called for an ambulance. Upon arriving at GSRMC's emergency room, Fay was treated for overwhelming sepsis and septic shock. Defendant Dr. Law apologized to Plaintiff for his wife's condition.

Fay was pronounced dead at 10:00 p.m. on January 28, 2002, approximately 48 hours after her presentation and treatment by GSRMC staff, Defendants Dr. Law and Dr. Young and after being discharged rather than admitted for inpatient management, observation and care.

Plaintiff filed a Complaint on January 27, 2004 in Horry County Court of Common Pleas alleging medical malpractice.

DIRECTED VERDICT STANDARD

When considering a directed verdict motion, the trial court is required to view the evidence and the inferences that can be drawn from that evidence in the light most favorable to the nonmoving party. Hinkle v. National Cas. Ins. Co., 354 S.C. 92, 579 S.E.2d 616 (2003); Hurd v. Williamsburg County, 363 S.C. 421, 611 S.E.2d 488 (2005). The trial court's directed verdict ruling will be reversed only when there is no evidence to support the rulings or where the rulings are controlled by an error of law. Hinkle, 354 S.C. at 96, 579 S.E.2d at 618. When ruling on a motion for a directed verdict, the trial court is concerned with the existence or nonexistence of evidence, not its weight. State v. Weston, 367 S.C. 279, 292, 625 S.E.2d 641, 648 (2006).

DISCUSSION

I. Decedent Experienced Conscious Pain and Suffering Prior To Her Death.

Decedent Fay experienced conscious pain and suffering prior to her death on January 28, 2002. If there is any evidence from which a jury could reasonably conclude a decedent experienced conscious pain and suffering, the issue must be submitted to the jury." Vereen v. Liberty Life Ins. Co., 306 S.C. 423, 432, 412 S.E.2d 425, 431 (Ct. App. 1991). The South Carolina survival statute provides that a cause of action for injuries to a person shall survive the person's death, with damages recoverable by the legal representative of the deceased. S.C. Code Ann. § 15-5-90. Actual damages in a survival action are awarded for the benefit of the decedent's estate. Scott v. Porter, 340 S.C. 158, 530 S.E.2d 389 (Ct. App. 2000). Appropriate damages in survival actions include those for medical, surgical, and hospital bills, conscious

pain, suffering, and mental distress of the deceased. Welch v. Epstein, 342 S.C. 279, 536 S.E.2d 408 (Ct. App. 2000).

Following Decedent's discharge from GSRMC on Saturday, she experienced nausea, severe abdominal pain, extreme chills, and vomiting over the course of the weekend. Moreover, Decedent had been prescribed pain medication by the Defendants for her discomfort and slept fretfully over the weekend. There is clear evidence indicating that Decedent experienced conscious pain and suffering prior to her death of which the extent is an issue to be determined by the jury.

On the Monday afternoon of Decedent's death, Plaintiff arrived home to find Decedent gagging, gasping for air, and emitting a white, foamy substance from her mouth. Decedent had also urinated and defecated on herself. Additionally, Defendants administered pain medication to Decedent upon her arrival to the emergency room on Monday. Notwithstanding any conscious pain and suffering experienced by the Decedent from Monday afternoon until the time of her death, there is clear evidence that Decedent experienced pain and suffering the Saturday and Sunday before her death.

In Smalls v. South Carolina Dep't of Educ., 339 S.C. 208, 528 S.E.2d 682 (Ct. App. 2000), the court addressed whether an eight year old girl killed while crossing the road experienced any conscious pain and suffering prior to her death. In Smalls, the child's father testified that he found his daughter unconscious following the accident and that she never regained consciousness prior to her death. However, the father also testified that when he first arrived on the scene of the accident, his daughter was gasping for air and moaning. Id., 339 S.C. at 217, 528 S.E.2d at 686. Similar to Smalls, Plaintiff found Decedent gagging and gasping for air several hours before her death.

The Smalls court denied the directed verdict motion, relying upon the decision of Croft v. Hall, 208 S.C. 187, 37 S.E.2d 537 (1946). In Croft, the victim was seriously injured in an automobile wreck and survived for about twenty-nine hours before she died. Id. at 193-194, 37 S.E.2d at 539. The attending physician, nurses, and others testified the victim did not consciously suffer pain after being injured in the wreck. Id. at 194, 37 S.E.2d at 540. In contrast, the victim's mother testified that her daughter made terrible noises and opened her eyes at times. Id. The Croft court concluded the "factual showing thereabout was weak but there was more than a scintilla of evidence tending to prove the point." Id.

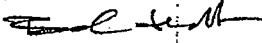
The evidence in this case provides more than a scintilla of evidence that Decedent experienced conscious pain and suffering prior to her death. Decedent's pain, nausea, and chills coupled with gagging and her gasps for air shortly before her death provide sufficient evidence for a jury to consider the issue. This is competent evidence of the demonstrable suffering Decedent experienced before the catastrophic event which caused her to stop breathing. Accordingly, Defendants' Motion for Directed Verdict should be denied.

CONCLUSION

A Directed Verdict in favor of Defendants would be improper in this case because there is sufficient evidence that Decedent experienced conscious pain and suffering prior to her death to submit the issue of survival damages to a jury. The Plaintiff therefore prays this Honorable Court deny the Defendants' Motion for Directed Verdict.

Respectfully Submitted,

MIKE KELLY LAW GROUP, LLC

BY: 

Ruskin C. Foster
Brad D. Hewett
500 Taylor Street
Post Office Box 8113
Columbia, SC 29202
803/726-0123
Attorney for Plaintiff

Columbia, South Carolina
May 17, 2010

STATE OF SOUTH CAROLINA)
)
COUNTY OF HORRY)

IN THE COURT OF COMMON PLEAS

Sean D. Fay, as Personal Representative
for the Estate of Kelly L. Fay, deceased,

Civil Action Nos. 2008-CP-26-9047
2008-CP-26-9368

Plaintiff,

v.

Grand Strand Regional Medical
Center, LLC, d/b/a South Strand
Ambulatory Care Center,
Stephen W. Law, D.O., and
Richard Young, M.D.,

Defendants.

**NOTICE OF MOTION AND
MOTION TO ALTER OR AMEND
JUDGMENT AND/OR MOTION
FOR RECONSIDERATION**

TO: THE HONORABLE J. MICHAEL BAXLEY

RUSKIN C. FOSTER, ESQUIRE, COUNSEL FOR PLAINTIFF

MONTEITH P. TODD, ESQUIRE, RANDOLPH L. LEE, ESQUIRE, COUNSEL FOR
DEFENDANT GRAND STRAND REGIONAL MEDICAL CENTER, LLC

YOU WILL PLEASE TAKE NOTICE that the undersigned attorneys for the Defendant Stephen W. Law, D.O., will move before the Honorable J. Michael Baxley at such time and place as may be set by the Court, for an Order, pursuant to Rule 59(e), *SCRCP*, altering, amending, and/or reconsidering the Order Denying Defendant Law's Post Trial Motions, filed June 24, 2010. Counsel for the Defendant Law received written notice of entry of the Order on July 12, 2010.

The Defendant Law's motion is based upon the following grounds:

1. The Order Denying Defendant Law's Post Trial Motions has not addressed each of the grounds for relief as set forth in the Defendant Law's Post-Trial Motions. The Court failed

to address the basis for the Defendant Law's JNOV Motion. Specifically, the Court has not addressed Dr. Law's position that the only reasonable inference to be drawn from the evidence is that Dr. Law complied with all accepted standards of care for an emergency physician and did not cause harm to the Plaintiff or his decedent. The Court has also not addressed Dr. Law's position that the only reasonable inference that can be drawn from the evidence is that the proximate cause of the decedent's death was the failure of the Plaintiff to follow the discharge instructions to take the decedent back to the emergency department. Likewise, the Court has not addressed Dr. Law's position that the only reasonable inference to be drawn from the evidence is that the Plaintiff was either solely responsible for the decedent's death or was more than fifty percent at fault as a matter of law. The Court is respectfully requested to alter or amend its current Order to specifically address the Defendant Law's JNOV Motion.

2. In its Order Denying Defendant Law's Post Trial Motions, the Court has addressed only portions of the Defendant Law's Motion for New Trial, specifically the exclusion of evidence of the Plaintiff's extramarital affair and subsequent remarriage and the limiting of the testimony of the decedent's mother, stepfather and brother. The Court has not addressed the excessiveness of the verdict or the Defendant's request for relief under the Thirteenth Juror Doctrine. The Court is respectfully requested to alter or amend its current Order to specifically address these grounds for a new trial.

3. In its Order Denying Defendant Law's Post Trial Motions, the Court has not addressed the Defendant Law's Motion for New Trial Nisi Remittitur. The Court has also not addressed Dr. Law's request that the judgment be enrolled using the percentage of fault as found by the jury and specifically that the judgment against Dr. Law be enrolled as six percent (6%) of

the damages awarded by the jury. The Court is respectfully requested to alter or amend its current Order to specifically address these motions.

The Defendant's motion is based upon the pleadings filed in this case; the trial record; the Order Denying Defendant Law's Post Trial Motions, filed June 24, 2010; the Defendant Law's Post-Trial Motions; the rules of court; and such other matters as may be properly presented to the Court at the time of the hearing.

Respectfully submitted,

BY:


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(803) 806-8222

Counsel for Defendant Stephen W. Law, D.O.

Florence, South Carolina

July 21, 2010

(22108)

STATE OF SOUTH CAROLINA

IN THE COURT OF COMMON PLEAS

COUNTY OF HORRY

Sean D. Fay, as Personal Representative of
the Estate of Kelly L. Fay, deceased,

Civil Action No.: 08-CP-26-9047
08-CP-26-9368

Plaintiff,

vs.

Grand Strand Regional Medical Center,
LLC, d/b/a South Strand Ambulatory Care
Center, Jane Doe and unidentified nurse
employed with Grand Strand Regional
Medical Center, LLC, Stephen W. Law,
D.O., Carolina Health Specialists, Dr.
Richard Young, M.D. and Grand Strand
Urology, LLP

Defendants.

**PLAINTIFF'S SUPPLEMENTAL
MEMORANDUM IN OPPOSITION TO
DEFENDANT DR. STEPHEN W. LAW'S
MOTION FOR RECONSIDERATION**

Plaintiff in the above-referenced action, by and through the undersigned counsel, hereby respectfully submits this supplemental memorandum in opposition to Defendant Stephen W. Law's Motion for Reconsideration. The grounds for this memorandum are discussed more thoroughly below. The Plaintiff prays this Court deny the Defendant's Motion for Reconsideration.

Standard of Review

The purpose of Rule 59(e) SCRPC to alter or amend a judgment is to request the trial judge to reconsider matters properly encompassed in a decision on the merits. Arnold v. State, 309 S.C. 157, 420 S.E.2d 834 (1992). Once the issue is properly raised by a Rule 59(e) motion, it appears that it is preserved and a second motion is not required if the trial court does not

specifically rule on the issue so raised. Collins Music Co., Inc., v. IGT, 353 S.C. 559, 579 S.E.2d 524 (Ct. App. 2002) (citing James F. Flanagan South Carolina Civil Procedure, (2d ed., 1996)).

I. DEFENDANT HAS FILED AN IMPROPER SUCCESSIVE MOTION WHICH MERELY RESTATES HIS PRIOR POST TRIAL MOTION.

- a. Defendant Law's Motion for Reconsideration is almost a duplicate of his initial post-trial motions and provides no additional assertion of fact or argument of law.**

Defendant Law's Motion to Alter or Amend Judgment and/or Motion for Reconsideration ("Motion for Reconsideration") is an improper successive motion as it does not challenge something that was altered from the original judgment as a result of Defendant's Law's initial post-trial motions. In Coward Hund Const. Co., Inc. v. Ball Corp., 336 S.C. 1, 518 S.E.2d 56 (Ct. App. 1999), the Court of Appeals held that a successive Rule 59(e), SCRCP, motion, following the denial of a similar motion, did not toll the time for filing appeal, where the court's ruling on the first motion did not change its ruling at trial. Defendant Law filed motions for judgment notwithstanding the verdict, new trial, to alter, amend and vacate the verdict, or remittitur on June 7, 2010. The Honorable J. Michael Baxley denied Defendant Dr. Law's post-trial motions in an Order signed June 23, 2010 ("Order"). Subsequently, Defendant Dr. Law filed the Motion for Reconsideration on July 21, 2010, which is presently before this Court. While the issue of whether Defendant's Motion for Reconsideration tolls the time period for filing an appeal is not presently before this Court, the filing remains improper.

While Defendant's Motion for Reconsideration requests this Court to rule on issues presented but not explicitly addressed in Defendant Law's initial post-trial motions, the Motion for Reconsideration should be treated based on its "substance and effect" rather than how it is captioned by Defendant Dr. Law. See, Quality Trailer Products, Inc. v. CSL Equipment Co., 349 S.C. 216, 220, 562 S.E.2d 615, 618 (2002) (citing Mikle v. Blackmon, 255 S.C. 136, 140, 177

S.E.2d 548, 549 (1970)). Defendant Dr. Law's Motion for Reconsideration is merely a restatement of arguments he made in his initial post-trial motions, upon which a denial by this Court resolved these issues and ripened them for appellate review. See, Collins Music Co., Inc., v. IGT, 353 S.C. 559, 579 S.E.2d 524 (Ct. App. 2002).

In Collins, our Court of Appeals addressed a similar scenario and provided the following:

Coward Hund and *Quality Trailer* clearly stand for the proposition that although a successive post-trial motion for relief is permissible, the subsequent motion must seek relief on issues coming to light as a result of an order following an initial post-trial motion that alters or amends the judgment. The successive motion cannot be a motion to alter or amend that merely recites arguments in a previous Rule 59(e) motion, as was the case in *Coward Hund*, or the recaptioning of a previous Rule 50 or Rule 52 motion as a Rule 59(e) motion, as was done in *Quality Trailer*.

Id., 353 S.C. at 564-565. While the Motion for Reconsideration seeks the reversal of the Order, Defendant Dr. Law provides no additional assertion of fact or argument of law. Accordingly, and for the reasons previously provided in Plaintiff's Memorandum in Opposition to Defendant Dr. Law's Motion for Reconsideration, this motion should be denied.

CONCLUSION

As a result of the aforesaid, the Plaintiff therefore prays this Honorable Court deny the Defendant's Motion for Reconsideration.

Respectfully Submitted,

MIKE KELLY LAW GROUP, LLC

BY: 

Ruskin C. Foster
Brad D. Hewett
Post Office Box 8113
Columbia, SC 29202
803/726-0123
Attorney for Plaintiff

Columbia, South Carolina
May 26, 2011

THE STATE OF SOUTH CAROLINA
In the Court of Appeals

RECEIVED

JUL 21 2010

APPEAL FROM HORRY COUNTY
Court of Common Pleas

SC Court of Appeals

J. Michael Baxley, Circuit Court Judge

Case Numbers: 2008-CP-26-9047 and 2008-CP-26-9368

Sean D. Fay, as Personal Representative of the Estate of
Kelly L. Fay, Deceased, ...

Respondent

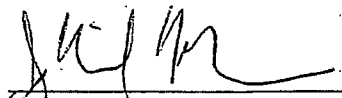
v.

Grand Strand Regional Medical Center, LLC d/b/a South Strand
Ambulatory Center and Stephen W. Law, DO of whom Grand
Strand Regional Medical Center, LLC d/b/a South Strand
Ambulatory Center is Appellant.

NOTICE OF APPEAL

Defendant Grand Strand Regional Medical Center, LLC d/b/a South Strand Ambulatory Center, appeals the order of the Honorable J. Michael Baxley dated June 23, 2010, denying Defendant's post-trial motions. Appellant received written notice of entry of this order on July 12, 2010.

July 21, 2010



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Sowell Gray Stepp & Laffitte, LLC
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Attorneys for Appellant Grand Strand

Other Counsel of Record:

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Attorney for Respondent

J. Boone Aiken, III, Esquire
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Florence, SC 29503
(843) 669-8787
Attorney for Defendant Stephen W. Law, DO

FORM 4

STATE OF SOUTH CAROLINA)

COUNTY OF HORRY)

Sean D. Fay, as Personal
Representative for the Estate of
Kelly L. Fay, Deceased,

Plaintiff,

vs.

Grand Strand Regional Medical
Center, LLC, d/b/a South Strand
Ambulatory Care Center, and
Stephen W. Law, D.O.,

Defendants.

IN THE COURT OF COMMON PLEAS

FOR THE FIFTEENTH JUDICIAL CIRCUIT

DOCKET NO.: 08-CP-26-9047
08-CP-26-9368

ORDER DENYING DEFENDANT HOSPITAL'S
POST TRIAL MOTIONS

CLOCK IN TIME CANCELLED
HORRY COUNTY
10 JUL 22
CLERK OF COURT

FILED
HORRY COUNTY
JUL 24 PM 3:15
CLERK OF COURT
ANNE HUGHES-WARD

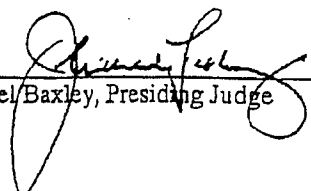
Defendant Grand Strand Regional Medical Center, LLC moves pursuant to Rules 50 and 59, SCRPC, for judgment notwithstanding the verdict, a new trial absolute, or in the alternative, a new trial *nisi remittitur*. This medical negligence case was tried before the Court May 24 through 28, 2010. The jury rendered a verdict in favor of the Plaintiff for \$3 million dollars actual damages, attributing to Defendant Hospital ninety (90%) percent comparative negligence. The Defendant Hospital claims that the jury verdict is excessive and cannot reasonably be based on the evidence submitted at trial. Further, Defendant states that the Court erred in excluding testimony of the decedent's husband's extra-marital affair some two years prior to decedent's death, his subsequent remarriage after decedent's death, and for limiting testimony of the decedent's mother, stepfather, and brother, all appearing for the Defendants.

Prior to trial, the Court conducted hearings on Plaintiff's motion in limine to exclude the testimony of the Plaintiff's extramarital affair and subsequent remarriage. The Court ruled in favor of the Plaintiff because the remarriage of the Plaintiff after his wife's death is clearly excluded under longstanding South Carolina law and has no relevance to the matter at issue in the trial. Wooten v. Amspacher, 307 S.E.2d 232 (1983). Plaintiff's extramarital affair has no bearing on whether the Defendants' negligence was the cause of decedent's death, which was the real battleground of this case, and thus was far more prejudicial than probative. The Court limited the testimony of the decedent's family at trial because it was duplicative, in an already lengthy trial, and did not go to the cause of the decedent's death. The verdict and its amount were not contrary to the evidence presented at trial, which involved the unexpected death of an otherwise healthy twenty-five year old. The jury in this case deliberated for approximately twelve hours over two days, and this Court is disinclined to disturb their findings.

After further review of the evidence presented at trial, the in limine motions, the jury charges, and Defendant Law's post trial motions, the Defendant Law's post trial motions are hereby DENIED, and the jury verdict confirmed.

IT IS SO ORDERED.

June 23, 2010


J. Michael Baxley, Presiding Judge

This judgment was entered on the _____ day of June 2010, and a copy mailed first class this _____ day of June, 2010 to attorneys of record or to parties as follows:

Attorney for Plaintiff

Ruskin Foster, Esquire
Mike Kelly Law Group, LLC
500 Taylor Street
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Attorney for Defendant Dr. Law

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Florence, SC 29503

CLERK OF COURT

THE STATE OF SOUTH CAROLINA
In the Court of Appeals

APPEAL FROM Horry County
Court of Common Pleas

J. Michael Baxley, Circuit Court Judge

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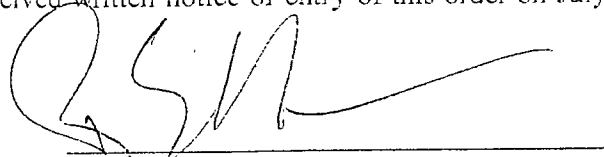
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v.

Grand Strand Regional Medical Center, LLC d/b/a South Strand
Ambulatory Center and Stephen W. Law, DO of whom Grand
Strand Regional Medical Center, LLC d/b/a South Strand
Ambulatory Center is Appellant.

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July 26, 2010



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Sowell Gray Stepp & Laffitte, LLC
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Attorneys for Appellant Grand Strand

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SC Court of Appeals

Other Counsel of Record:

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(803) 726-0123
Attorney for Respondent

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Attorney for Defendant Stephen W. Law, DO

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FOR THE FIFTEENTH JUDICIAL CIRCUIT

DOCKET NO.: 08-CP-26-9047
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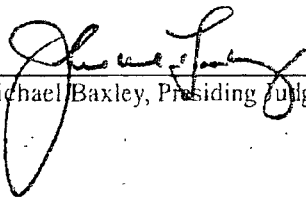
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IT IS SO ORDERED.

June 23, 2010



J. Michael Baxley, Presiding Judge

This judgment was entered on the _____ day of June 2010, and a copy mailed first class this _____ day of June, 2010 to attorneys of record or to parties as follows:

Attorney for Plaintiff

Ruskin Foster, Esquire
Mike Kelly Law Group, LLC
500 Taylor Street
Columbia, SC 29201

Attorney for Defendant Hospital

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Aiken, Bridges, Elliott, Tyler, & Saleeby, PA
P.O. Drawer 1931
Florence, SC 29503

CLERK OF COURT

THE STATE OF SOUTH CAROLINA
In The Court of Appeals

RECEIVED

JUL 30 2010

SC Court of Appeals

APPEAL FROM HORRY COUNTY
Court of Common Pleas

J. Michael Baxley, Circuit Court Judge

Case Numbers: 2008-CP-26-9047 and 2008-CP-26-9368

Sean D. Fay, as Personal Representative for the Estate of
Kelly L. Fay, Deceased, ...Respondent/Appellant

v.

Grand Strand Regional Medical Center, LLC, d/b/a South Strand
Ambulatory Care Center, Jane Doe and unidentified nurse employed
with Grand Strand Regional Medical Center, LLC, Stephen W. Law, D.O.,
Carolina Health Specialists, Dr. Richard Young, M.D.
and Grand Strand Urology, LLP, ...Defendants

of whom

Richard Young M.D., Grand Strand Urology, LLP
and Stephen W. Law, D.O are Respondents

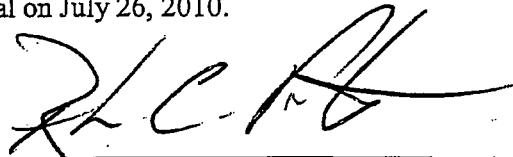
and

Grand Strand Regional Medical Center, LLC d/b/a South Strand
Ambulatory Center is Appellant/Respondent.

NOTICE OF CROSS APPEAL

Sean D. Fay, as Personal Representative for the Estate of Kelly L. Fay, Deceased, appeals the decision of Honorable J. Michael Baxley dismissing Defendant Richard Young, M.D. and Grand Strand Urology, LLP as Defendants after the close of the evidence. Respondent also appeals Judge Baxley's decision not to charge the jury on spoliation of evidence in addition to Judge Baxley's refusal to charge other jury charges to which Respondent excepted. Lastly, Respondent appeals Judge Baxley's refusal to permit the issue of punitive damages to be considered by the jury.

These decisions were rendered by Judge Baxley on May 26, 2010. Respondent received written notice of Appellant's Amended Notice of Appeal on July 26, 2010.



Ruskin C. Foster
Brad D. Hewett
Mike Kelly Law Group, LLC
500 Taylor Street
Post Office Box 8113
Columbia, South Carolina 29202
(803) 726-0123
Attorneys for Respondent

July 30th, 2010

THE STATE OF SOUTH CAROLINA
In The Court of Appeals

APPEAL FROM HORRY COUNTY
Court of Common Pleas

RECEIVED

AUG 06 2010

The Honorable J Michael Baxley, Circuit Court Judge SC Court of Appeals

Case Nos. 08-CP-26-9047 and 08-CP-26-9368

Sean D. Fay, as Personal Representative for the
Estate of Kelly L. Fay, Deceased, ... Respondent/Appellant,

v.

Grand Strand Regional Medical Center, LLC, d/b/a
South Strand Ambulatory Care Center, Jane Doe and
unidentified nurse employed with Grand Strand
Regional Medical Center, LLC, Stephen W. Law,
D.O., Carolina Health Specialists, Dr. Richard
Young, M.D. and Grand Strand Urology, LLP, ... Defendants
of whom

Richard Young M.D., Grand Strand Urology, LLP
and Stephen W. Law, D.O. are Respondents
and

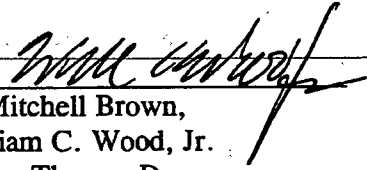
Grand Strand Regional Medical Center, LLC d/b/a
South Strand Ambulatory Care Center is Appellant/Respondent.

SECOND AMENDED NOTICE OF APPEAL

Pursuant to Rule 203 of the South Carolina Appellate Court Rules, Defendant
Grand Strand Regional Medical Center, LLC d/b/a South Strand Ambulatory Center,
("Appellant/Respondent") hereby appeals the Judgment filed May 28, 2010 and order
of the Honorable J. Michael Baxley, dated June 23, 2010 denying Defendant's post-trial
motion. Appellant/Respondent received written notice of entry of this order on July 12,

2010. Copies of the appealed judgment and order are attached for reference as Exhibit

A.

By: 

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Randolph L. Lee,
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8000 Weston Parkway #340
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Attorneys for Appellant/Respondent
Grand Strand Regional Medical Center, LLC
d/b/a South Strand Ambulatory Center

August 6, 2010

Other Counsel of Record:

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Post Office Drawer 1931
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(843) 669-8787

Attorney for Defendant Stephen W. Law, DO

Marian Scalise, Esquire
Lydia McGee, Esquire
Richardson Plowden Carpenter & Robinson, PA
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Myrtle Beach, SC 29578
Attorneys for Defendants Richard Young, MD and Grand Strand Urology, LLP

Exhibit A

FORM 4

**STATE OF SOUTH CAROLINA
COUNTY OF HORRY
IN THE COURT OF COMMON PLEAS**

JUDGMENT IN A CIVIL CASE

CASE NO. 2008-CP-26-9047

Sean D. Fay

Grand Strand Regional

VS.

Medical Center, et al

PLAINTIFF(S)

DEFENDANT(S)

CHECK ONE:

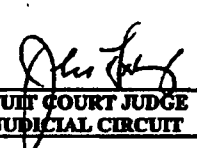
- ☒ **JURY VERDICT.** This action came before the court for a trial by jury. The issues have been tried and a verdict rendered.
- ☐ **DECISION BY THE COURT.** This action came to trial or hearing before the court. The issues have been tried or heard and a decision rendered.
- ☐ **ACTION DISMISSED (CHECK REASON):** ☐ Rule 12(b), SCRCP; ☐ Rule 12(a), SCRCP (Vol. Nonsuit); ☐ Rule 43(k), SCRCP (Settled); ☐ Other
- ☐ **ACTION STRICKEN (CHECK REASON):** ☐ Rule 40(j), SCRCP; ☐ Bankruptcy; ☐ Binding arbitration, subject to right to restore to confirm, vacate or modify arbitration award; ☐ Other.
- ☐ **DISPOSITION OF APPEAL TO THE CIRCUIT COURT (CHECK APPLICABLE BOX):**
☐ Affirmed; ☐ Reversed; ☐ Remanded; ☐ Other
- NOTE: ATTORNEYS ARE RESPONSIBLE FOR NOTIFYING LOWER COURT, TRIBUNAL, OR ADMINISTRATIVE AGENCY OF THE CIRCUIT COURT RULING IN THIS APPEAL.**

IT IS ORDERED AND ADJUDGED:

- ☐ See Attached order. (Formal order to follow)
☐ Statement of Judgment by the Court:

We, the Jury, find in favor of the Plaintiff against the Defendants in the amount of Two Million Eight Hundred Eighty Dollars (2,880,000.00)

Dated at Conway, South Carolina, this 28th day of May 2010.


**CIRCUIT COURT JUDGE
15TH JUDICIAL CIRCUIT**

This judgment was entered on the _____ day of _____, 20____, and a copy mailed first class this _____ day of _____, 20____ to attorneys of record or to parties (when appearing pro se) as follows:

Ruskin C. Foster

Marian W. Scallise

Monteith Powell

J. Boone Alken, III

ATTORNEY(S) FOR THE PLAINTIFF(S)

ATTORNEY(S) FOR THE DEFENDANT(S)

CLERK OF COURT

SCCA SCRCP Form 4 (Revised 06/2008)

STATE OF SOUTH CAROLINA)

COUNTY OF Horry)

IN THE COURT OF COMMON PLEAS

FOR THE FIFTEENTH JUDICIAL CIRCUIT

Sean D. Fay, as Personal
Representative for the Estate of
Kelly L. Fay, Deceased,

Plaintiff,

vs.

Grand Strand Regional Medical
Center, LLC, d/b/a South Strand
Ambulatory Care Center, Stephen
W. Law, D.O.,

Defendants.

DOCKET NO.: 08-CP-26-9047
08-CP-26-9368

VERDICT

1. a. Was the Defendant Grand Strand Regional Medical Center, LLC negligent?

☒ YES

☐ NO (Go to Question 2, do not answer 1 b)

- b. Was Defendant Grand Strand Regional Medical Center, LLC's negligence a proximate cause of the Plaintiff's injuries?

☒ YES

☐ NO

2. a. Was the Defendant Dr. Stephen W. Law negligent?

☒ YES

☐ NO (Do not answer 2 b)

- b. Was Defendant Dr. Stephen W. Law's negligence a proximate cause of the Plaintiff's injuries?

☒ YES

☐ NO

If you determined that neither of the Defendants were negligent or that the negligence of neither of the Defendants proximately caused the Plaintiff's injury, then you may stop your deliberations and return your verdict.

3. Was the Plaintiff negligent?

☒ YES

☐ NO (Go to Question 7)

4. Was the Plaintiff's negligence a proximate cause of the Plaintiff's own injuries?

☒ YES

☐ NO

FILED
Horry County
2018 MAY 28 PM 12:36
MELANIE HUGGINS-WARD
CLERK OF COURT

<u>4</u> %	Plaintiff	} Grand Strand - 90%
<u>96</u> %	Defendants	
<u>100</u> %	Total	

6. Was the Plaintiffs' negligence greater than fifty percent?
 YES (Stop deliberations)
X NO (Go to Question 7)

\$ 3 million Actual Damages

Michael A. Waldowski
Michael A. Waldowski, Foreperson
May 27, 2010

Verdict amount for Plaintiff to be entered:
\$ 2,880,000

Julius F. Long
Circuit Judge
5/28/10

FORM 4

STATE OF SOUTH CAROLINA)

IN THE COURT OF COMMON PLEAS

COUNTY OF HORRY)

FOR THE FIFTEENTH JUDICIAL CIRCUIT

Sean D. Fay, as Personal
Representative for the Estate of
Kelly L. Fay, Deceased,

DOCKET NO.: 08-CP-26-9047
08-CP-26-9368

Plaintiff,

vs.

ORDER DENYING DEFENDANT HOSPITAL'S
POST TRIAL MOTIONS

Grand Strand Regional Medical
Center, LLC, d/b/a South Strand
Ambulatory Care Center, and
Stephen W. Law, D.O.,

Defendants.

FILED
JUN 24 PM 3:15
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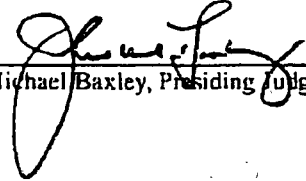
9-3
1
Defendant Grand Strand Regional Medical Center, LLC moves pursuant to Rules 50 and 59, SCRPC, for judgment notwithstanding the verdict, a new trial absolute, or in the alternative, a new trial *nisi remittitur*. This medical negligence case was tried before the Court May 24 through 28, 2010. The jury rendered a verdict in favor of the Plaintiff for \$3 million dollars actual damages, attributing to Defendant Hospital ninety (90%) percent comparative negligence. The Defendant Hospital claims that the jury verdict is excessive and cannot reasonably be based on the evidence submitted at trial. Further, Defendant states that the Court erred in excluding testimony of the decedent's husband's extra-marital affair some two years prior to decedent's death, his subsequent remarriage after decedent's death, and for limiting testimony of the decedent's mother, stepfather, and brother, all appearing for the Defendants.

Prior to trial, the Court conducted hearings on Plaintiff's motion in limine to exclude the testimony of the Plaintiff's extramarital affair and subsequent remarriage. The Court ruled in favor of the Plaintiff because the remarriage of the Plaintiff after his wife's death is clearly excluded under longstanding South Carolina law and has no relevance to the matter at issue in the trial. Wooten v. Amspacher, 307 S.E.2d 232 (1983). Plaintiff's extramarital affair has no bearing on whether the Defendants' negligence was the cause of decedent's death, which was the real battleground of this case, and thus was far more prejudicial than probative. The Court limited the testimony of the decedent's family at trial because it was duplicative, in an already lengthy trial, and did not go to the cause of the decedent's death. The verdict and its amount were not contrary to the evidence presented at trial, which involved the unexpected death of an otherwise healthy twenty-five year old. The jury in this case deliberated for approximately twelve hours over two days, and this Court is disinclined to disturb their findings.

After further review of the evidence presented at trial, the in limine motions, the jury charges, and Defendant Hospital's post trial motions, the Defendant Hospital's post trial motions are hereby DENIED, and the jury verdict confirmed.

IT IS SO ORDERED.

June 23, 2010


J. Michael Baxley, Presiding Judge

This judgment was entered on the _____ day of June 2010, and a copy mailed first class this _____ day of June, 2010 to attorneys of record or to parties as follows:

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Attorney for Defendant Hospital

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Sowell, Gray, Stepp, & Laffitte, LLC
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Bappen Lee
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Attorney for Defendant Dr. Law

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CLERK OF COURT

IN THE STATE OF SOUTH CAROLINA
In The Court of Appeals

APPEAL FROM HORRY COUNTY
Court of Common Pleas

J. Michael Baxley, Circuit Court Judge

Case Numbers: 2008-CP-26-9047 and 2008-CP-26-9368

Sean Fay, as Personal Representative for the Estate of
Kelly L. Fay, Deceased, ... Respondent/Appellant

v.

Grand Strand Regional Medical Center, LLC, d/b/a South Strand
Ambulatory Care Center, Stephen W. Law, D.O., Dr. Richard
Young, M.D., and Grand Strand Urology, LLP, ... Defendants

Of whom

Richard Young M.D., And Grand Strand Urology, LLP
are Respondents

And

Stephen Law, D.O. is Appellant

And

Grand Strand Regional Medical Center, LLC d/b/a South Strand
Ambulatory Center is Appellant/Respondent.

NOTICE OF MOTION AND MOTION TO DISMISS APPEAL
AGAINST RICHARD YOUNG, M.D. AND GRAND STRAND UROLOGY, LLP

Pursuant to Rules 203(d)(3) and 240 of the South Carolina Appellate Court Rules, the Respondents Richard Young, M.D. and Grand Strand Urology, LLP move to dismiss the appeal filed by Plaintiff appealing the directed verdict ruling dismissing these Defendants from this case.

BY: Marian W. Scalise
Marian W. Scalise, Esquire
Lydia L. Magee, Esquire
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843/448-1008
Counsel for Respondents Richard
Young M.D., Grand Strand Urology, LLP

October 6, 2011

Other counsel of record:

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Bluestein Nichols Thompson & Delgado, LLC
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Counsel for Respondent/Appellant Stephen W. Law, D.O.

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William C. Wood, Jr., Esquire
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919-439-2228

Counsel for Grand Strand Regional Medical Center

Authorities Cited

Rule 203(b)(1), SCACR	2, 7, 12
Rule 203(d)(3), SCACR	2
Rule 240, SCACR	2
<u>Badeaux v. Davis</u> , 337 S.C. 195, 522 S.E.2d 835 (Ct. App. 1999)	8
<u>Holroyd v. Requa</u> , 361 S.C. 43, 54, 603 S.E.2d 417, 422 (Ct. App. 2006)	7
<u>Olson v. Faculty House of Carolina, Inc.</u> , 344 S.C. 194, 214, 544 S.E.2d 38, 48 (Ct. App. 2000)	8, 9, 10, 12
<u>State v. Brown</u> , 351 S.C. 522, 528-29, 570 S.E.2d 559, 562 (Ct. App. 2002)	9
<u>Wise v. South Carolina Dep't of Corrections</u> , 372 S.C. 173, 174, 642 S.E.2d 551, 551 (2007)	7

IN THE STATE OF SOUTH CAROLINA
In The Court of Appeals

APPEAL FROM HORRY COUNTY
Court of Common Pleas

J. Michael Baxley, Circuit Court Judge

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Kelly L. Fay, Deceased, ... Respondent/Appellant

v.

Grand Strand Regional Medical Center, LLC, d/b/a South Strand
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Young, M.D., and Grand Strand Urology, LLP, ... Defendants

Of whom

Richard Young M.D., And Grand Strand Urology, LLP
are Respondents

And

Stephen Law, D.O. is Appellant

And

Grand Strand Regional Medical Center, LLC d/b/a South Strand
Ambulatory Center is Appellant/Respondent.

MEMORANDUM IN SUPPORT OF MOTION TO DISMISS APPEAL
AGAINST RICHARD YOUNG, M.D. AND GRAND STRAND UROLOGY, LLP

Pursuant to Rules 203(d)(3) and 240 of the South Carolina Appellate Court Rules, Defendants Richard Young M.D. and Grand Strand Urology, LLP move for an Order dismissing Plaintiff's appeal of Judge Baxley's directed verdict for the Defendants Richard Young M.D. and Grand Strand Urology, LLP on the basis that Plaintiff failed to timely serve his notice of appeal.

The trial of this case began on May 17, 2010, in Horry County before the Honorable J. Michael Baxley. Defendants Dr. Young and his practice Grand Strand Urology, LLP moved for summary judgment prior to the beginning of trial and then moved for a directed verdict at the conclusion of the Plaintiff's case. Both motions were denied.

However, on May 26, 2010, during the Defendants' case in chief, Judge Baxley requested a bench conference to discuss the remaining witnesses to be called and the motions to be made at the close of all the evidence. Judge Baxley advised counsel for all parties that at the conclusion of the Defendants' case it would be "the Court's most likely intention to dismiss this case against Dr. Young at the conclusion of all the evidence upon the appropriate motion." [Trial Transcript pg. 1659] Judge Baxley very clearly stated the basis for his likely ruling dismissing Dr. Young and his practice on the record by stating:

... I've given this substantial thought. I have followed this issue closely once it was crystallized at the summary judgment motion that was made prior to us drawing the jury and beginning the trial, and thus I've listened closely throughout this testimony for evidence of Dr. Young's involvement or culpability, if you wish to state it that way, but before we talk about that, let's look at the big picture.

Every weekend, there are hundreds of physicians who are on call for various specialties throughout this state, and what the evidence

shows here is that Dr. Young took a telephone call. He had a telephone conversation, and then he made an appointment or at least allow--suggested that the person, now deceased, make an appointment for--or call Monday morning to have an appointment with him. That was, I think, ostensibly, just looking at the big picture; that was the involvement that Dr. Young had, without getting into specifics.

I can tell you again, still looking at the big picture, that this Court cannot enact judicially or support a public policy that would require a physician that every time that specialist or physician takes a phone call with regard to a patient, that he is automatically locked in for responsibility for whatever the outcome may be. This is--thus it's not the way medicine is practiced in South Carolina and it cannot be that our courts would set up a system where the doctor would have liability for what simply occurs in the course of a telephone call when . . . the on-call physician is not really the one who is making the decision here.

[Plaintiff] complain[s] . . . that the hospital didn't take a discharge temperature. You theorize from that, and there is testimony to the effect that she must have had a temperature, although there's evidence to the contrary, but that because there was no discharge temperature, she was febrile at the time she left, she had an infection, she went home, and she died from that. This is the Plaintiff's theory. Well, if there was a mistake that was made, the mistake was made by the hospital or by Dr. Law, and of course that's hotly disputed, but not by Dr. Young.

South Carolina's public policy has to be that an on-call specialist must be able to rely on the information given to him by a competent, capable, and certified emergency room physician. Otherwise, again, there'd be no end to the duty on the physicians, that is those who are on call, the specialists, to verify every piece of information that they are given in a telephone conversation, and the practice of . . . medicine, nor does the practice of law for that matter. . . just simply can't permit that. . .

I just tipped, if you want to put it that way, the lawyers to the point that it appeared to me that Dr. Young was going to be released from this case at the end of all the evidence so that he would not feel it necessary to call additional witnesses in his favor, but it just seems to me that we cannot support a policy that would put that kind of burden on a specialist or on a physician who is on call. . . this issue about whether or not there was a mistake made by Dr.

Law, well the hospital, again, . . . this is where the battleground in this case is, not what Dr. Young did.

The only evidence in the record that would tend to make it appear that Dr. Young had something to do with this decision and what came from Dr. Law on a leading question from you, which was appropriate on cross-examination, you said wasn't this really a joint decision between the two of you that she could go home, and the response to that was yes.

Now when I have these issues, before I take the evidence I have to give every inference to the non-moving party. However, when I've heard the evidence, there's not a lot of inferences to simply be given because I've heard what the evidence is, and the evidence on that point is that . . . and this is consistent with construing what Dr. Law's testimony was when he called it a joint decision.

I think what he probably was saying was that Dr. Young might have given Dr. Young the credence to reverse the decision to release her, but it was his decision to release her. Dr. Law testified to that, and Dr. Young has testified to that. There's no evidence to the contrary, and thus, for that reason, Dr. Young has no responsibility here. And then finally, just like Dr. Law cannot . . . admit someone to the hospital, well, Dr. Young can't discharge someone from the emergency room when they're being treated by Dr. Law. Obviously, the decision to discharge was Dr. Law's, and thus therein is where your complaint lies, not with Dr. Young.

These are the reasons that the Court would intend at the appropriate time to release Dr. Young from the case upon appropriate motion.

I just simply have that discussion with you now so that the record ~~would be clear and in the event of appellate review of that~~ decision, your position, as well as the Court's position, would be stated.

[Trial Transcript pg.1663-1666]

Judge Baxley specifically stated that he was not making a determination as to the existence of a doctor-patient relationship, that it was not necessary to his ruling, and he stated, "I find as a matter of law there's no negligence on the part of Dr. Young and don't

even reach the patient/physician issue simply because there's no underlying negligence on which recovery could be grounded." [Trial Transcript pg. 1667]

Following that colloquy on May 26, 2010, counsel for Dr. Young and Grand Strand Urology, LLP moved for directed verdict. [Trial Transcript pg. 1807-1811, 1815] Judge Baxley directed a verdict for Dr. Young and Grand Strand Urology, LLP on May 26, 2010, and verbally entered judgment on the record for these Defendants that day¹. [Trial Transcript pg. 1815-1817]

Following the grant of Dr. Young's and Grand Strand Urology, LLP's motion for directed verdict, the remaining Defendants Grand Strand Regional Medical Center's and Dr. Law's motions for a directed verdict were denied. [Trial Transcript pg. 1817-1825]

The trial proceeded against Dr. Law and the Hospital the next day with closing arguments, jury charges, and the beginning of jury deliberations on May 27, 2010. The jury returned a verdict against the hospital and Dr. Law on May 28, 2010 (two days after Dr. Young and Grand Strand Urology had been dismissed from the case), and Judge Baxley entered judgment against Defendants Dr. Law and Grand Strand Regional Medical Center and filed his Form 4 Order on May 28, 2010. [Exhibit A, Form 4 Order with attached verdict form]

PROCEDURAL POSTURE

Defendants Hospital and Dr. Law filed post-trial motions for a new trial on or about June 8, 2010. Judge Baxley denied those motions by separate Orders served June

¹ Judge Baxley did not sign a written order reflecting that Dr. Young and Grand Strand Urology, LLP had been dismissed. However, the Form Four Order filed May 28, 2010, with attached Jury Verdict indicates that Dr. Young and Grand Strand Urology, LLP had been removed as Defendants in the caption on the verdict form. See Exhibit A, Form 4 Order with attached verdict form.

23, 2010, and filed June 24, 2010; counsel for Dr. Young and Grand Strand Urology, LLP was not copied on these Orders.

Counsel for Dr. Law then filed a motion to alter or amend judgment and/or a motion for reconsideration pursuant to Rule 59 of the South Carolina Rules of Civil Procedure on July 21, 2010; on that same day, counsel for the Hospital filed a Notice of Intent to Appeal with this Court. However, counsel for Dr. Young and Grand Strand Urology, LLP was never served with notice of this appeal. The Hospital then filed an Amended Notice of Appeal on or about July 26, 2010; again, counsel for Dr. Young and Grand Strand Urology, LLP, was never served with the Amended Notice of Appeal.

On July 30, 2010, Plaintiff's counsel filed a memorandum opposing Dr. Law's motion for reconsideration. On July 30, 2010, Plaintiff also filed a Notice of Cross-Appeal appealing Judge Baxley's dismissal of Dr. Young and Grand Strand Urology, LLP and further appealing Judge Baxley's rulings in favor of the Defendant Hospital on issues of jury charges as well as Judge Baxley's refusal to permit the jury to consider the issue of punitive damages. Counsel for Dr. Young and Grand Strand Urology, LLP received written notice of Plaintiff's cross-appeal on August 2, 2010. On August 6, 2010, counsel for the Hospital filed a Second Amended Notice of Appeal and attorneys from the Nelson Mullins Law Firm entered a Notice of Appearance in the case.

The Plaintiff's attorney served a Motion to stay the time limits for appeal on August 10, 2010. On August 20, 2010, counsel for Dr. Law filed a Motion to Dismiss the Appeals without prejudice, or alternatively, a Motion to stay the time limits to appeal and remand the case to Judge Baxley for determination of Dr. Law's Motion for

Reconsideration. Attorneys from Davidson & Lindemann, P.A. also entered an appearance in the case on Dr. Law's behalf.

Then on August 24, 2010, counsel for the Hospital served a return to Dr. Law's Motion to Dismiss the Appeals objecting to the motion but not opposing the Motion to stay the time limits to appeal. The Motion to stay the time limits to appeal was granted by the Court of Appeals on September 24, 2010.

Finally, on September 9, 2011 counsel for Dr. Stephen Law received an order from Judge Baxley adjudicating the Motion to alter or Amend Judgment and/or Motion for Reconsideration. Counsel for Dr. Law then sent his Notice of Appeal to be filed with the Court of Appeals on September 23, 2011.

ARGUMENT

- I. Plaintiff's Failure To Serve His Notice Of Appeal Within 30 Days Of The Directed Verdict In Favor Of Dr. Young and Grand Strand Urology, LLP, Or Alternatively Within 30 Days Of The Filing Of The "Form Four" Order, Deprives This Court Of Subject Matter Jurisdiction And The Appeal Must Be Dismissed.

"Whenever it appears that an appellant has failed to comply with the requirements of the South Carolina Appellant Court Rules, an order of dismissal shall be issued."

Wise v. South Carolina Dep't of Corrections, 372 S.C. 173, 174, 642 S.E.2d 551, 551

(2007) (citing Rule 231(a), SCACR). The Court of Appeals "generally only lacks jurisdiction over an appeal when the notice of appeal is untimely. The notice of appeal must be served in civil cases within thirty days after receipt of written notice of entry of final order." Rule 203(b)(1), SCACR; Holroyd v. Requa, 361 S.C. 43, 54, 603 S.E.2d 417, 422 (Ct. App. 2006). "The failure to timely serve a notice of appeal 'divests this court of subject matter jurisdiction and results in dismissal of the appeal.'" Id. 361 S.C. at

54, 603 S.E.2d at 423 (citing Canal Ins. Co. v. Caldwell, 338 S.C. 1, 5, 524 S.E.2d 416, 418 (Ct. App. 1999)). Furthermore, “the timely service of an appeal is a jurisdictional requirement that cannot be waived.” Olson v. Faculty House of Carolina, Inc., 344 S.C. 194, 214, 544 S.E.2d 38, 48 (Ct. App. 2000). However, the lack of subject matter jurisdiction can be raised at any time. Badeaux v. Davis, 337 S.C. 195, 522 S.E.2d 835 (Ct. App. 1999).

In the case of Olson v. Faculty House of Carolina, Inc., one issue heard on appeal was whether Plaintiff was required to serve a notice of appeal within 30 days of the grant of summary judgment in favor of the University of South Carolina. In Olson, the Plaintiff sued The Faculty House and the University of South Carolina when she slipped and fell at the dining club operated in a building leased from the University. She initially sued the operator of the club Faculty House, and then later she sought to add the University as a Defendant when she learned that it owned the premises. The University argued that the action was barred by the statute of limitations; the Circuit Court agreed and granted summary judgment to the University. However, Plaintiff did not immediately appeal this ruling and, instead, pursued her claims against Faculty House. Only one year later, when some of Plaintiff’s claims against Faculty House were dismissed, did the Plaintiff appeal the grant of summary judgment to the University.

In Olson, the Court of Appeals found that the lower court’s grant of summary judgment to the University was a final order because it left nothing further for determination. The Court of Appeals found that: “Any judgment or decree, leaving some further act to be done by the court before the rights of other parties are determined, is interlocutory; **but if it so completely fixes the rights of the parties that the court has**

nothing further to do in the action, then it is final.” Id. 344 S.C. at 48, 544 S.E.2d at 213 (citing Adickes v. Allison & Bratton, 21 S.C. 245, 259 (1883) (emphasis in original)).

The Court of Appeals noted the fact that the Plaintiff had continuing claims against co-Defendant Faculty House was irrelevant to the dismissal of the University. **“Nothing short of direct appeal could resurrect the action against the University. In today’s world the proliferation of parties is a common occurrence. Were we to adopt [Plaintiff’s] view, a dismissed party would be on hold indefinitely.”** Id. 344 S.C. at 48, 544 S.E.2d at 214.

Although the Olson case is dissimilar from the case at bar in that in Olson the Defendant was dismissed via summary judgment, and here the Defendants were dismissed via directed verdict, the reasoning and holding of Olson is still applicable to this case. Dr. Young and Grand Strand Urology were dismissed with finality from this case on May 26, 2010, prior to the commencement of closing arguments and jury deliberations.² The jury’s verdict was rendered and filed on May 28, 2010. At that point, all issues regarding Defendants Dr. Young and Grand Strand Urology, LLP were resolved by the circuit judge and were ripe for appellate review. Thus, the time for Plaintiff to serve his notice of appeal began to run from the date of the verbal ruling granting the directed verdict on May 26, 2010, or at the latest, from the date of the filed “Form Four” verdict form against the remaining co-Defendants on May 28, 2010.

²Defendants submit that Judge Baxley’s verbal ruling directing the verdict for Defendants was final and that a written order was not required to make this ruling final in order to begin the time period for Plaintiff to serve his notice of appeal. In State v. Brown, 351 S.C. 522, 528-29, 570 S.E.2d 559, 562 (Ct. App. 2002) (reversed on other grounds), the Court of Appeals held that because the Defendant sent in his notice of appeal within 21 days of the magistrate judge’s verbal ruling, and the deadline for service of the appeal was 25 days (as provided by the 1997 version of that particular statute), the Court of Appeals found that the appeal had been timely filed.

However, Plaintiff inexplicably waited until July 30, 2010, over two months after Dr. Young's and Grand Strand Urology, LLP's dismissal from the case before filing and serving his notice of appeal against Dr. Young and Grand Strand Urology, LLP. As in Olson, the fact that the Plaintiff had remaining claims against other Defendants was irrelevant to and independent from Dr. Young's and Grand Strand Urology LLP's dismissal from the case. As the Court of Appeals in Olson stated, "[n]othing short of direct appeal" could resurrect the action against Dr. Young and his practice. Id.

Once Dr. Young and Grand Strand Urology, LLP were directed a verdict, there was nothing further to be determined regarding their rights, and no further act needed to be completed by the Court to make the ruling final, especially once closing arguments commenced and the jury began to deliberate, and even more so once the "Form Four" Order was filed on May 28, 2010.

The record indicates that Plaintiff's counsel realized the finality of the directed verdict, as evidenced by the discussion between counsel and Judge Baxley regarding how the jury would be advised as to Dr. Young's and his practice's dismissal from the case. First, on May 26, 2010, the following colloquy took place between Plaintiff's counsel and Judge Baxley prior to Dr. Young's and Grand Strand Urology LLP's motion for directed verdict:

Mr. Foster: . . . what concerns me probably more at this moment than anything, is the way that Dr. Young is going to be released and the way the jury is going to perceive that. . . .

Judge Baxley: Well, what I would intend to do at the close of the evidence, if the motion is made, to grant that motion, and then prior to charging the jury would tell them that Dr. Young has been released from the Court- -by the Court as a matter of law and your case against him has been dismissed, he is no longer a party.

[Trial Transcript pg. 1668]

After Dr. Young and Grand Strand Urology were directed verdicts, the issue again arose the following day on May 27th regarding what the jury would be told about these Defendants' dismissal from the case. Counsel for the hospital indicated to the Court that "we're okay with you just telling [the jury] that Dr. Young has been released." [Trial Transcript pg. 1832] However, Plaintiff's counsel requested that the Court tell the jury that Plaintiff had released Dr. Young from the case as a matter of law. [Trial Transcript pg. 1833] However, the Court declined to make either of those statements as requested because the Court felt that it may lead to an:

inference in that there was a payment made for [Dr. Young] to leave. That may affect the Plaintiff's damages. I don't know how it may be taken. I think the best course is simply to tell them that at the end of the case the Court takes motions from all the parties and upon motion of Dr. Young's counsel, the Court dismissed Dr. Young from the lawsuit because as a matter of law there was no liability under South Carolina law, and thus leave it there.

[Trial Transcript pg. 1832-1834]

The Court ultimately told the jury panel that he had heard motions the day before and advised the jury that:

Dr. Young is not seated here with Counsel at the Defendants' table and that is because at the close of all the evidence, Dr. Young's attorneys made a motion yesterday to dismiss him from the lawsuit, and the Court granted that motion on the basis that for the facts that were put forth in this trial, as a matter of law South Carolina does not permit recovery against Dr. Young under those circumstances. He is now dismissed from this case by the Court. I tell you that so obviously you will realize his lawyers are not participating in the trial today.

[Trial Transcript pg. 1835-1836]

At the latest, the time for Plaintiff to serve his notice of appeal against Dr. Young and Grand Strand Urology, LLP began to run on May 28, 2010, to be timely under the South Carolina Rules of Appellate Procedure. Because Plaintiff did not serve his notice of appeal until July 30, 2010, his appeal against Dr. Young and Grand Strand Urology, LLP is not timely and must be dismissed. If Plaintiff's notice of appeal is found to be timely, it would undermine the finality of summary judgments and directed verdicts since the losing party would always be able to come back at a date beyond the thirty day time limit prescribed by the Rules of Appellate Procedure to appeal the dismissal, perhaps even years later, depending on the circumstances of the case. As the Olson Court so succinctly stated, to consider Plaintiff's notice of appeal to be timely would mean that "a dismissed party would be on hold indefinitely." Id. 344 S.C. at 48, 544 S.E.2d at 214. This is a result that the jurisprudence and legislature of this state could not have intended.

Accordingly, Dr. Young and Grand Strand Urology, LLP move this Court to dismiss Plaintiff's appeal against them because Plaintiff failed to timely serve his notice of appeal within thirty days of the final order dismissing Dr. Young and Grand Strand Urology, LLP.

II. ~~Because Plaintiff Failed To Serve His Notice Of Cross-Appeal Within 30 Days Of Judge Baxley's Order Denying Dr. Law's And The Hospital's Post-Trial Motions, Plaintiff's Appeal Is Untimely And Must Be Dismissed.~~

Rule 203(b)(1) provides that, "when a party makes a timely post-trial motion for judgment notwithstanding the verdict, to alter or amend the judgment, or for a new trial, 'the time for appeal for all parties shall be stayed and shall run from receipt of written notice of entry of the order granting or denying such motion.'" Id. 361 S.C. at 54, 603 S.E.2d at 422-23. Although Dr. Young and Grand Strand Urology, LLP contend that the

time for Plaintiff to serve his notice of appeal against them began to run once the directed verdict was final on May 26, 2010, or at the latest on May 28, 2010, Defendants alternatively submit that Plaintiff still failed to serve his notice of appeal within thirty days of the denial of co-Defendants' post-trial motions, and therefore the cross-appeal must be dismissed.

In the case at bar, co-Defendants Dr. Law and Grand Strand Regional Medical Center served post-trial motions on June 8, 2010. The post-trial motions were denied by written order of Judge Baxley served on June 23, 2010 and filed on June 24, 2010. Significantly, Judge Baxley did not send a copy of his orders denying the co-Defendants' post-trial motions to counsel for Dr. Young and his practice, as he evidently considered that they had already been dismissed from the case, and the post-trial motions and orders did not pertain to them.

Plaintiff did not serve his notice of cross-appeal against Dr. Young and his practice until July 30, 2010; or not until six days after the thirty-day time period to serve his notice of appeal had lapsed, assuming *arguendo* that Dr. Young's and Grand Strand Urology's dismissal was not final prior to or on May 26 or May 28, 2010. Additionally, because Plaintiff failed to include within his notice of cross-appeal any indication of when he received Judge Baxley's Orders denying the co-Defendants' post-trial motions, Plaintiff has failed to offer any evidence as to why the time for serving his cross appeal should be extended beyond the thirty day period prescribed by Rule 203. Accordingly, Plaintiff's notice of cross-appeal must be dismissed against Dr. Young and Grand Strand Urology, LLP for failing to comply with the requirements of Rule 203(b)(1), SCACR.

CONCLUSION

Dr. Young and Grand Strand Urology, LLP are entitled to dismissal of Plaintiff's
cross-appeal against them on the basis that the appeal was not timely served pursuant to
South Carolina Appellate Court Rule 203(b)(1).

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10-6, 2011.
Myrtle Beach, South Carolina

Attorneys for Defendants Richard Young, M.D. and
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1	STATE OF SOUTH CAROLINA)	COURT OF COMMON PLEAS
2	COUNTY OF HORRY)	(08-CP-26-9047)
3		(08-CP-26-9368)
4	SEAN D. FAY, as Personal)	
5	Representative of the)	
6	Estate of Kelly L. Fay,)	
7	deceased.)	TRANSCRIPT OF RECORD
8		
9	GRAND STRAND REGIONAL)	FOR
10	MEDICAL CENTER, LLC, dba)	May 26 - 27, 2010
11	SOUTH STRAND AMBULATORY)	Conway, South Carolina
12	CARE CENTER, et al)	
13		
14	B E F O R E:	
15	HONORABLE J. MICHAEL BAXLEY, Judge; and a jury.	
16	A P P E A R A N C E S:	
17	RUSKIN C. FOSTER, ESQ.	
18	BRADLEY HEWITT, ESQ.	
19	ATTORNEYS FOR PLAINTIFF	
20	MONTEITH P. TODD, ESQ.	
21	RANDOLPH L. LEE, ESQ.	
22	ATTORNEYS FOR DEFENDANTS, GRAND STRAND	
23	J. BOONE AIKEN, III, ESQ.	
24	ATTORNEY FOR DEFENDANTS, LAW AND CAROLINA HEALTH	
25	~~MARIAN SCALISE, ESQ.~~	
	LYDIA L. MAGEE, ESQ.	
	ATTORNEYS FOR DEFENDANT, YOUNG	
	DIXIE COX EUBANK	
	CIRCUIT COURT REPORTER	
	FIFTEENTH JUDICIAL CIRCUIT	

JURY OUT/ON RECORD

1 **THE COURT:** We'll be in recess now.

2 **(THE FOLLOWING TAKES PLACE AFTER A LUNCH BREAK AND**
3 **OUTSIDE THE PRESENCE OF THE JURY.)**

4 **THE COURT:** All right, while our jury is out, let's just
5 -- let's go on the record and memorialize what happened in a
6 conversation earlier this morning at the bench that was not on
7 the record.

8 I am aware that the parties in this case, I expect,
9 probably are going to have Two Hundred Thousand Dollars in
10 costs. We are in our eighth day of trial. This upcoming
11 weekend is Memorial Day Weekend. The Court is, of course,
12 concerned about judicial economy, as well as alleviating
13 expenses, but more particularly if we can avoid calling
14 particular witnesses and specifically experts on the area of
15 urology, I felt I needed to tell the parties if that was a
16 possibility.

17 I called the lawyers up. I asked them if -- what motions
18 would be made at the end of the trial most likely, and all of
19 the Defense Counsel told me they would be making the same
20 motions, which were motions for a directed verdict at the end
21 of the case.

22 At that point, I advised Counsel for Dr. Young that it
23 was the Court's most likely intention to dismiss this case
24 against Dr. Young at the conclusion of all the evidence upon
25 the appropriate motion. I did that, again, because if that

1 **THE COURT:** Let me -- let me respond to you, Counsel,
2 and I've given this substantial thought. I have followed this
3 issue closely once it was crystalized at the summary judgment
4 motion that was made prior to us drawing the jury and
5 beginning the trial, and thus I've listened closely throughout
6 this testimony for evidence of Dr. Young's involvement or
7 culpability, if you wish to state it that way, but before we
8 talk about that, let's look at the big picture.

9 Every weekend, there are hundreds of physicians who are
10 on call for various specialties throughout this state, and
11 what the evidence shows here is that Dr. Young took a
12 telephone call. He had a telephone conversation, and then he
13 made an appointment or at least allow- -- suggested that the
14 person, now deceased, make an appointment for -- or call
15 Monday morning to have an appointment with him. That was, I
16 think, ostensibly, just looking at the big picture, that was
17 the involvement that Dr. Young had, without getting into
18 specifics.

19 I can tell you again, still looking at the big picture,
20 that this Court cannot enact judicially or support a public
21 policy that would require a physician that every time that
22 specialist or physician takes a phone call with regard to a
23 patient, that he is automatically locked in for responsibility
24 for whatever the outcome may be. This is -- thus it's not the
25 way medicine is practiced in South Carolina and it cannot be

JURY OUT/ON RECORD

1 that our courts would set up a system where the doctor would
2 have liability for what simply occurs in the course of a
3 telephone call when a physician is on call when the phy- --
4 when the on-call physician is really not the one who is making
5 the decisions here.

6 You complain -- now, getting down to the little picture
7 of this specific case, you complain that the hospital didn't
8 take a discharge temperature. You theorize from that, and
9 there is testimony to the effect that she must have had
10 temperature, although there's evidence to the contrary, but
11 that because there was no discharge temperature, she was
12 febrile at the time she left, she had an infection, she went
13 home, and she died from that. This is the Plaintiff's theory.
14 Well, if there was a mistake that was made, the mistake was
15 made by the hospital or by Dr. Law and, of course, that's
16 hotly disputed, but not by Dr. Young.

17 South Carolina's public policy has to be that an on-call
18 specialist must be able to rely on the information given to
19 him by a competent, capable, and certified emergency room
20 physician. Otherwise, again, there'd be no end to the duty on
21 the physicians, that is those who are on call, the
22 specialists, to verify every piece of information that they
23 are given in a telephone conversation, and the practice of law
24 -- well, the practice of medicine, nor does the practice of
25 law for that matter, although I misstated it, just simply

JURY OUT/ON RECORD

1 can't permit that and, therefore, the Court's ruling -- and
2 again, I don't have all the evidence in.

3 I just tipped, if you want to put it that way, the
4 lawyers to the point that it appeared to me that Dr. Young was
5 going to be released from this case at the end of all the
6 evidence so that he would not feel it necessary to call
7 additional witnesses in his favor, but it just seems to me
8 that we cannot support a policy that would put that kind of
9 burden on a specialist or on a physician who is on call, and
10 now, of course, the decision -- this issue about whether or
11 not there was a mistake made by Dr. Law, well, the hospital,
12 again, that -- this is where the battleground in this case is,
13 not what Dr. Young did.

14 The only evidence in the record that would tend to make
15 it appear that Dr. Young had something to do with this
16 decision and what came from Dr. Law on a leading question from
17 you, which was appropriate on cross-examination, you said

18 wasn't this really a joint decision between the two of you
19 that she could go home, and the response of that was yes.

20 Now, when I have -- have these issues, before I take the
21 evidence I have to give every inference to the non-moving
22 party. However, when I've heard the evidence, there's not a
23 lot of inferences to simply be given because I've heard what
24 the evidence is, and the evidence on that point is that -- and
25 perhaps -- and this is consistent with construing what Dr.

JURY OUT/ON RECORD

1 Law's testimony was when he called it a joint decision.

2 I think what he probably was saying was that Dr. Young
3 might have -- he might have given Dr. Young the credence to
4 reverse the decision to release her, but it was his decision
5 to release her. Dr. Law testified to that, and Dr. Young has
6 testified to that. There's no evidence to the contrary, and
7 thus for that reason, Dr. Young has no responsibility here.

8 And then finally, just like Dr. Law cannot discharge --
9 excuse me, cannot admit someone to the hospital, well, Dr.
10 Young can't discharge someone from the emergency room when
11 they're being treated by Dr. Law. Obviously the decision to
12 discharge was Dr. Law's, and thus therein is where your
13 complaint lies, not with Dr. Young.

14 These are the reasons that the Court would intend at the
15 appropriate time to release Dr. Young from the case upon
16 appropriate motion.

17 I just simply have that discussion with you now so that
18 the record would be clear and in the event of appellate review
19 of that decision, your position, as well as the Court's
20 position, would be stated.

21 If you have something further either side wishes to add
22 so -- for completeness of the record, we'll be glad to hear
23 from you at this time before we call the jury back in.

24 **MR. FOSTER:** Your Honor, could I just make one more
25 statement and one question, Your Honor?

JURY OUT/ON RECORD

1 **THE COURT:** Go ahead.

2 **MR. FOSTER:** Thank you, Your Honor. Your Honor, I would
3 just like to read from Roberts v. Hunter, which is -- I
4 believe we all agree is the current law in South Carolina, and
5 what we were going to request the Court to charge was -- was
6 this out of **Roberts**: The establishment of a doctor/patient
7 relationship is prerequisite to a claim of medical
8 malpractice. The relation is a consensual one wherein the
9 patient knowingly seeks the assistance of a physician and the
10 physician knowingly accepts him as a patient, and we believe
11 that that was fully established through the records, and the
12 signing, and the phone conversation between Dr. Law and Dr.
13 Young.

14 Now, my question to you is this, Your Honor -- I
15 understand your ruling. I just wanted to put that on the
16 record.

17 **THE COURT:** Very good, and, Counsel, I should reply to

18 that. I probably didn't say this, but the decision is not
19 based on the patient/physician issue. The Court does not
20 reach that issue. It's not necessary to determination here.
21 I find as a matter of law there's no negligence on the part of
22 Dr. Young and don't even reach the patient/physician issue ---

23 **MR. FOSTER:** Okay.

24 **THE COURT:** --- simply because there's no underlying
25 negligence on which a recovery could be grounded.

JURY OUT/ON RECORD

1 **MR. FOSTER:** I understand, Your Honor. We're all
2 getting tired.

3 Can I ask this, Your Honor, and this is what would --
4 what concerns me probably more at this moment than anything,
5 is the way that Dr. Young is going to be released and the way
6 the jury is going to perceive that. I mean, does Your Honor
7 have any idea how you intend to handle that or ---

8 **THE COURT:** Well, what I would intend to do, and again,
9 this is going to happen at the end of all the evidence, which
10 is when their motion would be appropriate, and again, we're
11 still taking evidence here and it's possible something could
12 come out, I suppose, that would reverse that. I doubt it
13 because the two people involved in that conversation, which is
14 pivotal, that telephone conversation, now have both testified,
15 which is Dr. Law and Dr. Young, but I would intend at the
16 close of the evidence, if the motion is made, to grant that
17 motion, and then prior to charging the jury would tell them
18 that Dr. Young has been released from the Court -- by the
19 Court as a matter of law and your case against him has been
20 dismissed, he is no longer a party. That's the way I
21 generally tell it.

22 **MR. FOSTER:** Any chance, Your Honor, we can just say
23 that Dr. Young is no longer in the case and it's not -- and it
24 is not for their consideration one way or the other?

25 **THE COURT:** Well, let me just simply say that I'll let

MOTIONS

1 We did the best we could.

2 **THE COURT:** Very good.

3 All right, anything else now before we go into motions?

4 (No response.)

5 All right, let's take up our motions at the close of the
6 case. We'll go first to Dr. Young.

7 **MS. SCALISE:** Thank you, Your Honor. May it please the
8 Court.

9 First, I'd like to incorporate by reference all of the
10 arguments that were made in relation for summary judgment
11 memorandum, the arguments made at the hearing on the motion
12 for summary judgment, and arguments made at the close of
13 Plaintiff's evidence. In addition, Your Honor, as a matter of
14 law, the only reasonable inference that the jury could
15 determine based on the evidence and testimony is that Dr.
16 Young was not negligent or culpable, first, as it pertains to
17 the physician/patient relationship. We believe that there is

18 no evidence of a physician/patient relationship on the
19 testimony that has been heard by this jury is that Dr. Law
20 called to arrange follow-up because Dr. Law had already
21 determined that the patient was capable of being discharged
22 because the stone was not going to pass.

23 The agreement was for Dr. Young to see the patient in the
24 future. In looking at the Roberts v. Hunter case, 426 S.E.2d
25 797, that case found that there was no physician/patient

MOTIONS

1 relationship when the doctor agreed to see the patient, but
2 the patient was never examined, so absent contact with the
3 patient, we believe that there is no physician/patient
4 relationship.

5 Additionally, Your Honor, the issue of the on-call status
6 does not establish a physician/patient relationship. There's
7 no testimony that the hospital or the emergency room physician
8 can create a physician/patient relationship for Dr. Young.
9 Additionally for public policy reasons, the on-call status
10 cannot create a doctor/patient relationship. Otherwise, no
11 physician would ever take calls, so, Your Honor, based on the
12 testimony and the evidence in this case, the only inference
13 from this is that Dr. Young did not have a physician/patient
14 relationship with Kelly Fay.

15 Secondly, Your Honor, we believe that there's no evidence
16 as a matter of law that Dr. Young was negligent or culpable.
17 Dr. Siroky's testimony was that the standard of care require

18 that Dr. Young find out (a) the size of the stone, (b) the
19 location of the stone, (c) obstruction, and (d) if there was
20 an infection.

21 Based -- Dr. Young has testified that he found out that
22 information. That's why specifically when he was testifying I
23 checked on the board everything that he said, went through all
24 those different issues, so based on Dr. Young's testimony, he
25 has met the standard of care as required by Dr. Siroky, so

MOTIONS

1 that's the only reasonable inference that a jury could make is
2 that Dr. Young did comply with the standard of care.

3 Specifically, there is no testimony that Dr. Young did
4 not have the right to rely on the information Dr. Law gave.
5 The information that Dr. Law gave was accurate. There was no
6 reason for Dr. Young to not believe he was receiving accurate
7 information, so, in fact, the only and consistent evidence is
8 that Dr. Young had this right to rely on Dr. Law.

9 Dr. Law told him that she was afebrile, or told Dr. Young
10 that the patient was afebrile. If Dr. Law was incorrect and
11 the patient was febrile, Dr. Law would not have any -- Dr.
12 Young would not have any evidence of this or reason to dispute
13 the same, and thus he has a right to rely on the information
14 given.

15 As a matter of public policy, there's no requirement to
16 quiz another physician as to the time a temperature was taken,
17 and I would incorporate into this the comments that Your Honor
18 made earlier on these same topics.

19 And, in fact, if truly there was a requirement for a
20 specialist to quiz a doctor, then doctors would never get
21 anything done because they would have to be questioning the
22 accuracy of the information given, so as a matter of public
23 policy, they must be able to rely on the information that they
24 are given, so the only reasonable inference is that Dr. Young
25 was not negligent or culpable in Kelly Fay's death.

MOTIONS

1 Thirdly, we move for directed verdict just simply on
2 public policy grounds, that the law in South Carolina cannot
3 be that every time a specialist takes a phone call, the
4 specialist is automatically responsible for what happens. The
5 on-call urologist must be able to rely on the information
6 given to him by competent, capable, and board certified
7 emergency room physicians. Otherwise, there's no end to the
8 specialist's duty to verify every piece of information and for
9 public policy reasons the law cannot require that a specialist
10 be -- I can't read my writing -- Dr. Law could not -- I mean,
11 Dr. Young cannot be responsible for that. Otherwise, it would
12 impose a tremendous burden on the specialist, which is against
13 public policy.

14 Next, Your Honor, as a matter of law, the only reasonable
15 inference that a jury could determine was that the failure to
16 take a discharge temperature, if that is a deviation by the
17 hospital and/or Dr. Law, that that broke any causal chain of
18 alleged negligence on the part of Dr. Young, so the hospital
19 and/or Dr. Law's alleged negligence was a superseding
20 intervening act of negligence, and for that reason we believe
21 that a directed verdict is appropriate.

22 Additionally, as it pertains to the Sunday phone call, if
23 the jury finds that the patient should have been told to come
24 back, or if they have any questions about that issue of the
25 phone call, as a matter of law the only reasonable inference

MOTIONS

1 that a jury could determine is that Dr. Young had no
2 involvement or responsibility with that phone call, and
3 there's no testimony whatsoever to the contrary of that, so if
4 the jury finds any negligence associated with the phone call,
5 that again breaks this causal chain as well, so the hospital's
6 alleged negligence is a superseding intervening act of
7 negligence, and for that reason again, we believe a directed
8 verdict is appropriate.

9 And last, Your Honor, I'd have to refer to my Answer, but
10 in my Answer I've listed various specifications of negligence
11 as to Sean Fay ---

12 **THE COURT:** All right.

13 **MS. SCALISE:** --- and/or Kelly Fay, so I would
14 incorporate what those specifications were into this argument,
15 and I believe that the only reasonable inference that a jury
16 could -- could determine was that the Plaintiff's negligence
17 far outweighed any alleged negligence on the part of Dr. Young
18 and so because of that, based on the comparative negligence
19 law, a jury would have to find that he was -- his negligence
20 was greater and exceeded in far excess any alleged negligence
21 on the part of Dr. Young, so accordingly, a directed verdict
22 would be appropriate on a comparative ground as well. Thank
23 you, Your Honor.

24 **THE COURT:** Very good. Thank you, and Mr. Foster, you,
25 in our earlier colloquy, placed your reasons on the record for

MOTIONS

1 that they were concerned about -- that they were concerned
2 about infection, Dr. Law was concerned about infection, that
3 he relayed all the pertinent information to Dr. Young.

4 Their expert said that they should have been concerned
5 with infection, and ultimately that's what came to pass, so
6 whether there was a break in the causal chain -- there never
7 should have been a break. If there was a break in the causal
8 chain, it was still foreseeable that that would happen, and we
9 oppose it on those grounds. Thank you, Your Honor.

10 **THE COURT:** All right. It's not necessary for a
11 response. If you wish to make one, however, for the record,
12 you may briefly.

13 **MS. SCALISE:** Just for the record, thank you, Your
14 Honor, that I believe that the amendment should be allowed so
15 that the pleadings conform to evidence. First, the issue he
16 just raised about foreseeable risk, I don't believe it's
17 foreseeable that a patient who was told to return to the
18 emergency room is not going to return, but also it's not
19 foreseeable that if truly the conversation took place with the
20 emergency room, that the emergency room is not going to tell
21 them to come back in, or that the temperature would not be
22 accurate. Thank you, Your Honor.

23 **THE COURT:** Very good. The Court is prepared to rule,
24 and my ruling is the same from our discussion that we had
25 earlier today. First of all, it's not necessary to reach,

MOTIONS

1 and, therefore, I do not reach the issue of whether or not
2 there was a physician/patient relationship established between
3 Dr. Young and Ms. Fay.

4 The Court just finds as a matter of law that there is,
5 first of all, there is no negligence on the part of Dr. Young
6 who has a right to rely on any information given to him by a
7 competent, capable, and board certified emergency physician.
8 To hold otherwise would turn the practice of medicine on its
9 head in South Carolina, but furthermore, I am going to permit
10 the parties, Dr. Young specifically, to amend his pleadings to
11 allege superseding or intervening negligence.

12 There's really no surprise here because this came before
13 the testimony, the motion did, before the testimony of Dr.
14 Young and Dr. Law and thus could have been explored during the
15 time they were on the stand, but furthermore, it cannot --
16 does not seem to the Court that that could be a shock or
17 surprise because that issue sort of permeates the factual

18 scenario from which arose this unfortunate event, and thus for
19 all these reasons, the Court is going to grant dismissal to
20 Dr. Young at this time, and it is so ordered.

21 Dr. Young, you are free to leave if you wish. You are
22 free to remain for the day if you wish, but I'm going to
23 dismiss Dr. Young at this time from the case.

24 All right, very good. All right, now, other motions at
25 the close of the Plaintiff's case. I have one motion under

MOTIONS

1 advi- -- really under -- I deferred and kept it under
2 advisement, but I will be glad to hear from you, whatever
3 motions you may have.

4 **MR. TODD:** Well, Your Honor, the first motion would be
5 the motion you have under advisement concerning the dismissal
6 of striking the punitive damages.

7 **THE COURT:** All right. The Court is prepared to take
8 that up. Rather than take an argument from you at this time,
9 let me just hear from you, Mr. Foster, what evidence do you
10 have that you believe would warrant submission of punitive
11 damages to the jury.

12 **MR. FOSTER:** Your Honor, the evidence is -- just on law
13 or the evidence, or do you care?

14 **THE COURT:** I'm well familiar with the law. What I'd
15 like to hear is just specifically the evidence that you
16 believe this record contains that would permit punitive
17 damages.

18 **MR. FOSTER:** Your Honor, they breached a basic standard
19 of care, because that's all we've heard all day long, is that
20 a fever and kidney stone or an infection and a kidney stone,
21 but especially a fever at this point, is a true urologic
22 emergency and that Dr. Young would have rushed her -- rushed
23 her to the O.R. and drained that kidney, and for the failure
24 of the hospital, through -- by and through the nurses to even
25 take a temperature on this -- on Kelly after eight o'clock in

MOTIONS

1 the morning, knowing -- that knowing that that's an emer- --
2 that's an emergent situation, if she had -- if her fever would
3 have gone up, we think, shows a conscious disregard for her
4 rights, and we feel as though that rises to the level of
5 recklessness or the conscious failure to use due care, Your
6 Honor, and the Supreme Court has also ruled, as you know, that
7 the failure to use the care necessary under the circumstances
8 constitutes gross negligence, and we think that that gets the
9 issue to the jury.

10 We're not asking you for a directed verdict on it, but we
11 at least think the jury should be able to consider punitives
12 in their deliberations. Just that basic failure to even take
13 -- just put a thermometer in somebody's mouth on the part of
14 Grace New, we think, and even Ms. Doolittle on discharge, if
15 the jury so decides, is such a basic element of medical care.

16 Everybody -- everybody that's testified in this case has
17 testified that a fever and a kidney stone is an emergency and
18 that a temperature is a vital sign. They've got a policy.

19 We're quibbling about what the definition of is, is, on the
20 abdominal policy, but it clearly states -- and not only that,
21 Your Honor, apparently they blew this up, but I want to show
22 you this, and I've been looking for this the whole time, but
23 this is the 2003 that they provided me.

24 This is the March 31, 2003, vital sign record, and it
25 says it replaces the January 1999 policy, and all we could

MOTIONS

1 ever get, all we could ever get is the 1978 vital sign policy.
2 If you look at the 2003, it replaces the '99. It does say
3 abnormal vital signs will be repeated within one hour of --
4 I'm sorry. Urgent, repeat vital signs in one hour, sooner if
5 condition warrants. Vital signs may be then recorded every
6 two to four hours and upon discharge from the unit, but we
7 can't get that '99 policy from them.

8 **THE COURT:** All right.

9 **MR. FOSTER:** And we think -- we think not only was there
10 a vital sign policy in place, but the one that -- even the '78
11 one that gives us -- with a chief complaint of abdominal pain
12 in the medical records gives us evidence of a conscious -- and
13 she didn't give any excuse, like we were busy, I didn't do it
14 because of this, I just didn't do it because I didn't think I
15 needed to.

16 **THE COURT:** All right, very good. Counsel, one of the
17 good things about this docket, this multi-week docket that I
18 am privileged to administer, is I've got good lawyers. I've
19 got experienced trial lawyers who are appearing in front of me
20 consistently.

21 **MR. FOSTER:** Can I add one other thing, Your Honor,
22 about ---

23 **THE COURT:** Well, that's good. You're certainly not
24 listening to what I'm saying, so go ahead.

25 **MR. FOSTER:** I'm sorry, Your Honor. Somebody was

MOTIONS

1 handing me a note.

2 THE COURT: That's all right; go ahead. I see that; go
3 ahead.

4 MR. FOSTER: I apologize.

5 THE COURT: No, go ahead. You are making a record. Put
6 it on.

7 MR. FOSTER: Your Honor, we also have the issue of
8 spoliation of evidence. We think there's -- there's at least
9 circumstantial -- there's direct and circumstantial evidence
10 in this case that there were records that were generated that
11 were not contained within the medical records. Somehow
12 they're gone. Nobody seems to know where they are. Not only
13 that, but we have the issue of the Grand Strand medical
14 records where somebody told Dr. Chi that she was seen at South
15 Strand with a kidney stone and a urinary tract -- a UTI two
16 days prior.

17 THE COURT: Okay. All right, very good. There's no
18 need to take further argument on it. The Court is prepared to
19 rule. What I was saying ---

20 MR. AIKEN: Will your ruling be global or ---

21 THE COURT: It's getting ready to be.

22 MR. AIKEN: --- if not, I have arguments for Dr. Law.

23 THE COURT: It's getting ready to be. Are you ready?
24 You're good.

25 MR. AIKEN: All right.

MOTIONS

1 **THE COURT:** All right, what I was starting to say, one
2 of the good things about this -- this level of what we're
3 doing here is I've got good, experienced lawyers. You've been
4 on both sides of this case, Mr. Foster. You are -- you are
5 embroiled in a tremendous battle over whether or not the
6 failure to take her temperature was negligence to begin with,
7 and you're asking the Court to let you go to the jury on
8 punitive damages. I mean, really, just lawyer to lawyer, do
9 you believe that's in the best interest of the Plaintiff at
10 this point based on the way that the evidence has broken? I
11 mean, I'm looking at the big picture.

12 I start with just -- with that rhetorical question, but I
13 conclude with this ruling. This is not a case for punitive
14 damages. There's no conscious disregard or wilful failure to
15 comply. I mean, there may be a failure to comply, but it's
16 certainly not some conscious, wilful, knowing, reckless
17 disregard of the rights of others.

18 It's a very unfortunate incident, but nevertheless, the
19 Court finds that this clearly is not a punitive damages case.
20 And again, we had this discussion, although as Judge Anderson,
21 Judge Joe Anderson says, it's not the sine qua non of punitive
22 damages, there's no evidence of financial worth or capability.
23 That's yet another flaw as to punitives. The Court is going
24 to strike punitives as well because simply this -- this is not
25 a punitive damages case, and for these reasons, the Court is

1 going to grant the motion globally to remove punitive damages
2 from the case.

3 **MR. FOSTER:** Thank you, Your Honor.

4 **THE COURT:** Yes sir. Thank you.

5 Now, anything further from the Defense side?

6 **MR. TODD:** We move for a directed verdict on the same
7 grounds as I earlier -- lack of reliability concerning
8 causation testimony, regarding causation, and also the only
9 reasonable inference from the evidence is that the cause of
10 this death is Sean Fay's failure to bring his wife back to
11 the ---

12 **THE COURT:** Well, this is the battleground of the case
13 and that is the issue for the jury, and I decline -- deny your
14 motion, would decline to grant you any further relief at this
15 time.

16 Anything further on behalf of Dr. Law?

17 **MR. AIKEN:** Yes sir, Your Honor, somewhat reluctantly,
18 and you can argue alternative theories. I would also move to
19 -- move to amend Dr. Law's Answer to assert intervening
20 negligence or superseding negligence of the hospital if the
21 Court finds the only reasonable inference is that call was
22 made, those conversations took place as alleged by Mr. Fay.
23 I'm not saying it happened. I'm just moving to amend to
24 assert that.

25 I had this much to look at tonight on intervening

MOTIONS

1 negligence. I didn't know we would get to the arguments
2 today, ---

3 **THE COURT:** All right.

4 **MR. AIKEN:** --- but just two bullet points, the
5 negligence of a third party intervening between the negligence
6 of the Defendant and the Plaintiff's injury will insulate the
7 Defendant from liability only where the third party's
8 negligence was unforeseeable.

9 **THE COURT:** All right. Let me stop you. Are you saying
10 that -- are you referring to the hospital's failure to take a
11 discharge temp?

12 **MR. AIKEN:** No sir, I'm not mentioning discharge. I'm
13 talking about the phone call on Sunday, if that conversation
14 took place, clearly he should have been -- he should have been
15 told to come in, if that conversation took place. Quite
16 frankly, I'm not going to argue that to the jury.

17 **THE COURT:** I hear you.

18 **MR. AIKEN:** I'm just making the motion at this time.

19 **THE COURT:** I follow. Counsel, well let me -- what says
20 the -- well, who wants to be the first to be heard on that?

21 **MR. TODD:** We're going to oppose it, Your Honor.

22 **MR. FOSTER:** We oppose it as well.

23 **THE COURT:** All right. Well, Mr. Aiken, your motion is
24 different, because first of all, all the testimony has closed.
25 There's no one able now to respond to what you raise and what

MOTIONS

1 could be a cognizable argument in front of the jury. I do
2 find that the parties are surprised by the late date of this
3 motion, and I simply deny the motion for you to assert that
4 claim at this eleventh plus hour.

5 **MR. AIKEN:** I did not argue with my usual fervor.

6 **THE COURT:** All right, very good. Anything further?

7 **MR. AIKEN:** Yes sir. I would also just move for a
8 directed verdict on liability for Dr. Law and adopt my
9 arguments that I made earlier at the directed verdict motion
10 stage after the Plaintiff's case. Number one, the only
11 reasonable inference to be drawn from this evidence in every
12 light favorable to the Plaintiff is the sole negligence --
13 correction. The death of Kelly Fay was the sole negligence of
14 Sean Fay by not following clear discharge instructions from
15 Dr. Law.

16 Even Mr. Foster's experts have no reason to challenge the
17 credibility of the dictated note. They were both told to come
18 back if her condition worsened, if you have fever, chills,
19 nausea. According to Mr. Fay, that's what she developed.
20 According to their expert, Dr. Stratton, if they had -- if
21 Sean had taken her back -- excuse me, Mr. Fay, had taken her
22 back Sunday, she would be alive today. If he had taken her
23 back Monday, if she had gotten to the hospital by ten o'clock
24 Monday, she would be alive today. That's the sole negligence.
25 That's the sole ---

MOTIONS

1 **THE COURT:** Counsel, the jury has left.

2 **MR. AIKEN:** I understand, but I certainly, if I may,
3 alternatively, the only reasonable inference to be drawn from
4 the evidence is that if Mr. Fay was not solely negligent, he
5 was at least comparatively negligent, greater than fifty-one
6 percent.

7 **THE COURT:** All right. Again, without taking argument
8 from the other side, this is the battleground of what -- one
9 of the battlegrounds of the case. There is ample evidence for
10 these issues to go to the jury. The Court denies any further
11 relief at this time.

12 All right, now, anything further from the Defense side?
13 Hearing nothing, anything from the Plaintiff's side now with
14 regard to motions before we close the record for today?

15 **MR. FOSTER:** Just for the record, Your Honor, we would
16 put on the record that we would move for a directed verdict
17 for the same -- on the same grounds that Mr. Aiken did, that
18 the only reasonable inference to be drawn from the evidence is
19 that the conscious disregard of Dr. Law and the nurses at the
20 hospital was the sole cause of Kelly Fay's death and based on
21 all the testimony, we think there is adequate testimony to
22 support that, and we would move for a directed verdict on
23 liability as to that.

24 **THE COURT:** All right. For the same reasons,
25 denied, ---

MOTIONS

1 **(THE FOLLOWING TAKES PLACE OUTSIDE THE PRESENCE OF THE**
2 **JURY.)**

3 **THE COURT:** All right, is the Plaintiff ready?

4 **MR. FOSTER:** Not quite, Your Honor. Just one more
5 minute if you would, please.

6 **THE COURT:** Mr. Todd, do you have a copy of your 22 that
7 you wanted added to the charge? All right, thank you.

8 And I'll ask the Defendants this while Mr. Foster is
9 getting ready. Was there some agreement of the language for
10 which the Court would instruct the jury that there's a
11 dismissed party here?

12 **MR. TODD:** Your Honor, we're okay with you just telling
13 them that Dr. Young has been released.

14 **THE COURT:** You simply say that Dr. Young has been
15 released from the case?

16 **MR. TODD:** I think that's what the Plaintiff asked.

17 **THE COURT:** Well, I -- I -- I don't mean to throw a kink
18 in your works here, but I decline to do that because to me,
19 there may be an inference in that there was a payment made for
20 him to leave. That may affect the Plaintiff's damages. I
21 don't know how it may be taken.

22 I think the best course is simply to tell them that at
23 the end of the case the Court takes motions from all the
24 parties and upon motion of Dr. Young's Counsel, the Court
25 dismissed Dr. Young from the lawsuit because as a matter of

MOTIONS

1 law there was no liability under South Carolina law, and thus
2 leave it there. That's what I always do.

3 Now, are you wounded by that?

4 **MR. FOSTER:** Yes sir. I think I'd rather you say
5 something like you said yesterday, that Dr. Young is -- I
6 have, rather than motions or anything like that, that I have
7 released Dr. Young from this case as a matter of law and his
8 involvement in the case is not for your consideration any
9 more, or something to that effect.

10 **THE COURT:** Doctor, y'all's Counsel is here. I'll be
11 glad to -- I think this affects you. I'll be glad to hear
12 from you if you have a position.

13 **MS. SCALISE:** If I have a position?

14 **THE COURT:** Yes. Your client is behind you, as well. I
15 mean, their professional reputation is at stake and other
16 issues here do go far beyond what is happening in the
17 courtroom, so what say you?

18 **MS. SCALISE:** I think, Your Honor, your wording that you
19 have just -- that ultimately and that you did yesterday -- as
20 far as this morning what you said, that is a fair statement to
21 the jury.

22 **THE COURT:** Counsel, I would decline to tell them
23 anything other than what I've just said this morning that I'm
24 going to do because some other indication to them would first
25 of all make it appear that Dr. Young -- may appear to create

MOTIONS
JURY IN

1 an inference that he's paid to be -- has made a payment in
2 settlement to be released. Again, that would -- that language
3 may enure to the Plaintiff's detriment as well, so I decline
4 to accept the recommendation and the Court will explain as the
5 Court foresees it best.

6 All right, are you ready for the jury, Mr. Foster?

7 **MR. FOSTER:** Yes. I'm ready as I'm going to be.

8 **THE COURT:** Okay. That's a thick book.

9 **MR. FOSTER:** Well, of course, all this is just -- I tell
10 you what I can do.

11 **THE COURT:** I was just going to say, you're going to
12 scare the jury when they see all that.

13 **MR. FOSTER:** No, I don't want them to think we're going
14 back through the whole case. Let me just pull some pages out,
15 Your Honor.

16 **THE COURT:** While you're doing that, please bring in the
17 jury.

18 All right, the jury is coming in, ladies and gentlemen.
19 Please be aware.

20 **(THE FOLLOWING TAKES PLACE WITHIN THE PRESENCE OF THE**
21 **JURY.)**

22 **THE COURT:** All right, welcome back, ladies and
23 gentlemen. Did you think we had forgotten you this morning?
24 I apologize for the delay. I always -- one of the things
25 that's important to me is that the jury believe that the Court

COURT TO JURY

1 perceives that your time is important, and it is. It is
2 critically important, but sometimes things happen that just
3 require -- we are about some fairly important business in the
4 Court, and sometimes things happen that we have to stop,
5 resolve what we have in front of us, and then move forward.

6 I had set a settlement conference in another case this
7 morning, not related to this case. It took longer than
8 anticipated, and thank you for your understanding of that, but
9 let me ask you, ladies and gentlemen, since we were last
10 together, is there any member of this jury panel who has had a
11 discussion about the facts of this case with any party or been
12 contacted by any party? If so, please raise your hand, and
13 let's let the record reflect no one has raised their hand, and
14 thank you again, as I've thanked you throughout this trial,
15 for complying with the Court's request and instructions.

16 Let me say to you that at the end of the day yesterday
17 there were -- and this always happens at the end of the
18 testimonial phase of the case, the parties make certain
19 motions, and yesterday upon the -- you notice there's a change
20 in the seating in the courtroom here.

21 Dr. Young is not seated here with Counsel at the
22 Defendant's table, and that is because at the close of all the
23 evidence, Dr. Young's attorneys made a motion yesterday to
24 dismiss him from the lawsuit, and the Court granted that
25 motion on the basis that for the facts that were put forth in

COURT TO JURY

1 this trial, as a matter of law South Carolina law does not
2 permit recovery against Dr. Young under those circumstances.
3 He is now dismissed from this case by the Court. I tell you
4 that so that obviously you will realize his lawyers are not
5 participating in the trial today.

6 Now, the way we proceed in the final arguments is,
7 although both sides of the case have the same amount of time,
8 the Plaintiff is allowed to open and close final argument, and
9 the reason they are given that benefit is they bear the burden
10 of proof in the main claim which they've asserted, so they
11 will -- you will hear from them first and then you will hear
12 from them last. Again, all parties have the same amount of
13 time.

14 There's one other thing I really meant to mention to you
15 earlier in this trial. You probably heard a little bit of
16 spill-over noise that's coming from that secure door right
17 there. What that door is, that leads to an internal elevator

18 that is secure for which people on the criminal side of this
19 Court, the General Sessions Court, are brought in and out of
20 the courthouse from the detention center. That's why you will
21 hear chains and other things, unfortunately, that may sort of
22 -- quite often when it's quiet in the courtroom, you can hear
23 it.

24 We try to keep that room as quiet as we can because
25 what's -- but what's actually happening is on the other side

FORM 4

**STATE OF SOUTH CAROLINA
COUNTY OF HORRY
IN THE COURT OF COMMON PLEAS**

JUDGMENT IN A CIVIL CASE

CASE NO. 2008-CP-26-9047

Sean D. Fay

Grand Strand Regional

VS.

Medical Center, et al

PLAINTIFF(S)

DEFENDANT(S)

CHECK ONE:

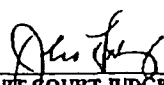
- ☒ **JURY VERDICT.** This action came before the court for a trial by jury. The issues have been tried and a verdict rendered.
- ☐ **DECISION BY THE COURT.** This action came to trial or hearing before the court. The issues have been tried or heard and a decision rendered.
- ☐ **ACTION DISMISSED (CHECK REASON):** ☐ Rule 12(b), SCRPC; ☐ Rule 12(a), SCRPC (Vol. Nonsuit); ☐ Rule 43(k), SCRPC (Settled); ☐ Other
- ☐ **ACTION STRICKEN (CHECK REASON):** ☐ Rule 40(j), SCRPC; ☐ Bankruptcy; ☐ Binding arbitration, subject to right to restore to confirm, vacate or modify arbitration award; ☐ Other;
- ☐ **DISPOSITION OF APPEAL TO THE CIRCUIT COURT (CHECK APPLICABLE BOX):**
☐ Affirmed; ☐ Reversed; ☐ Remanded; ☐ Other
 NOTE: ATTORNEYS ARE RESPONSIBLE FOR NOTIFYING LOWER COURT, TRIBUNAL, OR ADMINISTRATIVE AGENCY OF THE CIRCUIT COURT RULING IN THIS APPEAL.

IT IS ORDERED AND ADJUDGED:

- ☐ See Attached order. (Formal order to follow)
☐ Statement of Judgment by the Court:

We, the Jury, find in favor of the Plaintiff against the Defendants in the amount of Two Million Eight Hundred Eighty Dollars (2,880,000.00)

Dated at Conway, South Carolina, this 28th day of May 2010.


**CIRCUIT COURT JUDGE
15TH JUDICIAL CIRCUIT**

This judgment was entered on the _____ day of _____, 20____, and a copy mailed first class this _____ day of _____, 20____ to attorneys of record or to parties (when appearing pro se) as follows:

Ruskln C. Foster

Marian W. Scallie

Montelth Powell

ATTORNEY(S) FOR THE PLAINTIFF(S)

J. Boone Alken, III
ATTORNEY(S) FOR THE DEFENDANT(S)

CLERK OF COURT

SCCA SCRPC Form 4 (Revised 06/2008)

STATE OF SOUTH CAROLINA)

COUNTY OF HORRY)

Sean D. Fay, as Personal
Representative for the Estate of
Kelly L. Fay, Deceased,

Plaintiff,

vs.

Grand Strand Regional Medical
Center, LLC, d/b/a South Strand
Ambulatory Care Center, Stephen
W. Law, D.O.,

Defendants.

IN THE COURT OF COMMON PLEAS

FOR THE FIFTEENTH JUDICIAL CIRCUIT

DOCKET NO.: 08-CP-26-9047
08-CP-26-9368

VERDICT

1. a. Was the Defendant Grand Strand Regional Medical Center, LLC negligent?

☒ YES

☐ NO (Go to Question 2, do not answer 1 b)

b. Was Defendant Grand Strand Regional Medical Center, LLC's negligence a proximate cause of the Plaintiff's injuries?

☒ YES

☐ NO

2. a. Was the Defendant Dr. Stephen W. Law negligent?

☒ YES

☐ NO (Do not answer 2 b)

b. Was Defendant Dr. Stephen W. Law's negligence a proximate cause of the Plaintiff's injuries?

☒ YES

☐ NO

If you determined that neither of the Defendants were negligent or that the negligence of neither of the Defendants proximately caused the Plaintiff's injury, then you may stop your deliberations and return your verdict.

3. Was the Plaintiff negligent?

☒ YES

☐ NO (Go to Question 7)

4. Was the Plaintiff's negligence a proximate cause of the Plaintiff's own injuries?

☒ YES

☐ NO

FILED
HORRY COUNTY
2018 MAY 28 PM 12:36
MELANIE HUGGINS - WARD
CLERK OF COURT

<u>4</u> %	Plaintiff	} Grand Jurand - 50%
<u>96</u> %	Defendants	
<u>100</u> %	Total	

7. Please state the amount of damages, if any, sustained by the Plaintiffs. [Do not reduce the Plaintiff's total damages based on the percentage of negligence by any party. After you have answered these questions, the Judge will compute the amount of damages for which the Defendants are responsible based on the percentage of each Defendant's negligence which you have decided proximately caused the Plaintiff's injuries. You are to determine only the total amount of the Plaintiff's damages and enter that amount below.]

I certify that these decisions are unanimous decisions of the jury.

Verdict amount for Plaintiff to be entered:
\$2,880,000

Julius F. King
Circuit Judge
5/28/10

IN THE STATE OF SOUTH CAROLINA
In The Court of Appeals

APPEAL FROM HORRY COUNTY
Court of Common Pleas

J. Michael Baxley, Circuit Court Judge

Case Numbers: 2008-CP-26-9047 and 2008-CP-26-9368

Sean Fay, as Personal Representative for the Estate of
Kelly L. Fay, Deceased, ... Respondent/Appellant

v.

Grand Strand Regional Medical Center, LLC, d/b/a South Strand
Ambulatory Care Center, Stephen W. Law, D.O., Dr. Richard
Young, M.D., and Grand Strand Urology, LLP, ... Defendants

Of whom

Richard Young M.D., And Grand Strand Urology, LLP
are Movants/Respondents

And

Stephen Law, D.O. is Respondent/Appellant

And

Grand Strand Regional Medical Center, LLC d/b/a South Strand
Ambulatory Center is Appellant/Respondent.

REPLY BY MOVANTS RICHARD YOUNG, M.D. AND GRAND STRAND
UROLOGY, LLP TO RESPONDENT/APPELLANT SEAN D. FAY AS PERSONAL
REPRESENTATIVE FOR THE ESTATE OF KELLY L. FAY, DECEASED'S,
RETURN TO MOVANTS' MOTION TO DISMISS THE APPEAL
AGAINST RICHARD YOUNG, M.D. AND GRAND STRAND UROLOGY, LLP

Pursuant to Rules 203(d)(3) and 240 of the South Carolina Appellate Court Rules, Defendants Richard Young M.D. and Grand Strand Urology, LLP [hereinafter "Movants"] Reply to Sean D. Fay, as personal representative of the Estate of Kelly L. Fay, Deceased's [hereinafter "Plaintiff"], Return to Movants' Motion to Dismiss the appeal against them.

- I. BECAUSE THE ORDER GRANTING DIRECTED VERDICT TO MOVANTS WAS A FINAL RULING PLAINTIFF WAS REQUIRED TO SERVE HIS NOTICE OF INTENT TO APPEAL WITHIN 30 DAYS OF THE COURT'S VERBAL RULING, OR ALTERNATIVELY, WITHIN 30 DAYS OF THE FORM 4 ORDER.
 - A. The directed verdict dismissing Movants from the case was a final order and was not interlocutory.

Responding to the arguments posited in Plaintiff's Return, Plaintiff fails to even recognize the most significant factor in an analysis of whether Plaintiff's appeal must be dismissed for failure to timely file, that Judge Baxley's grant of directed verdict to Movants was a final ruling. Plaintiff argues that the directed verdict was not a final order, but was somehow an interlocutory ruling because it did not dispose of the entire case against the remaining co-Defendants. However, at of the time of Judge Baxley's verbal ruling on May 26, 2010, Movants were no longer parties to the case and had been dismissed with finality regarding all claims against them¹. Thus, there was nothing more to be done to determine the rights between the Plaintiff and Movants from that point in time forward because Movants had been dismissed with finality from the case.

¹ Movants alternatively submit that the date of the Form 4 Order, May 28, 2010, made the verbal ruling directing the verdict for Movants a final order, and that even using that date the Plaintiff failed to file his notice of intent to appeal against Movants after the expiration of 30 days. See Movants' Memorandum in Support of Motion to Dismiss Appeal.

Plaintiff instead argues that he had a choice and was permitted under S.C. Code Ann. § 14-3-330, to wait until a final judgment on the remainder of the claims against the co-Defendants was entered before filing a notice of intent to appeal. This argument is patently without merit and is not the rule in South Carolina as it applies to final rulings by directed verdict and summary judgment.

Plaintiff has failed to cite to any authority which would hold that a grant of a directed verdict which completely dismisses a party and all claims against that party from a lawsuit is only an intermediate/interlocutory order. Plaintiff cites to Link v. School District of Pickens County, 302 S.C. 1, 393 S.E.2d 176 (1990) for the proposition that that it is permissible to wait until “final judgment” to appeal an order granting summary judgment. However, the Link case involved only one Plaintiff and one Defendant, not multiple defendants. Moreover, the Defendant in Link was granted summary judgment on only one out of four of Plaintiff’s alleged causes of action. Thus, the Supreme Court held that this was an intermediate order, as the case proceeded to trial against the sole Defendant on Plaintiff’s remaining causes of action.

Plaintiff also cites to Culbertson v. Clemons, 322 S.C. 20, 471 S.E.2d 163 (1996) for the proposition that Movants’ directed verdict ruling was an intermediate order. However, Culbertson also did not deal with multiple defendants, and in that case there was still the issue of sanctions between the parties which had to be worked out after a final order of divorce was issued; thus “the rights of the parties had not been completely determined” when the final divorce decree was entered.

Plaintiff submits that, (1) only orders which deprive a party of a mode of trial to which that party is entitled, or (2) an order disqualifying counsel, must be appealed

before the entirety of the case is adjudicated. This is true; however, to be an accurate statement of law it must read that only interlocutory orders of the above categories are immediately appealable. Final orders are always immediately appealable and must be appealed within the timeframe proscribed by the Rules of Civil Procedure to give the appellate court jurisdiction. “Rule 203(b), SCACR, requires a party to serve his notice of appeal within thirty days after receiving written notice of the entry of a final order or judgment, and failure to do so divests [the appellate court] of subject matter jurisdiction and results in dismissal of the appeal.” USAA Property and Casualty Ins. Co., v. Clegg, 377 S.C. 643, 651, 661 S.E.2d 791, 795 (2008) (citing Canal Ins. Co. v. Caldwell, 338 S.C. 1, 4, 524 S.E.2d 416, 418 (Ct. App. 1999)). “The requirement of service of the notice of appeal is jurisdictional, i.e., if a party misses the deadline, the appellate court lacks jurisdiction to consider the appeal and has no authority or discretion to ‘rescue’ the delinquent party by extending or ignoring the deadline for service of the notice.” Elam v. S.C. Dep’t of Transp., 361 S.C. 9, 14-15, 602 S.E.2d 772, 775 (2004).

The key consideration for this Court in deciding whether to grant the Motion to Dismiss is that once Movants were dismissed from the case on May 26, 2010, that they were no longer parties to the action and the time for Plaintiff to file a notice of intent to appeal against them began to run from that date. Because Plaintiff waited more than thirty days to file his notice of intent to appeal against Movants, the appellate court lacks jurisdiction to consider the appeal.

B. The reasoning put forth in Olson v. Faculty House of Carolina Inc. is still good law and instructive in this case.

Plaintiff’s attempt to characterize the Olson v. Faculty House of Carolina Inc., 344 S.C. 194, 214, 544 S.E.2d 38, 48 (Ct. App. 2000), case as no longer being good and

accurate law is certainly an exaggeration. The Supreme Court affirmed the Olson case, no part of the opinion was overruled, and it was only in a footnote in the opinion that the Supreme Court vacated the discussion regarding the grant of summary judgment to the University. However, Movants point out that the cases and statutes on which that part of the discussion rely upon are still good law. Moreover, even though that part of the Court of Appeals' discussion in Olson was vacated for reasons which the Supreme Court does not make clear, it does not mean that the reasoning as laid forth by Judge Anderson is not persuasive and instructive as to the reasoning which should be applied to the case at bar, i.e., that Plaintiff waited too long to file his Notice of Intent to Appeal against Movants.

In discussing Olson, the Plaintiff attempts to characterize a grant of summary judgment as being distinctly different from a grant of a directed verdict; however, Plaintiff grossly minimizes the biggest similarity between the two motions because once each motion is granted, they are both final judgments. Thus, in that regard there is absolutely no distinction between a summary judgment's or directed verdict's effect upon the parties in a case in which either motion is granted.

Plaintiff further attempts to distinguish this case from the Olson case on the theory that in Olson the University was dismissed on the basis that the statute of limitations had expired, and that because co-Defendant Faculty House did not raise that same defense that the claims against Faculty House were separate and distinct from the claims of the University. However, this misconstrues the facts of the case as the actual claims against both Defendants were for premises liability negligence. See Olson v. Faculty House of Carolina, Inc., 354 S.C. 161, 580 S.E.2d 440 (2003) (affirming in result Olson v. Faculty House of Carolina Inc., 344 S.C. 194, 214, 544 S.E.2d 38, 48 (Ct. App.

2000) and holding that the common law negligence principles of premises liability applied to the case, not the higher standard as argued by the Plaintiff set forth under the Accessibility Statute). Similarly in this case, the claims alleged against all Defendants were the same---medical negligence.

Plaintiff alternatively argues that even if the Olson case is still applicable, that is “wrong and should be overruled.” As an initial matter, this raises the question of whether a case can be overruled on review of a motion to dismiss. However, without offering any basis or authority for his opinion, Plaintiff’s argument that Olson is “wrong,” cannot be supported and is not persuasive.

II. BECAUSE PLAINTIFF FAILED TO SERVE HIS NOTICE OF CROSS-APPEAL PURSUANT TO THE TIME CONSTRAINTS OF RULE 203(C), SOUTH CAROLINA RULES OF CIVIL PROCEDURE, THE APPEAL MUST BE DISMISSED

Plaintiff alternatively contends that because he filed a Notice of Cross-Appeal against Defendant Grand Strand Regional Medical Center, and included for the first time a notice of appeal against Movants Dr. Young and Grand Strand Urological Associates, LLP, that this somehow means that he timely served his notice of appeal within the time constraints of Rule 203(c), SCACR. However, Plaintiff is incorrect. The Rules of Civil Procedure do not change for a Plaintiff just because there are multiple defendants in a case; however, Plaintiff would submit that when there are multiple defendants then a directed verdict for one Defendant is not a final judgment. This simply does not make sense.

Rule 203(c) clearly states that a respondent may initiate a cross-appeal by serving a notice of appeal on all adverse parties and all parties of record “within five days after

receipt of appellant's notice of appeal." Movants point out to the Court that Plaintiff waited until nine days after he received Grand Strand Regional Medical Center's first Notice of Intent to Appeal before filing his Notice of Cross-Appeal.

Assuming without admitting that Plaintiff is correct in his interpretation of Rule 203(c), if Plaintiff was going to appeal the directed verdict ruling as to Movants, he had to do so when he first received notice of the Notice of Intent to Appeal filed by the co-Defendants. It is telling that even in Plaintiff's Return brief, Plaintiff has still failed to provide the date for when he received the Hospital's First Notice of Appeal. Looking back retrospectively, Plaintiff would have no way of knowing that the Hospital was going to later file an Amended Notice of Appeal on July 26, 2010, then giving him a chance to "timely" file his notice of appeal against Movants. Movants submit that Plaintiff simply attempted to use this as his opportunity to slip in a notice of appeal against Movants coupled with the cross-appeal against hospital. Movants disagree with Plaintiff's characterization that the application of Rule 203(c) in these circumstances would create "a trap for unwary lawyers;" it is instead the proper application of the rule as the legislature intended.

CONCLUSION

Plaintiff contends that it would lead to an absurd result to require him to file a timely notice of appeal against Movants because to do so may require Plaintiff to incur financial costs and fees in doing so. However, that same argument applies to the Movants in this case as Plaintiff's failure to timely file his Notice of Appeal against them has caused Movants to incur costs and fees to defend against the appeal and move for its dismissal.

It would be absurd to require that a party who has been dismissed with finality from a case involving multiple defendants, either by summary judgment, directed verdict, Rule 12(b)(6), or otherwise to anticipate that it would be subjected to an appeal of that final order once all remaining parties' claims have finally been adjudicated. In some factual scenarios this could be years later. To hold otherwise would put an enormous burden on the Defendant, who at least at the trial level has been adjudicated to be without liability, and who should be able to deal with any issues regarding liability at the time when the initial allegations are brought against him instead of being fearful of being dragged back into litigation at some later unknown date, perhaps even years down the road.

Furthermore, the jurisdictional requirement of filing a notice of intent to appeal within 30 days of the trial court's final order dismissing Movants does not present an onerous burden upon trial counsel because the notice of intent to appeal does not need to be extensive.

Accordingly, for all the foregoing reasons cited herein and in Movant's Memorandum in Support of the Motion to Dismiss Plaintiff's Appeal against them, Dr. Young and Grand Strand Urology, LLP are entitled to dismissal of Plaintiff's appeal on the basis that the appeal was not timely served pursuant to South Carolina Appellate Court Rule 203(b)(1).

[Signature on following page]

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THE STATE OF SOUTH CAROLINA
In The Court of Appeals

APPEAL FROM HORRY COUNTY
Court of Common Pleas
J. Michael Baxley, Circuit Court Judge

Case Nos. 2008-CP-26-9047 and 2008-CP-26-9368

Sean D. Fay, as Personal Representative for the
Estate of Kelly L. Fay, Deceased, ... Respondent/Appellant,

v.

Grand Strand Regional Medical Center, LLC, d/b/a
South Strand Ambulatory Care Center, and Stephen
W. Law, D.O., Dr. Richard Young, M.D., and
Grand Strand Urology, LLP, ... Defendants,

Of whom Grand Strand Regional Medical Center,
LLC d/b/a South Strand Ambulatory Care Center is, ... Appellant/Respondent.

And Of Whom Stephen W. Law, D.O. is, ... Respondent/Appellant,

And Of Whom Dr. Richard Young, M.D., and
Grand Strand Urology, LLP, are, ... Respondents.

CERTIFICATE OF COUNSEL

The undersigned hereby certifies that the Record on Appeal contains all material
proposed to be included by any of the parties and not any other material.

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May 8, 2013

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Grand Strand Urology, LLP, ... Defendants,

Of whom Grand Strand Regional Medical Center,
LLC d/b/a South Strand Ambulatory Care Center is, ... Appellant/Respondent.

And Of Whom Stephen W. Law, D.O. is, ... Respondent/Appellant,

And Of Whom Dr. Richard Young, M.D., and
Grand Strand Urology, LLP, are, ... Respondents.

PROOF OF SERVICE

I, the undersigned Administrative Assistant of the law offices of Nelson Mullins Riley & Scarborough LLP, attorneys for Grand Strand Regional Medical Center, LLC d/b/a South Strand Ambulatory Care Center, do hereby certify that I have served all counsel in this action with a copy of the pleading(s) hereinbelow specified by mailing a copy of the same by United States Mail, postage prepaid, to the following address(es):

Pleadings: Record on Appeal

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SC Court of Appeals

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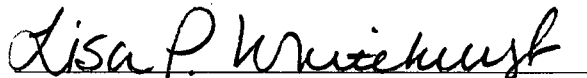
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May 8, 2013