

THE STATE OF SOUTH CAROLINA
In the Court of Appeals

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APPEAL FROM GEORGETOWN COUNTY
Court of Common Pleas

SC Court of Appeals

Diane S. Goodstein, Circuit Court Judge

Appellate Case No 2015-000331
Case No. 12-CP-22-1004

Nadene Holliday, Individually and as Personal Representative
of the Estate of David Holliday, ...Appellant,

vs.

Waccamaw Community Hospital and
Kent M. McGinley, M.D., ... Defendants,

of whom

Waccamaw Community Hospital is the.....Respondent.

RECORD ON APPEAL

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IN THE COURT OF COMMON PLEAS
FOR THE FIFTEENTH JUDICIAL CIRCUIT
CASE NO. 2012-CP-22-01004

vs.

Defendants.

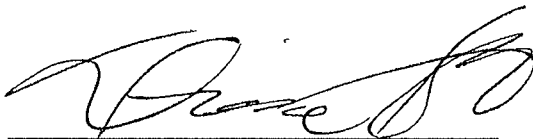
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- b. failing to independently monitor Defendant McGinley following his discipline by the Medical Board and upon his return to work at Defendant Hospital;
- c. failing to revoke Defendant McGinley's hospital privileges and appointment to the medical staff when it learned of his unethical, fraudulent, criminal actions and unfitness of character; and
- d. reappointing Defendant McGinley to the medical staff and renewing his hospital privileges after learning of his unethical, fraudulent, criminal actions and unfitness of character; and
- e. continuing its contractual relationship with Defendant McGinley and his pathology practice after learning of his unethical, fraudulent, criminal actions and unfitness of character.

After careful consideration of the briefs submitted by the parties and the arguments of counsel on January 12 and January 13, 2015, **I FIND** that South Carolina does not recognize a cause of action for negligent credentialing arising out of a corporate negligence theory. Now, therefore, it is

ORDERED, ADJUDGED AND DECREED that Defendant Waccamaw's Motion to Dismiss, pursuant to Rule 12(b)(6), SCRCPP, is hereby granted and that Defendant Waccamaw is dismissed from this lawsuit with prejudice.

AND IT IS SO ORDERED.



Diane S. Goodstein, Presiding Judge
Fifteenth Judicial Circuit

January 20, 2015
St. George, South Carolina

STATE OF SOUTH CAROLINA) IN THE COURT OF COMMON PLEAS
COUNTY OF GEORGETOWN) CASE NO.: 2012-CP-01004

Nadene Holliday, Individually and as
Personal Representative of the Estate of
David Holliday,

Plaintiff,

vs.

Waccamaw Community Hospital and
Kent M. McGinley, M.D.,

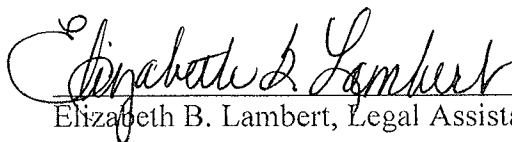
Defendants.

CERTIFICATE OF SERVICE

I, Elizabeth B. Lambert, an employee of McNair Law Firm, P A., attorneys for the Defendant, Waccamaw Community Hospital, in the above captioned matter, certify that I have today, February 4, 2015, emailed a copy of the order of The Honorable Diane S. Goodstein dated January 30, 2015, filed February 3, 2015, and deposited a copy of the order in the United States Mail, first class, postage prepaid and addressed to the following persons:

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Elizabeth B. Lambert, Legal Assistant

February 4, 2015

STATE OF SOUTH CAROLINA

COUNTY OF DARLINGTON

RUTH J. PERSON,

Plaintiff,

v.

CAROLINA PINES REGIONAL
MEDICAL CENTER,

Defendant.

) IN THE COURT OF COMMON PLEAS
) FOURTH JUDICIAL CIRCUIT
) CASE NO. 2004-CP-16-322

**ORDER DENYING DEFENDANT'S
MOTION FOR SUMMARY JUDGMENT**

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DARLINGTON COUNTY

FILED

I. INTRODUCTION

This case presents a novel issue, and frames an important question of public policy. Stated succinctly, if a hospital negligently performs or disregards its responsibilities to properly credential and privilege physicians working within the hospital, as Plaintiff alleges here, and someone is injured thereby, is there legal redress under South Carolina law?

This matter arose in medical malpractice. Plaintiff, who suffered from severe gastroesophageal reflux disease, underwent an antireflux laproscopic Nissen fundoplication, performed by surgeon Thomas V. Mincheff, at Carolina Pines Regional Medical Center on April 25, 2001. This surgery is intended to rebuild the connection between the stomach and the swallowing tube (esophagus). The operation consists of a plication (wrapping or folding) of the fundus (part of the stomach) around the lower end

of the esophagus. In the operation, the adjacent portion of the stomach is wrapped once around the esophagus and sutured in position, creating a one-way valve that allows food to pass into the stomach while preventing gastric contents from backing up in the other direction. Complications arose during the attempt at laparoscopy that caused the surgeon to convert the procedure to an "open" antireflux operation. Plaintiff claims that she was severely injured during the open surgery.

Plaintiff's complaint included professional negligence claims against Dr. Mincheff, assisting surgeon C. Brooks Bannister, their professional association known as Hartsville Surgical Center, together with a negligent credentialing or corporate negligence cause of action against Carolina Pines. Plaintiff previously resolved her medical malpractice action against the surgeons and Hartsville Surgical Center, leaving only the claim against the hospital for resolution.

Plaintiff asserts she incurred significant injuries from Carolina Pines' negligent failure to properly evaluate Dr. Mincheff's education, training, and experience before granting him privileges to perform open and laparoscopic antireflux surgical procedures upon her at the hospital. Plaintiff's claimed damages are substantial, including direct injury to her spleen and pancreas, a perforated colon, and the onset of life threatening pancreatitis. She was hospitalized for three months, placed into a medically induced coma, suffered a stroke, and sustained multiple complications and systemic failures with such overwhelming internal infection that her stomach had to be removed from her body.

and carried in a pouch attached to her abdomen for a period of twenty months. She incurred medical bills of over \$700,000. Plaintiff is presently forty-seven years of age, is primarily wheelchair bound, suffers from multiple ongoing sequelae, has profound scarring and disfigurement, and alleges a substantial reduction in quality of life and life expectancy. Settlement with the surgeons was in the amount of \$1,000,000.

Plaintiff's expert witnesses have opined that Dr. Mincheff's inadequate education, training, and experience involving open and laparoscopic antireflux surgery caused Ms. Person's medical complications, that a properly conducted credentialing process would have revealed such inadequacies, and that the hospital was grossly negligent in granting privileges to Dr. Mincheff to perform the procedure.

Sub 3
Carolina Pines filed a Rule 56 Motion for Summary Judgment contending South Carolina has never and should not now allow a patient to pursue a negligence cause of action against a hospital involving credentialing and privileging of physicians; that confidentiality statutes prohibit such an action; that Dr. Mincheff is neither an agent nor an employee of the hospital; that there is no duty extending from the hospital to a patient with respect to credentialing and privileging of physicians, and if there is such a duty, it is superceded by the physician's direct duty to the patient; that there is no proof of negligence against Dr. Mincheff, which is fatal to Plaintiff's derivative claim against the hospital; and, that there is no proof of proximate causation. In response, Plaintiff asserts South Carolina caselaw implicitly approves corporate negligence claims against hospitals.

that improperly grant surgical privileges to unqualified physicians. The Court must decide whether this issue of first impression under South Carolina law may proceed.

II. RULE 56 STANDARD OF REVIEW

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A trial court may properly grant a motion for summary judgment when "the pleadings, depositions, answers to interrogatories, and admissions on file, together with the affidavits, if any, show that there is no genuine issue as to any material fact and that the moving party is entitled to a judgment as a matter of law." Rule 56(c), SCRPC; Tupper v. Dorchester County, 326 S.C. 318, 487 S.E. 2d 187 (1997). In determining whether any triable issues of fact exist, the 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. 283, 365 S.E. 2d 24 (1988). Summary judgment is a drastic remedy which should be cautiously invoked so that a litigant is not improperly deprived of a trial on disputed factual issues. Baughman v. American Tel. and Tel. Co., 306 S.C. 101, 112, 410 S.E. 2d 537, 543 (1991). Summary judgment should not be granted with respect to a novel issue when inquiry into the facts is desirable to clarify application of the law. Shadwell v. Craigie, 361 S.C. 492, 605 S.E.2d 567 (2004).

III. DISCUSSION OF THE EVIDENCE

After review of the documents from the record in this case, analysis of the arguments of counsel, reading of the affidavits of witnesses, and consideration of the

memoranda provided by the parties, the Court finds that the record in this case contains the following evidence necessary to decide this summary judgment issue. Where there is dispute, the facts are construed in a light favorable to the non-moving party.

1. Carolina Pines is wholly owned by Health Management Associates, Inc. (HMA), a Delaware corporation, and is a for-profit entity.
2. The credentialing process at Carolina Pines is coordinated by a hospital employee referred to as a "credentialing specialist." Medical privileges are recommended by a committee of physicians known as the Medical Executive Committee. The ultimate decision on privileging is made by the Carolina Pines Board of Trustees, whom the hospital bylaws require to approve or reject the Medical Executive Committee's privileging recommendations (Art. V, §10). The Board of Trustees consists of fifteen people, approximately half of whom are physicians.
3. No surgeon can perform a particular surgical procedure at Carolina Pines until that surgeon is privileged by the hospital to do so [Art. VI, §(B)(1)].
4. Plaintiff has produced a credentialing certification expert, Laura A. Voigt, who has opined that a hospital has a duty to carefully evaluate a surgeon's educational background, training, and experience in the performance of a specific medical procedure before granting privileges to perform that procedure within the hospital.
5. Three physician members of the Carolina Pines Medical Executive Committee (Drs. Barker, Bannister, and Robinson) have testified by deposition that Carolina Pines has a duty to properly evaluate physicians applying for privileges, and that the purpose of the credentialing and privileging process is to insure patient safety.
6. The Joint Commission on Accreditation of Healthcare Organizations (JCAHO) is nationally recognized and accepted as a body that sets appropriate standards for physician privileging. The bylaws of Carolina Pines require that JCAHO standards be followed.
7. The Society of American Gastrointestinal Endoscopic Surgeons (SAGES) is nationally recognized and accepted as a body that recommends appropriate guidelines for physician privileging.
8. The standards of JCAHO and guidelines of SAGES provide that, prior to being privileged to perform a laproscopic Nissen fundoplication, an experienced surgeon has a learning curve of at least twenty procedures. Likelihood of patient injury is greater during this learning curve. During the learning curve, a properly trained and

experienced surgeon who is already privileged to perform laproscopic Nissen fundoplication is required to be present for the surgery. This observing physician is referred to as a "proctor." In the alternative, a properly trained and experienced surgeon who is already privileged to perform the procedure is required to assist in performing the surgery. This teaching physician is referred to as a "preceptor."

- 
9. To be appropriately privileged for laproscopic Nissen fundoplication, a surgeon must be proficient in conducting an "open" Nissen fundoplication, in the event the laproscopic procedure must be converted to an open procedure during the surgery.
 10. HMA, Inc. has hired an outside consulting firm for assistance with physician credentialing procedures and issues. The firm's recommendations are referred to as "The Greeley Report," and this document was published in 2000 and provided to Carolina Pines by January of 2005. The Greeley Report incorporates SAGES guidelines. To maintain proficiency in the open Nissen fundoplication, the Greeley Report requires that ten open procedures per year be performed by the physician. The Greeley Report also requires successful completion of 25 laproscopic Nissen fundoplication procedures in the twelve months prior to initial privileging, and 10 during the twelve months prior to renewal of privileges.
 11. Dr. Mincheff is a member of SAGES and is a licensed surgeon, and in 2001 had twelve years of experience in general surgery, including gastrointestinal surgeries of various types.
 12. Dr. Mincheff was initially granted privileges by Carolina Pines to perform open and laproscopic Nissen fundoplications in 1996 and re-privileged to do so in 1998 and 2000. Prior to being initially privileged for this specific procedure, Dr. Mincheff's training in the procedure consisted of attending two two-day seminars at Duke University and there performing the procedure on two pigs, as well as observing a surgeon perform the procedure on a human. Dr. Mincheff had never performed the procedure on a human. At no time did Carolina Pines require a proctor or preceptor to be present when Dr. Mincheff performed the procedure, and none was present. During the five years from his initial privileging to the April 25, 2001, surgery on Plaintiff, Dr. Mincheff performed approximately seven such procedures at Carolina Pines. On the date of Plaintiff's surgery, Dr. Mincheff had not performed an open Nissen fundoplication in ten years, and had performed only one on an adult in his medical career. Dr. Mincheff's surgical treatment of Plaintiff in performing the operation fell below the standard of care, according to Plaintiff's surgery expert.
 13. Plaintiff's expert Voight opined that Carolina Pines violated the applicable national standards of care in granting privileges to Dr. Mincheff to perform laproscopic Nissen fundoplication procedures at Carolina Pines and further

violated its own bylaws in 38 particulars with respect to Dr. Mincheff's privileging for this procedure.

IV. LEGAL POINTS AND AUTHORITIES

While the specific issue at Bar appears to be one of first impression, this case is not the first time our Courts have addressed the issue of a hospital's responsibility to assure the professional capabilities of medical personnel working within the hospital.

In Strickland v. Madden, 323 S.C. 63, 448 S.E. 2d 581 (Ct. App. 1994), and Simmons v. Tuomey Regional Medical Center, 330 S.C. 115, 498 S.E. 2d 408 (Ct. App. 1998), the South Carolina Court of Appeals considered issues involving corporate negligence actions against hospitals. Corporate negligence literally means holding a corporation responsible for its negligent acts, it is a form of direct liability. Strickland specifically addresses the doctrine of corporate negligence in the context of a hospital's duty to monitor the competency of its staff physicians. 323 S.C. 63, 448 S.E. 2d 581 (Ct. App. 1994). The central issue in Strickland was whether the hospital was negligent in failing to withdraw the physician's staff privileges prior to the patient's medical malpractice injury.

The Strickland opinion cites with approval a case from the state of Washington that recognized the doctrine of corporate negligence, requiring hospitals to appropriately evaluate physicians' competence involving the credentialing and privileging process.

We note, however, other jurisdictions have applied the doctrine of corporate negligence to impose on hospitals a non-delegable duty to patients to carefully select and review the competency of physicians using their

facilities. See e.g., Pedroza v. Bryant 101 Wn. 2d 226, 677 P. 2d 166 (1984) (State of Washington adopts doctrine of corporate negligence, citing public's perception of and reliance on hospital as a multi-faceted health care facility, as well as hospital's superior position to monitor and control physician performance).

The Strickland opinion even references a patient's duty to establish a standard of care under a corporate negligence credentialing or privileging claim.

Assuming South Carolina would likewise recognize the doctrine of corporate negligence, its application would nonetheless require a standard of care to be established, for example, pursuant to national hospital accreditation requirements or the hospital's own bylaws. Id. at 586.

Strickland infers that South Carolina would accept a corporate negligence claim involving hospital credentialing and privileging matters if a party could prove the existence of a "duty" and establish the "standard of care." The Strickland court stated:

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Therefore, even if we recognize a duty owed by Providence (hospital) to review the competence of its staff physicians, Strickland does not refer this Court to a standard of care by which we could determine if Providence (hospital) breached that duty when it failed to react to the incidents cited.

Id. at 72, 448 S.E. 2d at 586.

The South Carolina Court of Appeals revisited Strickland four years later in Simmons v. Tuomey Regional Medical Center, 330 S.C. 115, 498 S.E. 2d 408 (Ct. App. 1998). In Simmons, the defendant hospital took the position that Strickland did not impose the doctrine of corporate negligence on hospitals. This position was rejected by the Court, as follows:

Second, Strickland is not dispositive of the corporate negligence issue in South Carolina. The most definite statement Strickland makes about

corporate negligence is, "Assuming South Carolina would likewise recognize the doctrine of corporate negligence, its application would nonetheless require a standard of care to be established, for example, pursuant to national hospital accreditation requirements or the hospital's own bylaws." 323 S.C. at 72, 448 S.E. 2d at 586. (underscore supplied) The court then found that the plaintiff did not establish the requisite standard of care. Thus, Tuomey's conclusion that Strickland does not impose the doctrine of corporate negligence on hospitals is an assumption which is not supported by the language of the case.

Id. at 124.

It seems to this Court to be beyond dispute that Simmons established the right of patients to pursue corporate negligence actions against hospitals for breaching a duty to properly staff and supervise emergency rooms. The question raised in the instant case is whether that same right extends into South Carolina's operating rooms.

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The Court in Simmons refers to opinions from other states that would allow the instant case to proceed. Simmons specifically cites with approval an Alaskan case, Jackson v. Power, 743 P. 2d 1376 (Alaska 1987), that accepted JCAHO standards and hospital bylaws as proof the hospital owed a duty to insure physician competency to its patients. This is the same proof offered by Plaintiff in the instant case. Jackson goes on to cite cases from Arizona, Illinois, Washington, and Wisconsin, together with law review articles, all of which would allow Plaintiff's case in this action to proceed.

In short, this Court believes Strickland and Simmons portend South Carolina's acceptance of Ms. Person's negligent credentialing cause of action under the doctrine of corporate negligence. Plaintiff has followed these precedents and put forth evidence in

this case to establish the existence of Carolina Pines' duty owed to her and define the standard of care by which a jury could evaluate the hospital's decision to grant open and laparoscopic surgical privileges to Dr. Mincheff.

Under a traditional common-law negligence analysis, a plaintiff must show that (1) the defendant owes a duty of care to the plaintiff; (2) the defendant breached the duty by a negligent act or omission; (3) the defendant's breach was the actual and proximate cause of the damages; and (4) the plaintiff suffered an injury or damages. Steinke v. S.C. Dept. of Labor, Licensing, and Regulation, 336 S.C. 373, 387, 520 S.E. 2d 142, 149 (1999); Snipes v. Piggly Wiggly St. Andrews, Inc., 269 S.C. 479, 283 S.E. 2d 167 (1977). Stated briefly, the elements of any cause of action in tort are: (1) duty; (2) breach of that duty; (3) proximate causation; and (4) injury. The Plaintiff has produced evidence in the record of this case that creates a genuine issue of material fact as to each of these elements.

The issue of proximate cause in actions such as this has been addressed in other jurisdictions. In the seminal negligent credentialing case of Johnson v. Misericordia Community Hospital, 99 Wis. 2d 708, 301 N.W. 2d 156 (1981), the Wisconsin Supreme Court stated:

The failure of a hospital to scrutinize the credentials of its medical staff of applicants could foreseeably result in the appointment of unqualified physicians and surgeons to its staff. Thus, the granting of staff privileges to these doctors would undoubtedly create an unreasonable risk of harm or injury to their patients. Therefore, the failure to investigate a medical staff applicant's qualifications for the privileges requested gives rise to a foreseeable risk of unreasonable harm. (underscore provided)

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Id. at 710.

V. DEFENDANT'S ARGUMENTS

This case has been hotly contested. Carolina Pines relies upon McGee v. Bruce Hosp. System, 312 S.C. 58, 439 S.E.2d 257 (1993), and Durham v. Vinson, 360 S.C. 639, 602 S.E.2d 760 (2004), to support its proposition that Plaintiff has no viable claim because it is premised upon material and information that could be generated by a peer review committee and thus is privileged under South Carolina law. To bring such a claim should not be permitted as it will of necessity require a violation of the confidentiality statute surrounding the peer review process, S. C. Code Ann. 40-71-20 (1976). Carolina Pines argues that, even if the Plaintiff does not produce confidential information in the prosecution of her case, the Defendant will be required to do so in defense of the claim, thus the confidentiality statute is eviscerated by Plaintiff's claim.

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This Court finds the Defendant's arguments unpersuasive. With regard to Carolina Pines' position that Plaintiff's claim of necessity will require the production of protected documents, the holding in McGee specifically addresses this point. The confidentiality statute does not does not extinguish Plaintiff's ability to discover information critical to the negligent credentialing case, as it "does not protect information that is available from original sources." Id. at 61. McGee reads:

(I)nformation that is available from a source other than the committee does not become privileged simply by being acquired by the review committee. Accordingly, the statute does not protect information if obtained from alternative sources. Hence, the plaintiff seeking discovery cannot obtain documents which are available from the original source directly from the hospital committee, but may seek them from alternative sources.

Id. at 62.

The Supreme Court went on to state in McGee "the confidentiality statute was intended to protect the review process, but not restrict the disclosure of the result of the process." Id. at 60. Thus, the outcomes of Carolina Pines' credentialing proceedings of Dr. Mincheff are clearly not confidential nor insulated from Plaintiff's discovery or use at trial. Moreover, Section 40-71-20 "does not preclude the discovery of the general policies and procedures for staff monitoring." Id. at 60.

In this case, if Plaintiff can attain and present adequate evidence from non-privileged sources proving Carolina Pines improperly granted privileges to Dr. Mincheff, her negligence claim may proceed, notwithstanding South Carolina's peer review confidentiality and immunity statutory provisions. If Plaintiff cannot produce such evidence, then her claim must fail.

Likewise, this Court is not convinced that the immunity statute extends to a hospital. A close review of Section 40-71-10 reveals that the statute provides "monetary liability" and "cause of action for damages" immunity to peer review committee members.

In general, Sections 40-71-10 and 40-71-20 provide "confidentiality of certain proceedings, records, and information" and prevent persons from attaining, even under subpoena, data and information of committee meetings involving physicians' applications for hospital privileges. No one disputes Carolina Pines' MEC constitutes "a

committee of a medical staff of a licensed hospital" and that its individual members enjoy liability immunity under Section 47-71-10. Plaintiff herein disputes Carolina Pines' belief that Section 40-71-10(B) absolutely precludes her from pursuing a negligence claim against the hospital in this case.

In part, Carolina Pines relies upon Section 40-71-10(B)'s immunity provision, which states in relevant portion as follows:

There is no monetary liability on the part of, and no cause of action for damages arising against . . . an appointed member of a committee of a medical staff of a licensed hospital, provided the medical staff operates pursuant to written bylaws that have been approved by the governing board of the hospital... (underscore added)

In this case, Plaintiff's action is against Carolina Pines, not "an appointed member" of its Medical Executive Committee. Under the circumstances, the Court finds Section 40-71-10(B) does not hinder Ms. Person's corporate negligence action.

Our neighboring state of Georgia has a peer review immunity provision similar to South Carolina's Section 40-71-20. Section 31-7-132(a) of the Georgia Code states:

No professional health care provider nor any individual who serves as a member or employee of a professional health care provider or review organization nor any individual who furnishes counsel or services to a professional health care provider or review organization shall be held, by reason of the performance of peer review activities, to have violated any criminal law or to be civilly liable under any law unless he was motivated by malice toward any person affected by such activity.

In McCall v. Henry Medical Center, Inc., 250 Ga. App. 679, 551 S.E. 2d 739 (2001), a hospital unsuccessfully argued Georgia's peer review confidentiality and immunity provisions abrogated common law corporate negligence claims. The Georgia Court of

Appeals rejected the hospital's position as follows:

The peer review statutes provide two different types of protection to members of medical care peer review groups. One is immunity from civil or criminal liability for performing peer review functions, the other is a prohibition against discovery of peer review group materials. The General Assembly intended "to provide protection for those individuals who are members of peer review groups which evaluate the quality and efficiency of professional health care providers and to protect the confidentiality of their records." (citation omitted)

Id. at 681.

The McCall opinion continues:

It is established that "a hospital has a direct and independent responsibility to its patients to take reasonable steps to ensure that staff physicians using hospital facilities are qualified for privileges granted." (citation omitted)

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We do not believe that the General Assembly has indirectly eliminated, through peer review immunity, a hospital's responsibility to its patients to exercise reasonable care in ensuring that medical care providers are qualified. The ultimate purpose of the peer review law is to improve the delivery of medical care to the patient. "It was never intended that the peer review process be used in such a way as to effectively bar a plaintiff's tort action."

Id. at 682.

VI. CONCLUSION

In bringing this claim and making the allegations contained therein, Plaintiff poses this question: If a hospital won't police the privileging process to assure the protection of patient safety, in the absence of oversight by statute or regulatory authority, is there redress in the courts? Ultimately, our appellate courts may be called upon to specifically address this question. Strickland and Simmons implicitly recognize a patient's corporate

negligence action against a hospital involving credentialing and privileging issues. At the summary judgment stage, this Court has evaluated whether the Plaintiff herein has a right to pursue her action against Carolina Pines under traditional common law tort concepts of negligence, and finds that Plaintiff has submitted adequate evidence to raise a genuine issue of material fact as to whether (1) Carolina Pines owed her a duty; (2) Carolina Pines breached that duty; (3) Plaintiff incurred injury; and (4) Plaintiff's injury was proximately caused by Carolina Pines. This decision is in keeping with traditional notions of negligence law. Further, this decision supports a public policy previously enunciated by our Courts of protecting patient safety, in this instance where patients may be unaware of professional standards for training, experience, and proficiency in the performance of surgical procedures.

Carolina Pines' arguments that South Carolina's peer review statute trumps Plaintiff's action and eviscerates Carolina Pines' defense both fail under the facts of this case and the evidence produced thus far. Plaintiff's claim solely relies upon non-confidential information involving Dr. Mincheff's qualifications and Carolina Pines' "outcome of the decision-making process" discoverable under McGee and Durham. Accordingly, the Court denies Carolina Pines' motion for summary judgment under Rule 56, SCRCP.

IT IS SO ORDERED.

November 13, 2006

J. Michael Baxley, Presiding Judge

-15-

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DARLINGTON COUNTY

FILED

STATE OF SOUTH CAROLINA

COUNTY OF GEORGETOWN

) IN THE COURT OF COMMON PLEAS
) FOR THE FIFTEENTH JUDICIAL CIRCUIT
) CASE NO. 2012-CP-22-01004

NADENE HOLLIDAY, Individually and
As Personal Representative of the
ESTATE OF DAVID HOLLIDAY,

Plaintiff,

vs.

WACCAMAW COMMUNITY
HOSPITAL, KENT M. MCGINLEY,
M.D., WINYAH SURGICAL
SPECIALISTS, P.A., ANTHONY H.
DEHAAS, M.D., and MATTHEW J.
METZ, M.D.,

Defendants.

**SECOND AMENDED COMPLAINT
(JURY TRIAL DEMANDED)**

FILED
GEORGETOWN COUNTY, S.C.
2014 JUL 24 AM 9:50
ALMA Y. WHITE
CLERK OF COURT

Nadene Holliday, Individually and as Personal Representative of the Estate of David Holliday, complaining of the acts and/or omissions of Defendants, alleges and states as follows:

1. Plaintiff Nadene Holliday (hereinafter "Plaintiff"), pursuant to an order of the Probate Court of Horry County dated January 4, 2013, is the duly appointed, qualified, and acting Personal Representative of the Estate of David Holliday (hereinafter "Mr. Holliday"). Mr. Holliday died on November 13, 2012. At all times pertinent herein, the late Mr. Holliday was a citizen and resident of Horry County, South Carolina.

2. The Estate of David Holliday is being administered in the Probate Court of Horry County, Case No. 2013-ES-26-00031.

3. Plaintiff is a citizen and resident of Horry County, South Carolina, and is the wife of Mr. Holliday.

4. On information and belief, Defendant Waccamaw Community Hospital (hereinafter "Defendant Hospital") is a South Carolina non-profit corporation which does business in Georgetown County

5. At all relevant times, Defendant Hospital held itself out to the public, including Mr. Holliday, as a modern medical facility and well-staffed hospital that included trained and skilled physicians ("medical staff"). At all times relevant herein, Defendant Hospital acted by and through its agents, contractors, employees, officers and directors, actual or apparent, all or any of whom were acting within the course and scope of their employment, agency, duties, or authority, and for whom Defendant Hospital was responsible under the laws of *respondeat superior*, agency, and non-delegable duty.

6. At all times pertinent herein, Defendant Hospital's physicians and medical staff responsible for the care, supervision, and protection of Mr. Holliday acted within the course and scope of their authority, and for the benefit of Defendant Hospital as its actual and/or apparent agents and/or employees. Defendant Hospital held each of its physicians and medical staff responsible for the care, supervision, and protection of Mr. Holliday out to the public and to Mr. Holliday as qualified physicians and medical staff licensed to practice under the laws of the State of South Carolina.

7. Defendant Hospital was required to exercise ordinary and reasonable care in the selection and retention of its physicians, contractors, and medical staff.

8. In the care and treatment of patients, including Mr. Holliday, Defendant Hospital's physicians, contractors, and medical staff were required to exercise and use that degree of skill, care, and learning ordinarily used under the same or similar circumstances by members of the medical profession.

9. On information and belief, Winyah Surgical Specialists, P.A. (“Defendant Winyah”) is a professional association operating under the laws of the State of South Carolina as a medical practice specializing in general surgery.

10. On information and belief, Defendant Anthony H. deHaas, M.D. (“Defendant deHaas”), is a citizen and resident of Georgetown County, South Carolina. At all times relevant hereto, Defendant deHaas held himself out to the public and to Mr. Holliday as a qualified physician and specialist, Board Certified in General Surgery, licensed to practice medicine under the laws of the State of South Carolina and practicing at and for the benefit of Defendant Hospital as its actual and/or apparent agent and/or employee, and acting within the course and scope of his employment, agency, duty, or authority. At all times relevant hereto, Defendant deHaas also practiced medicine at and for the benefit of Defendant Winyah as its agent, owner, and/or employee.

11. On information and belief, Defendant Matthew J. Metz, M.D. (“Defendant Metz”), is a citizen and resident of Georgetown County, South Carolina. At all times relevant hereto, Defendant Metz held himself out to the public and to Mr. Holliday as a qualified physician and specialist, Board Certified in General Surgery, licensed to practice medicine under the laws of the State of South Carolina and practicing at and for the benefit of Defendant Hospital as its actual and/or apparent agent and/or employee, and acting within the course and scope of his employment, agency, duty, or authority. At the time of the events complained of herein, Defendant Metz practiced medicine at and for the benefit of Defendant Winyah as its agent, owner, and/or employee. On information and belief, Defendants deHaas and Metz held privileges to practice surgery at Defendant Hospital at all times relevant hereto.

12. On information and belief, Defendant Kent M. McGinley, M.D., (“Defendant McGinley”) is a citizen and resident of Georgetown County, South Carolina, and at all times relevant hereto, was holding himself out to the public and to Mr. Holliday as a qualified physician and specialist, Board Certified in Anatomic Pathology and Clinical Pathology, licensed to practice medicine under the laws of the State of South Carolina, and with offices in and/or privileges to practice at Defendant Hospital located in Georgetown County, South Carolina. At all times relevant hereto, Defendant McGinley practiced medicine at and for the benefit of Defendant Hospital as its actual and/or apparent agent and/or employee.

13. On information and belief, Defendant McGinley held privileges to practice pathology at Defendant Hospital at all times relevant hereto.

14. Prior to and during the month of October 2005, Defendant McGinley unlawfully obtained narcotics by creating false identifications and prescribing those narcotics to his aliases. On information and belief, Defendant McGinley obtained prescription narcotics by using false identities on 10-20 occasions. As a result of that conduct, his medical license was suspended by the South Carolina Board of Medical Examiners (“Medical Board”).

15. In its June 2006 Final Order, the Medical Board determined that Defendant McGinley violated multiple laws, regulations, and principles of medical ethics. It found that he was “not dedicated to providing competent medical service with compassion and respect for human dignity,” that he “did not respect the law,” and that he was “guilty of engaging in dishonorable, unethical, or unprofessional conduct that is likely to deceive, defraud, or harm the public.”

16. Defendant McGinley admitted to all of the allegations made against him by the Medical Board.

17. Despite being aware of Defendant McGinley's criminal, fraudulent, and unethical conduct, Defendant Hospital reappointed Defendant McGinley to its medical staff and its continued contractual relationship with him and his pathology practice.

18. On information and belief, Defendant Hospital deferred monitoring of Defendant McGinley to the Medical Board following its disciplinary action and upon Defendant McGinley's return to work at Defendant Hospital.

19. Venue is proper in this Court because a substantial part of the alleged acts or omissions giving rise to this claim occurred in Georgetown County.

20. At all times mentioned herein and relevant hereto, Mr. Holliday was received and treated as a paying patient by all of the Defendants. The Defendants agreed, for valuable consideration, to furnish Mr. Holliday with skilled, trained, ethical, and competent healthcare practitioners, with appropriate medical testing and treatment, and to use a reasonable degree of professional skill and diligence in the diagnoses, care, and treatment of Mr. Holliday.

21. The Defendants, in the treatment of patients such as Mr. Holliday, were required to exercise and use that degree of skill and learning ordinarily used under the same and/or similar circumstances by members of their profession. The Defendants owed a duty of reasonable care to Mr. Holliday to use that knowledge, skill, and care that is generally used in similar cases and circumstances by professionals in their field of specialized medicine.

22. Defendant Hospital had a duty to provide Mr. Holliday with competent medical care by ethical physicians.

23. Defendant Hospital had a duty to appoint to its medical staff only those physicians that were "competent in [their] respective field[s], worthy in character and in matters

of professional ethics, and [met] the requirements of the hospital's bylaws " 24A S.C. Code Ann Regs. 61-16, § 302.

24. Defendant Hospital had a duty to use reasonable and ordinary care in determining whether a physician met these criteria prior to both the physician's initial appointment and any later periodic reappointments. See 24A S.C. Code Ann. Regs. 61-16, § 301.

25. On July 19, 2007, Mr Holliday presented to the emergency room of Defendant Hospital complaining of pain in the upper right quadrant of his abdomen. At approximately 1.15 p m that day, Defendant deHaas performed a laparoscopic cholecystectomy to remove Mr Holliday's gallbladder. During the procedure, Defendant deHaas removed the gallbladder through the subxiphoid trocar site, which is not the appropriate site. Mr. Holliday's gallbladder was large enough with numerous stones that it required dilation of the subxiphoid port and incision to remove it. During removal, the gallbladder was placed in an endoscopic retrieval bag and sent to Defendant McGinley for processing.

26. The gallbladder specimen was then processed by Defendant McGinley. Although he observed that the gallbladder contained approximately 200+ brown multinodular gallstones, ranging in size from 0.3 cm to 0.8 cm, Defendant McGinley did not include any diagnosis of or concern about a potential malignancy, nor did he require or suggest any additional testing. Although the specimen contained evidence of malignancy, Defendant McGinley failed to detect or diagnose the condition. Defendant deHass also failed to review the gallbladder biopsy and failed to take any additional measures to determine the cause of Mr Holliday's gallbladder disease.

27. On February 8, 2010, Mr. Holliday went to Defendant Winyah complaining of intermittent pain in the subxiphoid area and expressed concern regarding a nodule which had

developed at the trocar site. At that office visit, Mr. Holliday was seen and treated by Defendant Metz, as Defendant deHaas had been deployed. Defendant Metz briefly looked at the incision site and ordered a CT scan of the abdomen with a follow-up appointment thereafter.

28 The following day, February 9, 2010, Mr. Holliday had a CT scan of the abdomen with oral and intravenous contrast at Defendant Hospital. Dr. G. T. Deschamps, Jr., who reviewed the scan, observed an irregular soft tissue density measuring approximately 3.5 centimeters involving the rectus sheath midline. Dr. Deschamps recommended a follow-up study in three to six months to ensure stability of the mass

29. Mr. Holliday returned for his follow-up appointment with Defendant Metz on February 15, 2012. At that visit, Defendant Metz told Mr. Holliday that the area of concern was simply scar tissue and that he should come back only if something were to change. Despite the results of the CT scan, Defendant Metz failed to review the prior pathology report from 2007, failed to biopsy the mass, and failed to follow up with Mr. Holliday to perform any additional radiological studies as recommended by the radiologist who reviewed the CT scan, or even inform Mr. Holliday that additional studies had been recommended.

30 Thereafter, on November 1, 2010, Mr. Holliday had back surgery at East Cooper Hospital and was placed in a back brace by his surgeon, Dr. Steven Poletti. After approximately one week of wearing the brace, Mr. Holliday began to experience discomfort in his chest area where the nodule from the trocar site incision was located. On the very same day that the brace was removed, Mr. Holliday contacted Defendant Winyah to schedule an appointment with Defendant deHaas.

31 On December 28, 2010, Mr. Holliday presented to Defendant Winyah for the pain in his subxiphoid area, and was seen by Defendant deHaas. Defendant deHaas conducted a

physical exam of Mr. Holliday's abdomen and reviewed the CT scan performed on February 9, 2010, which originally revealed a 3.5 centimeter mass. Defendant deHaas recommended removal of the abnormal tissue and scheduled surgery for January 13, 2011. Prior to performing the procedure, Defendant deHaas failed to perform an additional CT scan of Mr. Holliday's chest and abdomen, as well as a whole body PET scan.

32. Mr. Holliday underwent an excisional biopsy of the abdominal wall on January 13, 2011, performed by Defendant deHaas at Defendant Hospital. Between February 9, 2010, and January 13, 2011, the tumor had grown substantially as evidenced by a subsequent CT scan performed on January 27, 2011, after the excisional surgery. Defendant deHaas excised only six centimeters of the mass, failing to remove the entire tumor during the surgery. The impression of Defendant deHaas was that the mass was ossification of scar tissue either from the excision or trocar site placement during the gallbladder surgery in July 2007. Nonetheless, Defendant deHaas sent the tissue to pathology for processing.

33. The pathology report, issued by Steven B. Vallery, M.D., and dated January 13, 2011, revealed a well to moderately differentiated adenocarcinoma involving the surgical margin.

34. At Defendant deHaas's instruction, Mr. Holliday called to schedule a two-week follow-up visit. The first available appointment was February 2, 2011. Despite having received the pathology report containing a diagnosis of cancer in mid to late January, neither Defendant deHaas nor Defendant Winyah called Mr. Holliday to schedule an earlier appointment.

35. On January 25, 2011, prior to his scheduled follow-up appointment, Mr. Holliday noticed a "bubble" at the end of his incision site, which was painful. He immediately telephoned Defendant Winyah and scheduled an appointment with Defendant deHaas for the following day.

36. On January 26, 2011, Mr. Holliday arrived alone for his appointment with Defendant deHaas to have his incision checked. Defendant deHaas reported that the incision appeared to be normal, but then, to Mr. Holliday's shock and horror, explained that Mr. Holliday had metastatic carcinoma on his abdominal wall. Defendant deHaas went on to explain that the likely source of the adenocarcinoma was the gallbladder removed by Defendant deHaas from that port site during the July 19, 2007, surgery. Mr. Holliday left Defendant deHaas's office and drove straight to Plaintiff's place of employment so that he could tell her that he had cancer.

37. After learning of her husband's diagnosis, Plaintiff telephoned Defendant deHaas, who confirmed what he had told Mr. Holliday in his office. Defendant deHaas also stated that he reviewed the pathology report from the July 19, 2007, gallbladder surgery and compared it with the pathology report from the January 13, 2011, excision. He admitted that the gallbladder could have been cancerous at the time of its removal, but went undiagnosed.

38. On January 27, 2011, Mr. Holliday had a CT scan of his chest, abdomen, and pelvis at the Imaging Center at Waccamaw Medical Park. The scan revealed an area of soft tissue thickening on the anterior abdominal wall measuring approximately 11.6 centimeters in width and 3.3 centimeters from front to back on either side of the rectus sheath.

39. Mr. Holliday returned to see Defendant deHaas, as previously scheduled, on February 2, 2011. Defendant deHaas explained that the abnormalities of the soft tissues surrounding his subxiphoid port site were most likely consistent with metastatic disease in that area. He then began to discuss with Plaintiff and Mr. Holliday the need for additional testing and evaluation in order to formulate a treatment plan. However, at the request of Plaintiff and Mr. Holliday, Defendant deHaas referred Mr. Holliday to the Medical University of South Carolina ("MUSC"), where Defendant deHaas recommended they see a surgeon named Dr. Nestor

Esnaola. Because Mr. Holliday needed oncological treatment, and not surgery, Dr Esnaola referred him to Dr. Melanie Thomas at MUSC.

40. On March 9, 2011, Mr. Holliday began chemotherapy at MUSC in Charleston, South Carolina, and continued with this treatment until approximately August of 2012. In addition, he underwent approximately thirty radiation treatments at the MUSC facility in Georgetown.

41. As a result of the delay in diagnosing and treating Mr Holliday's gallbladder cancer, the cancer spread to his abdominal wall as well as in and around his liver and developed into a Stage IV disease.

42. Mr. Holliday died on November 13, 2012. His autopsy reported the cause of death as metastatic biliary carcinoma.

FOR A FIRST CAUSE OF ACTION

(Wrongful Death)

**(As Against Defendants Winyah Surgical Associates, P.A.,
Anthony H. deHaas, M.D., and Matthew J. Metz, M.D.)**

43. Plaintiff repeats, realleges, and incorporates each of the foregoing paragraphs as if fully set forth herein.

44. Plaintiff, as Personal Representative of the Estate of David Holliday, brings this action under the South Carolina Wrongful Death Act, S.C. Code Ann. §§ 15-51-10 to -60 (Law. Co-op. 1976 and Supp. 2012) on behalf of and for the benefit of the statutory beneficiaries of Mr. Holliday, namely his wife, Plaintiff Nadené Holliday.

45. The care provided to Mr. Holliday by Defendants fell below the accepted standards of medical care.

46. Defendant Winyah, acting through its actual and/or apparent agents and/or employees, and Defendant deHaas were careless, negligent, grossly negligent, reckless, willful, wanton, and heedless, in one or more or all of the following particulars, to wit:

- a. failing to properly and timely treat Mr. Holliday;
- b. failing to properly and timely care for Mr. Holliday;
- c. failing to properly and timely diagnose Mr. Holliday;
- d. failing to properly and timely monitor Mr. Holliday,
- e. failing to properly and timely evaluate Mr. Holliday;
- f. failing to remove Mr. Holliday's gallbladder specimen through the appropriate trocar site,
- g. failing to review the gallbladder biopsy taken from Mr. Holliday on July 19, 2007, to determine the cause of Plaintiff's gallbladder disease;
- h. failing to perform a CT scan of Mr. Holliday's chest and abdomen as well as a whole body PET scan prior to performing surgery on January 13, 2011;
- i. failing to excise the entire tumor during Mr. Holliday's surgery on January 13, 2011,
- j. failing to order or perform additional radiological studies on Mr. Holliday,
- k. failing to compare radiological and pathological studies of Mr. Holliday,
- l. failing to refer and/or consult on Mr. Holliday's case;
- m. failing to exercise that degree of knowledge, care, and skill in the care and treatment of Mr. Holliday's medical condition ordinarily possessed and exercised by licensed physicians similarly situated throughout the United States, including the State of South Carolina, and

- n. departing from generally accepted standards of the medical practice, which existed throughout the United States, including the State of South Carolina, in the care and treatment of Mr. Holliday's medical condition.

47. Defendant Winyah, acting through its actual and/or apparent agents and/or employees, and Defendant Metz were careless, negligent, grossly negligent, reckless, willful, wanton, and heedless, in one or more or all of the following particulars, to wit:

- a. failing to properly and timely treat Mr. Holliday;
- b. failing to properly and timely care for Mr. Holliday;
- c. failing to properly and timely diagnose Mr. Holliday;
- d. failing to properly and timely monitor Mr. Holliday;
- e. failing to properly and timely evaluate Mr. Holliday;
- f. failing to review the July 23, 2007, pathology report when examining Mr. Holliday on February 8, 2010;
- g. failing to perform a biopsy of the 3.5 centimeter mass which appeared on Mr. Holliday's CT scan of February 9, 2010;
- h. failing to follow up with Mr. Holliday and to perform additional radiological studies within three to six months of his examination in February 2010 as recommended by Dr. G. T. Deschamps, Jr., the radiologist who reviewed the CT scan of February 9, 2010;
- i. failing to order or perform additional radiological and pathological studies on Mr. Holliday,
- j. failing to compare radiological and pathological studies of Mr. Holliday;
- k. failing to refer and/or consult on Mr. Holliday's case;

- l. failing to exercise that degree of knowledge, care, and skill in the care and treatment of Mr. Holliday's medical condition ordinarily possessed and exercised by licensed physicians similarly situated throughout the United States, including the State of South Carolina; and
- m. departing from generally accepted standards of the medical practice, which existed throughout the United States, including the State of South Carolina, in the care and treatment of Mr. Holliday's medical condition

48 As a direct and proximate result of the negligent, careless, reckless, grossly negligent, willful, and/or malicious conduct of Defendants Winyah, deHaas, and Metz, as set forth above, Mr. Holliday's cancer went undiagnosed and untreated for approximately three-and-a-half years, causing the cancer to spread to his abdominal wall and liver and develop into a Stage IV disease, ultimately resulting in his death.

49 At the time of his death, Mr. Holliday was 72 years old and had a life expectancy of 12.01 years pursuant to S.C. Code Ann. § 19-1-150 (Law Co-op. and Supp. 2012).

50. As a direct and proximate result of the negligent, careless, reckless, grossly negligent, willful, and/or malicious conduct of Defendants Winyah, deHaas, and Metz as set forth above, Mr. Holliday's statutory beneficiary has suffered damages in the form of pecuniary loss; medical expenses, funeral and burial expenses; mental shock and suffering; wounded feelings; grief and sorrow; loss of companionship; loss of consortium; deprivation of the use and comfort of Mr. Holliday's society; loss of Mr. Holliday's experience, knowledge, and judgment in managing the affairs of himself and his beneficiary; loss of Mr. Holliday's ability to earn money for the support, maintenance, care, and protection of his wife; loss of services; and loss of prospective inheritance.

51. Plaintiff is entitled to recover actual and punitive damages in an amount to be determined by the trier of fact together with the costs and disbursements of this action.

FOR A SECOND CAUSE OF ACTION

(Wrongful Death)

(As Against Defendants Waccamaw Community Hospital and Kent M. McGinley, M.D.)

52. Plaintiff repeats, realleges, and incorporate each of the foregoing paragraphs as if fully set forth herein.

53. Plaintiff, as Personal Representative of the Estate of David Holliday, brings this action under the South Carolina Wrongful Death Act, S.C. Code Ann. §§ 15-51-10 to -60 (Law. Co-op. 1976 and Supp. 2012) on behalf of and for the benefit of the statutory beneficiaries of Mr. Holliday, namely his wife, Plaintiff Nadene Holliday.

54. The care provided to Mr. Holliday by Defendants fell below the accepted standards of medical care.

55. Defendant McGinley was careless, negligent, grossly negligent, reckless, willful, wanton, and heedless, in one or more or all of the following particulars, to wit: /

- a. failing to properly and timely diagnose Mr. Holliday;
- b. failing to properly and timely monitor Mr. Holliday;
- c. failing to properly and timely evaluate Mr. Holliday;
- d. failing to properly and accurately process and interpret the specimen taken of Mr. Holliday's gallbladder in July 2007, which showed evidence of malignancy;
- e. failing to prepare an accurate and proper pathology report;
- f. failing to perform additional pathological studies on Mr. Holliday;
- g. failing to refer and/or consult on Mr. Holliday's case;

- h. failing to exercise that degree of knowledge, care, and skill in the care and treatment of Mr. Holliday's medical condition ordinarily possessed and exercised by licensed physicians similarly situated throughout the United States, including the State of South Carolina; and
- i. departing from generally accepted standards of the medical practice, which existed throughout the United States, including the State of South Carolina, in the care and treatment of Mr. Holliday's medical condition.

56. Defendant Hospital was careless, negligent, grossly negligent, reckless, willful, wanton, and heedless, in one or more or all of the following particulars, to wit:

- a. failing to provide Mr. Holliday with a pathologist that was competent in the field of pathology, worthy in character and in matters of professional ethics, and that met the requirements of the hospital's bylaws;
- b. failing to independently monitor Defendant McGinley following his discipline by the Medical Board and upon his return to work at Defendant Hospital;
- c. failing to revoke Defendant McGinley's hospital privileges and appointment to the medical staff when it learned of his unethical, fraudulent, criminal actions and unfitness of character; and
- d. reappointing Defendant McGinley to the medical staff and renewing his hospital privileges after learning of his unethical, fraudulent, criminal actions and unfitness of character; and
- e. continuing its contractual relationship with Defendant McGinley and his pathology practice after learning of his unethical, fraudulent, criminal actions and unfitness of character.

57. As a direct and proximate result of the negligent, careless, reckless, grossly negligent, willful, and/or malicious conduct of Defendant Hospital and Defendant McGinley, as set forth above, Mr. Holliday's cancer went undiagnosed and untreated for approximately three-and-a-half years, causing the cancer to spread to his abdominal wall and liver and develop into a Stage IV disease, ultimately resulting in his death

58. At the time of his death, Mr. Holliday was 72 years old and had a life expectancy of 12.01 years pursuant to S.C. Code Ann. § 19-1-150 (Law. Co-op. and Supp. 2012).

59. As a direct and proximate result of the negligent, careless, reckless, grossly negligent, willful, and/or malicious conduct of Defendant Hospital and Defendant McGinley, as set forth above, Mr. Holliday's statutory beneficiary has suffered damages in the form of pecuniary loss; medical expenses, funeral and burial expenses, mental shock and suffering, wounded feelings; grief and sorrow; loss of companionship; loss of consortium; deprivation of the use and comfort of Mr. Holliday's society; loss of Mr. Holliday's experience, knowledge, and judgment in managing the affairs of himself and his beneficiary; loss of Mr. Holliday's ability to earn money for the support, maintenance, care, and protection of his wife; loss of services, and loss of prospective inheritance.

60. Plaintiff is entitled to recover actual and punitive damages in an amount to be determined by the trier of fact together with the costs and disbursements of this action.

FOR A THIRD CAUSE OF ACTION
(Survival)
(As Against All Defendants)

61 Plaintiff repeats, realleges, and incorporates each of the foregoing paragraphs as if fully set forth herein.

62. Plaintiff, as Personal Representative of the Estate of David Holliday, brings this action under S.C. Code Ann. § 15-5-90 (Law. Co-op. 1976 and Supp. 2012), on behalf of the Estate of David Holliday, deceased.

63. As a direct and proximate result of the negligent, careless, reckless, grossly negligent, willful, and/or malicious conduct of Defendants, as set forth above, from the time he presented to the emergency room on July 19, 2007, until the time of his death on November 13, 2012, Mr. Holliday suffered injuries to his person, including, but not limited to, severe and debilitating pain and injury; discomfort, trauma; significant inactivity and loss of total enjoyment of life; emotional stress; mental anguish; anxiety; impairment of earning capacity; and lost future earnings, all to Mr. Holliday's actual damages in an amount to be determined by the trier of fact.

64. Mr. Holliday's claims for damages survive his death and inure to the benefit of his estate.

65. As a direct and proximate result of the negligent, careless, reckless, grossly negligent, willful, and/or malicious conduct of Defendants, as set forth above, the estate of Mr. Holliday has been deprived of the present value of the accumulations that Mr. Holliday would have made to the estate had he lived out his normal life expectancy; has become liable for substantial sums of money for medicine and medical services, care, and treatment for Mr. Holliday's injuries; and has become liable for large sums of money for funeral and other related burial expenses.

66. As a direct and proximate result of the negligent, careless, reckless, grossly negligent, willful, and/or malicious conduct of Defendants as set forth above, and Mr. Holliday's death, Plaintiff is entitled to an award of actual damages in an amount to be determined by the trier of fact.

67. As a direct and proximate result of Defendants' reckless, willful, and/or malicious conduct as set forth above, Plaintiff is entitled to an award of punitive damages in an amount to be determined by the trier of fact.

FOR A FOURTH CAUSE OF ACTION
(Loss of Companionship, S.C. Code Ann. § 15-75-20)
(As Against All Defendants)

68. Plaintiff repeats, realleges, and incorporates each of the foregoing paragraphs as if fully set forth herein.

69. As a direct and proximate result of Defendants' negligent, careless, reckless, grossly negligent, and willful conduct, and/or other misconduct as referenced herein above, Plaintiff has suffered actual damages for the loss of consortium and companionship of her spouse.

70. As provided under S.C. Code Ann. § 15-75-20 (Law. Co-op. 1976 and Supp. 2012), Plaintiff is entitled to recover for the loss of consortium, love, affection, aid, comfort, society, companionship, and services of her husband and all other damages allowed for a loss of consortium and companionship claim under South Carolina law.

71. Plaintiff is informed and believes that she is entitled to judgment against these Defendants for actual damages in an amount to be determined by the trier of fact.

WHEREFORE, the Plaintiff prays for judgment against the Defendants for actual and punitive damages in an amount to be determined by the trier of fact, costs and expenses incurred in the prosecution of this case, and for such other and further relief as the Court deems just and proper.

DEMAND FOR TRIAL BY JURY

Pursuant to Rule 38(b) of the South Carolina Rules of Civil Procedure, Plaintiff hereby demands a trial by jury in this action for all issues so triable.

ROSEN, ROSEN & HAGOOD, LLC

By: 

Andrew D. Gowdown

Elizabeth J. Palmer

Rene S. Dukes

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(843) 577-6726 (o)

(843) 724-8036 (f)

ATTORNEYS FOR PLAINTIFF

Charleston, South Carolina

July 24, 2014

) IN THE COURT OF COMMON PLEAS

) CASE NO.: 2012-CP-22-01004

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4. Denies the allegations contained in Paragraph 5 of the Second Amended Complaint and would hasten to add that it is not legally liable for the acts of an independent contractor.

5. Denies the allegations contained in Paragraphs 6, 7 and 8 of the Second Amended Complaint, and demands strict proof thereof.

6. Neither admits nor denies the allegations contained in Paragraphs 9, 10 and 11 of the Second Amended Complaint as the same do not apply to Waccamaw.

7. Denies the allegations contained in Paragraphs 12, 13, 14, 15, 16, 17 and 18 of the Second Amended Complaint and demands strict proof thereof.

8. Admits the allegations contained in Paragraph 19 of the Second Amended Complaint.

9. Denies the allegations contained in Paragraphs 20, 21, 22, 23, and 24 of the Second Amended Complaint and demands strict proof thereof.

10. Admits on information and belief the allegations contained in Paragraph 25 of the Second Amended Complaint.

11. Denies on information and belief the allegations contained in Paragraphs 26 and 27 of the Second Amended Complaint and demands strict proof thereof.

12. Neither admits nor denies the allegations contained in Paragraphs 28, 29, 30, 31, 32, 33, 34, 35, 36, 37, 38, 39, 40 and 41 of the Second Amended Complaint as these allegations do not apply to Waccamaw.

FOR A SECOND DEFENSE AS TO PARAGRAPHS 1 - 42:

13. The Defendant, Waccamaw, reiterates the matters and defenses contained in Paragraphs 1 through 12 above, the same as if repeated verbatim herein.

14. The Defendant Waccamaw alleges that Dr. McGinley was an independent contractor for whose acts it was not legally liable.

FOR A FIRST DEFENSE TO THE FIRST CAUSE OF ACTION:

(Paragraphs 43 through 51)

15. The Defendant Waccamaw reiterates the matters and defenses contained in Paragraphs 1 through 14 above, the same as if repeated verbatim herein.

16. The Defendant Waccamaw neither admits nor denies the allegations contained in Paragraphs 43, 44, 45, 46, including sub paragraphs, 47 including subparagraphs, 48, 49, 5 and 51 of the Second Amended Complaint as those allegations do not apply to Waccamaw.

FOR A FIRST DEFENSE TO THE SECOND CAUSE OF ACTION:

(Paragraphs 52 through 60)

17. The Defendant Waccamaw reiterates the matters and defenses contained in Paragraphs 1 through 16 above, the same as if repeated verbatim herein.

18. The Defendant Waccamaw denies the allegations contained in Paragraphs 52 through 60 including all sub-paragraphs of the Second Amended Complaint and demands strict proof thereof.

FOR A SECOND DEFENSE TO THE SECOND CAUSE OF ACTION:

(Paragraphs 52 through 60)

19. The Defendant Waccamaw reiterates the matters and defenses contained in Paragraphs 1 through 18 above, the same as if repeated verbatim herein.

20. The Defendant Waccamaw alleges that the Plaintiff has failed to state a viable cause of action for corporate negligence against it; therefore, the allegations of the Second Cause of Action against Waccamaw should be dismissed pursuant to Rule 12(b)(6), SCRCF.

FOR A FIRST DEFENSE AS TO THE THIRD CAUSE OF ACTION:

(Paragraphs 61 through 67)

21. The Defendant Waccamaw reiterates the matters and defenses contained in Paragraphs 1 through 20 above, the same as if repeated verbatim herein.

22. The Defendant Waccamaw adopts and incorporates by reference all of the defenses heretofore pled in this Answer including but not limited to the defense of independent contractor and the defense of failure of Plaintiff to state a viable cause of action for corporate negligence against it.

FOR A FIRST DEFENSE TO THE FOURTH CAUSE OF ACTION:

(Paragraphs 68 through 71)

23. The Defendant Waccamaw reiterates the matters and defenses contained in Paragraphs 1 through 22 above, the same as if repeated verbatim herein.

24. The Defendant Waccamaw denies the allegations contained in Paragraphs 68 through 71 of Plaintiff's Second Amended Complaint and demands strict proof thereof.

FOR A SECOND DEFENSE TO THE FOURTH CAUSE OF ACTION:

(Paragraphs 68 through 71)

25. The Defendant Waccamaw reiterates the matters and defenses contained in Paragraphs 1 through 24 above, the same as if repeated verbatim herein.

26. The Defendant Waccamaw adopts and incorporate by reference all defenses heretofore pled in this Answer including but not limited to the defense of independent contractor and the defense of failure of Plaintiff to state a viable cause of action for corporate negligence against it.

FOR A FURTHER DEFENSE TO ALL CAUSES OF ACTION:

27. The Defendant Waccamaw reiterates the matters and defenses contained in Paragraphs 1 through 26 above, the same as if repeated verbatim herein.

28. The Defendant Waccamaw alleges that it is a charitable organization as defined by S.C. Code Ann. Section 33-56-170(1); therefore, is entitled to the protection of Section 33-56-180(A).

FOR A FURTHER DEFENSE TO ALL CAUSES OF ACTION:

29. The Defendant Waccamaw reiterates the matters and defenses contained in Paragraphs 1 through 28 above, the same as if repeated verbatim herein.

30. The Defendant Waccamaw alleges that the prior substance abuse, substance abuse treatment, or restriction of hospital privileges of Dr. McGinley are irrelevant and immaterial,

therefore, inadmissible into evidence, and in addition, violate Rules 401, 402 and 403, S.C. Rules of Evidence, S. C. Code Ann. §§ 40-71-10 and 40-71-20; S.C. Code Ann. § 44-53-140, S.C. Code Ann. §§ 17-22-130, 17-22-150 and 17-22-170, 42 C.F.R. § 2.64, and 42 U.S.C. § 290dd-2.

FOR A FURTHER DEFENSE TO ALL CAUSES OF ACTION:

31. This Defendant reiterates the matters and defenses contained in Paragraphs 1 through 30 of its Answer to Plaintiff's Second Amended Complaint the same as if repeated verbatim herein.

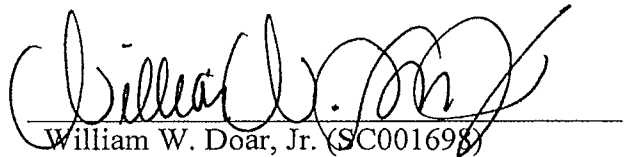
32. The Defendant Waccamaw Community Hospital alleges that this action against it is barred by S. C. Code Ann. Sec. 15-3-545(A), the three-year Statute of Limitations.

WHEREFORE, having fully answered, the Defendant, Waccamaw, prays that Plaintiff's Second Amended Complaint be dismissed as to it with costs.

Dated: December 22, 2014

MCNAIR LAW FIRM, P.A.

By



William W. Doar, Jr. (SC001698)

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GEORGETOWN 186975v1

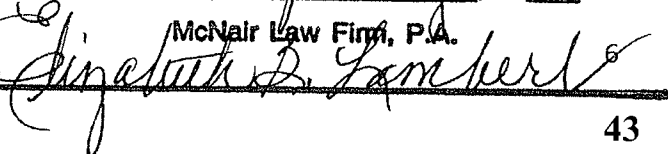
CERTIFICATE OF SERVICE

I certify that on this date a copy of the foregoing was served on each party or counsel of record by ☒ mailing, ☒ emailing, ☐ facsimile, or ☐ hand delivery in the manner prescribed by the applicable Rule of Civil Procedure.

This 6th day of January, 20 15

McNair Law Firm, P.A.

BY:



STATE OF SOUTH CAROLINA	)	IN THE COURT OF COMMON PLEAS
	)	FOR THE FIFTEENTH JUDICIAL CIRCUIT
COUNTY OF GEORGETOWN	)	CASE NO. 2012-CP-22-01004
NADENE HOLLIDAY, Individually and	)	
as Personal Representative of the ESTATE	)	
OF DAVID HOLLIDAY,	)	
	)	
Plaintiff,	)	
	)	
vs	)	
	)	
WACCAMAW COMMUNITY	)	
HOSPITAL, KENT M MCGINLEY,	)	
M.D , WINYAH SURGICAL	)	
SPECIALISTS, P.A., ANTHONY H.	)	
DEHAAS, M.D , and MATTHEW J.	)	
METZ, M.D.,	)	
	)	
Defendants	)	

NEGLIGENT CREDENTIALING: MEMORANDUM OF AUTHORITIES

South Carolina Treatment

- In Strickland v Madden, 323 S C 63, 448 S E 2d 581 (Ct. App. 1994), the plaintiff alleged the hospital was negligent in failing to withdraw the physician's staff privileges prior to the patient's injury.
 - Court took note that other jurisdictions have adopted corporate negligence & have recognized a duty, owed directly to patients, to carefully select and review the competency of physicians using their facilities,
 - The Strickland court assumed that South Carolina would likewise recognize the doctrine and explained that a plaintiff bringing such a claim would, consistent with traditional negligence standards, be required to establish the applicable standard of care and gave the examples of national hospital accreditation standards and a hospital's own bylaws as means by which this could potentially be done Id
- Corporate negligence, which literally means holding a corporation liable for its negligent acts, is a form of direct liability Simmons v Tuomey Reg'l Med Ctr., 330 S.C. 115, 123, 498 S.E 2d 408, 412 (Ct App. 1998) aff'd as modified, 341 S C. 32, 533 S.E.2d 312 (2000) (distinguishing between the direct liability of corporate negligence in the context of a hospital's duty to monitor the competency of its staff physicians and nondelegable duty).

- Acceptance recognized by Judge Baxley in In the matter of Person v. Carolina Pines Reg. Med. Ctr., C/A No. 2004-CP-16-322 (Darlington Cty. Ct. of Common Pleas, Nov. 14, 2006), the plaintiff alleged the defendant hospital was negligent in its credentialing of the defendant doctor. The defendant hospital moved for summary judgment, arguing that South Carolina did not recognize a corporate negligence cause of action. The trial court disagreed, holding that Strickland and Simmons I signify South Carolina's acceptance of a negligent credentialing cause of action under the corporate negligence theory

Generally: Negligent Credentialing as Type of Corporate Negligence

Corporate negligence "is no more than the application of common law principles of negligence and is not some recently developed doctrine upon which liability is based." Blanton v. Moses H Cone Mem'l Hosp., Inc., 319 N.C. 372, 375, 354 S.E.2d 455, 457 (1987)

Plaintiff's claims against Defendant Waccamaw, that it was negligent in its selection and retention of Defendant McGinley, arise out of a doctrine commonly referred to as "corporate negligence."

The concept of corporate negligence is broader than the concept of negligent credentialing in that corporate negligence includes acts of direct hospital negligence, such as negligence in supervising patient care or in failing to enforce hospital guidelines regarding patient care Larson v. Wasemiller, 738 N.W.2d 300 (Minn. 2007).

Corporate negligence has been defined as "the failure of a hospital, entrusted with the task of providing the accommodations necessary to carry out its purpose, to follow the established standard of conduct to which it should conform" Bader v. United Orthodox Synagogue, 148 Conn. 449, 172 A.2d 192 (1961); Pedroza v. Bryant, 101 Wash. 2d 226, 677 P.2d 166 (1984) (expressly adopting corporate negligence theory); Darling v. Charleston Comm. Mem. Hosp., 33 Ill.2d 326, 211 N.E.2d 253 (1965), cert. denied 383 U.S. 946, 86 S.Ct. 1204, 16 L.Ed.2d 209 (1966) (corporate negligence of hospital based on holding that hospital owed patient an independent duty of care); Johnson v. Misericordia Comm. Hosp., 97 Wis. 2d 521, 294 N.W.2d 501 (Ct. App. 1980), decision aff'd, 99 Wis. 2d 708, 301 N.W.2d 156 (1981); Insinga v. LaBella, 543 So. 2d 209 (Fla. 1989) (adopting corporate negligence doctrine); Thompson v. Nason Hosp., 527 Pa. 330, 591 A.2d 703 (1991) (adopting theory of corporate liability), Rodrigues v. Miriam Hosp., 623 A.2d 456 (R.I. 1993) (adopting doctrine of corporate negligence); Douglas v. Freeman, 117 Wash. 2d 242, 814 P.2d 1160 (1991) (applying corporate negligence to dental clinic)

"A review of the case law involving corporate negligence claims asserted against a hospital reveals that there are fundamentally two kinds of claims. (1) those relating to negligence in clinical care provided by the hospital directly to the patient, and (2) those relating to negligence in the administration or management of the hospital. The case law has treated the two types of claims differently." Estate of Waters v. Jarman, 144 N.C. App. 98, 101, 547 S.E.2d 142, 144 (N.C. 2001). Cases alleging a failure by the hospital to adequately monitor and oversee a

physician or which contend the hospital was negligent in granting privileges to unqualified physicians are examples of the latter, **and require the court to apply the reasonably prudent person standard of care in assessing negligence** Id at 102–03, 547 S E 2d at 145 (discussing Blanton v. Moses H. Cone Hosp., Inc., 319 N.C. 372, 375, 354 S.E.2d 455, 457 (1987))(emphasis added).

Acceptance of Negligent Credentialing in Other Jurisdictions

A cause of action for negligent credentialing is an independent cause of action arising out of a health care institution's direct responsibility to its patients to take reasonable steps to ensure that medical care providers are qualified. Wellstar Health Systems, Inc. v. Green, 258 Ga App 86, 572 S.E.2d 731 (2002), cert denied, (Jan. 27, 2003).

A hospital has a direct and independent responsibility to its patients to take reasonable steps to ensure that staff physicians using hospital facilities are qualified for privileges granted, and it follows that a cause of action for negligent credentialing of staff physicians is an independent cause of action against hospital that arises out of that responsibility Ladner v. Northside Hosp., Inc., 314 Ga. App 136, 723 S.E.2d 450 (2012).

In order to prevail on a negligent credentialing claim against a hospital, a plaintiff must prove that: (1) the hospital failed to meet the standard of reasonable care in the selection of the physician it granted medical staff privileges to whose treatment provided the basis for the underlying medical malpractice claim, (2) while practicing pursuant to negligently granted medical staff privileges, the physician breached the applicable standard of care; and (3) the negligent granting of medical staff privileges was a proximate cause of the plaintiff's injuries. Frigo v. Silver Cross Hosp and Medical Center, 377 Ill. App. 3d 43, 876 N.E 2d 697 (1st Dist. 2007).

A common law claim of negligent credentialing exists, and is not precluded by peer review statute Larson v Wasmiller, 738 N.W.2d 300 (Minn. 2007).

A negligent credentialing action against a hospital must establish: (1) the applicable standard of care, (2) the hospital departed from that standard of care, and (3) the departure proximately caused plaintiff's injury. Brookins v. Mote, 367 Mont. 193, 292 P 3d 347 (2012).

In an action against a hospital for negligent credentialing, the required element of the plaintiff's injury having been caused by the doctor's medical malpractice goes to the question of whether the hospital's alleged negligent credentialing of the doctor proximately caused the plaintiff's injury Schelling v. Humphrey, 123 Ohio St 3d 387, 916 N.E.2d 1029 (2009)

“Having recognized that hospitals owe a duty of ordinary care in selecting and maintaining only qualified members on their medical staff to insure quality care, diagnosis and treatment of their patients, we hold that the trial court properly instructed the jury that ‘A hospital is under a duty to exercise reasonable care to permit only competent medical doctors the privilege of using their facilities.’” Johnson v. Misericordia Cmty Hosp., 99 Wis. 2d 708, 737, 301 N W 2d 156, 170-71 (Wis 1981) (“The public is indeed entitled to expect quality care and treatment while a patient in

our highly technical and medically computed hospital complexes. The concept that a hospital does not undertake to treat patients, does not undertake to act through its doctors and nurses, but only procures them to act solely upon their own responsibility, no longer reflects the fact. The complex manner of operation of the modern-day medical institution clearly demonstrates that they furnish far more than mere facilities for treatment. They appoint physicians and surgeons to their medical staffs, as well as regularly employing on a salary basis resident physicians and surgeons, nurses, administrative and manual workers and they charge patients for medical diagnosis, care, treatment and therapy, receiving payment for such services through privately financed medical insurance policies and government financed programs known as Medicare and Medicaid.”)

For additional jurisdictions, see also: Tuscon Medical Center, Inc. v. Misevch, 113 Ariz. 34, 545 P.2d 958 (1976), Purcell v. Zimbelman, 18 Ariz App. 75, 500 P.2d 335 (1972); Elam v. College Park Hospital, 132 Cal App 3d 332, 183 Cal. Rptr. 156 (4th Dist 1982), Kitto v. Gilbert, 39 Colo App. 374, 570 P 2d 544, 550 (1977), Register v. Wilmington Medical Center, Inc., 377 A.2d 8 (Del. 1977); Insinga v. LaBella, 543 So 2d 209 (Fla 1989); Mitchell County Hospital Authority v. Joiner, 229 Ga 140, 189 S.E.2d 412 (1972); Darling v. Charleston Community Memorial Hospital, 33 Ill.2d 326, 211 N.E.2d 253 (1965), cert. den., 383 U.S. 946; Johnson v. St. Bernard Hospital, 79 Ill App 3d 709, 35 Ill Dec 364, 399 N.E.2d 198 (1979); Sibley v. Board of Sup'rs of Louisiana State University, 477 So. 2d 1094 (La. 1985), Copithorne v. Framingham Union Hosp., 401 Mass. 860, 520 N.E.2d 139 (1988); Ferguson v. Gonyaw, 64 Mich App 685, 236 N.W.2d 543 (1976), Foley v. Bishop Clarkson Memorial Hospital, 185 Neb. 89, 173 N.W.2d 881 (1970); Bost v. Riley, 44 N.C. App 638, 262 S.E.2d 391 (1980), Benedict v. St. Luke's Hospitals, 365 N.W.2d 499 (N.D. 1985), Corleto v. Shore Memorial Hospital, 138 N.J. Super. 302, 350 A.2d 534 (1975); Gridley v. Johnson, 476 S.W.2d 475 (Mo 1972), Albain v. Flower Hosp., 50 Ohio St. 3d 251, 553 N.E.2d 1038 (Ohio 1990), Strubhart v. Perry Memorial Hosp. Trust Authority, 1995 O.K. 10, 903 P.2d 263 (Okla. 1995); Thompson v. Nason Hosp., 527 Pa. 330, 591 A.2d 703 (Pa 1991); Rodrigues v. Miriam Hosp., 623 A.2d 456 (R.I. 1993); Pedroza v. Bryant, 101 Wash. 2d 226, 677 P.2d 166 (Wash 1984), Johnson v. Misericordia Cmty. Hosp., 99 Wis. 2d 708, 724-25, 301 N.W.2d 156, 164-65 (Wis. 1981); Greenwood v. Wierdsma, 741 P.2d 1079 (Wyo 1987)

Regulations and public policy of South Carolina favor the recognition of a duty owed by hospitals to patients to use due care in the selection and retention of its medical staff:

- A hospital, through its medical staff, has the responsibility of reviewing physicians' applications for membership on the staff and selecting those individuals which it deems to be qualified. In fact, in order to attract patients, hospitals frequently advertise that their medical staffs are comprised of the best and brightest physicians. For example, on its website, Defendant Waccamaw represents:

At Georgetown Memorial Hospital and Waccamaw Community Hospital, our trained professionals adopt a team approach in providing care for you and your family. Whether you are having outpatient testing or are an

inpatient, a skilled, caring interdisciplinary team of healthcare providers coordinates the evaluation and administration of your care and treatment.¹

- It would be illogical, and against the public policy of this State, to allow a hospital to represent to the public that it carefully selects its medical staff and then allow it to escape liability when it is negligent in selecting and retaining that medical staff and such negligence injures a patient.
- It is beyond question that a hospital's failure to use reasonable care and diligence in its selection and retention of physicians endangers the public at large. This is recognized by the regulations of this State
- The law of South Carolina not only imposes upon hospitals a duty to provide competent and appropriate medical care, it goes so far as to assign responsibility for the quality of medical care provided and sets forth the minimum qualifications that a physician must demonstrate in order to be eligible for membership on a hospital's medical staff
 - Hospitals have a duty to provide competent and appropriate medical care. See 24A S.C. Code Ann. Regs. 61-16, § 201 ("Every facility shall be organized, equipped, manned and administered in order that adequate care may be provided for each person admitted") Every hospital is required, by law, to have an organized medical staff, appointed by the governing hospital authority, which is responsible for the quality of care provided. See 24A S.C. Code Ann. Regs. 61-16, § 301.
 - In order to be eligible for medical staff membership, a physician must be "competent in his respective field, worthy in character and in matters of professional ethics, and meet the requirements of the hospital's bylaws" See 24A S.C. Code Ann. Regs. 61-16, § 302.
 - A hospital's "governing authority" must determine whether a physician meets these criteria prior to both the physician's initial appointment and any later periodic reappointments. See 24A S.C. Code Ann. Regs. 61-16, § 301
 - Simply holding a medical license, or being a member of a professional organization, or being certified by any clinical examining board, or holding clinical privileges or staff membership at another hospital does not automatically entitle a physician to medical staff membership – the criteria set forth above must still be met.

¹ See <http://www.georgetownhospitalsystem.org/about> (accessed 6/12/14)

ROSEN, ROSEN & HAGOOD, LLC



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ATTORNEYS FOR PLAINTIFF

Charleston, South Carolina
January 12, 2015

CERTIFICATE OF SERVICE

I certify that on January 12, 2015, I caused
to be: ☐ mailed
 ☐ hand delivered
 ☐ faxed
 ☒ e-mailed
a true copy of the foregoing pleading(s) to
each counsel of record.



IN THE COURT OF COMMON PLEAS
FOR THE STATE OF SOUTH CAROLINA
GEORGETOWN COUNTY

VIDEOTAPE DEPOSITION OF KENT M. MCGINLEY, MD
VOLUME I JANUARY 30, 2014

NADENE HOLLIDAY, Individually and as Personal
Representative of the ESTATE OF DAVID HOLLIDAY,

Plaintiff,

vs.

CASE NO. 2012-cp-22-1004

WACCAMAW COMMUNITY HOSPITAL; KENT M. MCGINLEY,
MD; WINYAH SURGICAL SPECIALISTS, PA; ANTHONY H.
DEHAAS, MD; and MATTHEW J. METZ, MD,

Defendants.

DEPONENT: KENT M. MCGINLEY, MD

DATE: JANUARY 30, 2014

TIME: 1:34 P.M.

LOCATION: GEORGETOWN MEMORIAL HOSPITAL
GEORGETOWN, SOUTH CAROLINA

REPORTED BY: RONDA K. BLANTON, RPR
NCRA REGISTERED PROFESSIONAL
REPORTER
CLARK & ASSOCIATES, INC.
P.O. BOX 73129
CHARLESTON, SC 29415
843-762-6294
office@clark-associates.com
WWW.CLARK-ASSOCIATES.COM

1 using the alias Brent Morris.

2 A. Yes.

3 Q. And then on October 19, 2005, you were
4 charged with a second count appears for obtaining
5 a controlled substance by fraud and forgery after
6 using a fraudulent Louisiana driver's license.

7 A. Yes.

8 Q. Using the alias Raymond Reid?

9 A. Yes.

10 Q. And you used that to obtain the
11 hydrocodone?

12 A. Yes.

13 Q. All right. Those were the only two
14 instances where you had fraudulently used
15 somebody else's identity to get medication?

16 A. No. I -- I had done it -- these were the
17 ones that they charged me with.

18 Q. Okay.

19 A. But I had done it additionally.

20 Q. How many other times?

21 A. Numerous other times.

22 Q. More than ten?

23 A. Yes.

24 Q. More than 20?

25 A. No.

1 **A. No.**

2 Q. Do you know the name Cindy Hutto,
3 H-U-T-T-O?

4 **A. No.**

5 Q. What were the Board's findings, to the
6 best of your recollection?

7 MR. MCCUTCHEON: Object to the form of
8 the question. Document speaks for itself.

9 Q. What happened as a result of the hearing?

10 **A. Let me ask you to clarify the question.**

11 Q. Clarify that question?

12 **A. Yes.**

13 Q. Okay. You went. You had a hearing.

14 **A. Yes.**

15 Q. All right. Some evidence was presented
16 against you.

17 **A. Yes.**

18 Q. Is that correct?

19 **A. Uh-huh. (Nods head.)**

20 Q. Okay. As I read this, you appeared at
21 the hearing and proceeded pro se, meaning without
22 counsel.

23 **A. Yes.**

24 Q. All right. And then during the course of
25 that hearing, you admitted to all the allegations

1 that were outlined in this final order; is that
2 correct?

3 A. Yes.

4 Q. Okay. And so you didn't dispute the fact
5 that you had falsified your identity to obtain --

6 A. Correct.

7 Q. -- drugs; right?

8 A. Correct.

9 Q. All right. And that you became addicted
10 to the drugs, which eventually led to your
11 arrest; right?

12 A. Correct.

13 Q. And that the criminal charges against
14 you, I think, were sent to the Georgetown County
15 Solicitor; is that right?

16 A. Yes.

17 Q. Okay. And in lieu of doing any sort of
18 jail time or having any sort of fine, it appears
19 that you did a pretrial intervention program?

20 A. Yes.

21 Q. Okay. Which consisted of what?

22 A. Monitoring, community service. I believe
23 part of it was attendance of meetings of
24 recovery. Urine drug monitoring, if I wasn't
25 clear about that. Meeting with counselor. That

1 IN THE COURT OF COMMON PLEAS
2 FOR THE STATE OF SOUTH CAROLINA
3 GEORGETOWN COUNTY

4 VIDEOTAPE DEPOSITION OF BRUCE P. BAILEY

5 NADENE HOLLIDAY, Individually and as Personal
6 Representative of the ESTATE OF DAVID HOLLIDAY,

7 Plaintiff,

8 vs. CASE NO. 2012-CP-22-1004

9 WACCAMAW COMMUNITY HOSPITAL; KENT M. MCGINLEY,
10 MD; WINYAH SURGICAL SPECIALISTS, PA; AND ANTHONY
11 H. DEHAAS, MD; and MATTHEW J. METZ, MD,

Defendants.

12 DEPONENT: BRUCE P. BAILEY

13 DATE: AUGUST 28, 2014

14 TIME: 2:32 P.M.

15 LOCATION: GEORGETOWN MEMORIAL HOSPITAL
16 GEORGETOWN, SOUTH CAROLINA

17 REPORTED BY: RONDA K. BLANTON, RPR
18 NCRA REGISTERED PROFESSIONAL
19 REPORTER
20 CLARK & ASSOCIATES, INC.
21 P.O. BOX 73129
22 CHARLESTON, SC 29415
23 843-762-6294
24 office@clark-associates.com
25 WWW.CLARK-ASSOCIATES.COM

1 feeling of imminent harm to a patient. I
2 could -- I would have the authority in
3 conjunction with the Chief of Staff to recommend
4 to the Board immediate summary suspension if
5 there is a feeling of immediate threat of harm to
6 staff or patients.

7 Q. And is that outlined somewhere, that --
8 that recommendation responsibility?

9 A: Yes. I think it's in the medical staff
10 bylaws, not the corporate bylaws.

11 Q. Have you ever seen that authority
12 exercised as it's outlined in Section 5?

13 A. Oh, this? (Indicating.) I have not
14 witnessed the Board taking any action on a
15 medical staff member contrary to what's been
16 recommended by the medical staff.

17 Q. Did the Board ever consider terminating
18 Dr. McGinley?

19 A. No.

20 Q. Why not?

21 A. He was never brought to them for
22 consideration of that.

23 Q. What does that mean?

24 A: There was never any medical staff action
25 that was taken regarding Dr. McGinley that would

1 have been reported to the Board for them to act
2 on. He was granted a leave of absence.

3 Q. Is there a separate credentialing
4 committee in place for each of the hospitals?

5 A. Yes.

6 Q. And I may have asked you this; and if I
7 did, I apologize. But in your position as CEO,
8 you don't take any role in the credentialing
9 process, or do you?

10 A. I -- I or one of my designees will sit
11 in on it. We do not review the -- we do not take
12 actions on the applications. Only the physicians
13 do.

14 Q. I'm next going to hand you what's been
15 marked as Exhibit 3.

16 (Plaintiff's Exhibit No. 3 was marked
17 for identification.)

18 Q. Can you identify that for me?

19 A. The affidavit of Bruce P. Bailey.

20 Q. All right. Will you turn to the second
21 page for me.

22 A. (Complies with request.)

23 Q. Is that your signature?

24 A. Yes, sir.

25 Q. All right; And without going into all

1 Q. That was ultimately passed out to the
2 Board of Trustees for approval?

3 A. Yes.

4 Q. And that approval was made by the Board
5 of Trustees to allow him to come back to work?

6 A. Yes.

7 Q. How was Dr. McGinley's competence
8 evaluated when his privileges were reinstated
9 following the suspension of his license?

10 A. He was -- he -- he requested leave of
11 absence so his clinical privileges and competence
12 were never in question by the credentials
13 committee. So the question was: Was his illness
14 resolved?

15 Q. And was a determination made on that
16 piece?

17 A. Yes. The discharge of him from the
18 treatment center as well as the agreement to --
19 with the RPP indicated to -- this is my
20 paraphrasing -- to the credentials committee that
21 the illness that required him to go on leave of
22 absence had been resolved, and he'd been released
23 to come back to practice.

24 Q. So his competence was never reevaluated
25 after he went through the rehabilitation process?

STATE OF SOUTH CAROLINA) IN THE COURT OF COMMON PLEAS

COUNTY OF GEORGETOWN) 2012-CP-22-1004

Nadene Holliday, Individually and)
as Personal Representative of the)
Estate of David Holliday,)

Plaintiff,)

Transcript of Record

vs.)

Waccamaw Community Hospital,)
et al.,)

January 12-13, 2015

Defendants.)

B E F O R E :

Honorable Diane Schafer Goodstein
Georgetown County Courthouse
Georgetown, South Carolina

A P P E A R A N C E S:

Richard S. Rosen, Esquire
Andrew D. Gowdown, Esquire
Elizabeth J. Palmer, Esquire
Attorneys for Plaintiff

John B. McCutcheon, Jr., Esquire
Lisa Arlene Thomas, Esquire
Attorney for Defendant,
Kent H. McGinley

William W. Doar, Jr., Esquire
Attorney for Defendant,
Waccamaw Community Hospital

Grace L. Hurley, CVR-CM-M
Circuit Court Reporter

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E X H I B I T S

C-1 Plaintiff's Answers to Waccamaw Community Hospital's
Request to Admit

1 (On the record, January 12, 2015. The following takes
2 place outside the presence of the jury panel.

3 THE COURT: Yes, Mr. Doar.

4 MR. DOAR: Your Honor, as I indicated, if this is the
5 appropriate time, I do have a couple of matters that I would
6 like to call to your attention.

7 Number one, I represent Waccamaw Community Hospital, and
8 they are a charitable organization, and the Plaintiffs have --
9 we -- I served Requests to Admit on the Plaintiffs, and I've
10 shown this to Mr. Gowdown, and I'd like to have this as a part
11 of the record, their admission of the, of the -- because we do
12 -- I have an exemption under that, under that statute.

13 THE COURT: Okay.

14 MR. DOAR: The other thing, Your Honor, is that I was,
15 please -- I, I was kind of -- didn't think we would finish
16 this case any -- in a week at all, and I was kind of amused by
17 Mr. Rosen's statement. I hope I'm -- anyway, initially this
18 case had four Defendants, and before the other two Defendants
19 were dismissed by the Plaintiff in the case, my expert witness
20 is from Wisconsin, and I had made arrangements with him, he
21 had a number of business commitments, and I had made
22 arrangements of him to come in on Thursday night and to
23 testify on Friday, and I had notified everybody about that,
24 and I still, that is still the schedule, that I would
25 certainly like to call the witness on Friday. Mr. Bruce

1 Bailey, who is also back here, he has -- he's the CEO of --
2 well, actually Georgetown Hospital System, but he also has a
3 pretty good schedule, and we were hoping to get his testimony
4 in this afternoon, but I don't know if -- what the Plaintiff's
5 ideas on that are. If he has to be here tomorrow, he can be
6 here tomorrow, but toward the end of the week he's going out
7 of the country. So we would, of course, like to get his, his
8 testimony in at, at, at that time.

9 THE COURT: Got you. Got you. So let's -- this -- let
10 me ask about, first of all about the charitable immunity
11 status of the Defendant Hospital. Any comment about that
12 other than okay?

13 MR. GOWDOWN: Your Honor, Andrew Gowdown. No, we have
14 no, no issue with that. We did admit the Requests to Admit.
15 We understand they're a charitable organization. So we don't
16 dispute that.

17 THE COURT: Got it. Got it. All right. And then with
18 regards to the scheduling?

19 MR. GOWDOWN: As I indicated to Mr. Doar previously, we
20 have no problem taking Mr. Schmidt out of line if we need to
21 if we're not done by that time. I think that we will be on --
22 by Friday, but to the extent we're not we have no objection to
23 that.

24 THE COURT: Okay. In other words, you don't want to call
25 him this afternoon. You want to call him -- you'll call him

1 before he goes out of town, but you would rather have an
2 opportunity to sort of place him in your case where, where
3 it'll be the least --

4 MR. GOWDOWN: Well, Your Honor, Mr. Schmidt's the one in
5 Wisconsin.

6 THE COURT: I'm sorry. Got it. Got it.

7 MR. GOWDOWN: That's okay, but Mr. Bailey, we would like
8 to start with today.

9 THE COURT: Oh, you do want to go ahead.

10 MR. GOWDOWN: Yes, Your Honor.

11 THE COURT: Okay. Okay. We're going to have to see. I
12 just don't know how long it's going to take us to, to get our
13 jury qualified and to get your openings. So we'll just have
14 to see.

15 MR. DOAR: Yes. I understand that. I just wanted to let
16 the Court know what, what we were hoping.

17 THE COURT: Wonderful. Wonderful. Now, I probably
18 should have done this -- hold up, because I'm -- hold up.

19 MR. MCCUTCHEON: We have -- each one of us has a motion,
20 Your Honor, both.

21 THE COURT: I know, but I meant to start with what we
22 talked about in the hall just before we started this morning.
23 I actually think Judge Hyman was kind enough to bring it to
24 your attention, which I really like, because it gave you all a
25 minute to sort of contemplate it, and that is that really I

1 have a husband and his name's Arnold Goodstein, and Mr. Doar
2 knew him because they served in the senate together like a
3 little while ago. Right?

4 MR. DOAR: Yes, ma'am.

5 THE COURT: We're not going to talk about how long.

6 MR. DOAR: A while.

7 THE COURT: It was a little while.

8 MR. DOAR: Twenty years.

9 THE COURT: Yes, sir. And, and then he practiced law
10 with Mr. Rosen, gosh, I've been on the bench now for going on
11 16 years. So, what?

12 MR. ROSEN: Sixteen years.

13 THE COURT: Sixteen years ago for like a year, and, and
14 all that was disclosed, and Mr., Mr. McCutcheon and I have
15 this very recent experience because I had the opportunity to
16 referee between he and Skeets, which is like an amazing
17 experience, and so everybody -- all those disclosures were
18 made, and as I understand it, you all have had an opportunity
19 to talk to your clients about that, and I guess I'll look to
20 the Plaintiffs first. Right? Yes, yes, and yes?

21 MR. MCCUTCHEON: Yes, ma'am.

22 MR. GOWDOWN: Yes, Your Honor.

23 THE COURT: No problem?

24 MR. GOWDOWN: No.

25 MR. MCCUTCHEON: No problem.

1 MR. DOAR: No problem, Your Honor.

2 THE COURT: Very well, and I would like the record to
3 reflect that Mr. Doar refused to tell me any stories regarding
4 my spouse that occurred in the senate that -- and I only knew
5 him a very short period of time as he was concluding his
6 senate days. I think it would be okay to tell me since I
7 didn't even know him then, but Mr. Doar, being the gentleman
8 that he is, has refused to disclose anything, and I shall tell
9 my husband that and he will say, "Thank you, Bill."
10 Wonderful. All right. Now, Mr. McCutcheon, I'm listening.

11 MR. MCCUTCHEON: Now, Your Honor, I have a motion in
12 limine and Mr. Gowdown has one.

13 THE COURT: Okay.

14 MR. MCCUTCHEON: My motion in limine, if the Court
15 please, and I think my motion and my memo has been, has been
16 filed with the Court. So I'll not -- I'll try not to be too
17 long-winded, but I do need -- this is a very important aspect
18 of this case. We are moving in this case, Your Honor, to
19 exclude all testimony in this case regarding the arrest,
20 substance abuse, treatment, substance abuse, restriction of
21 privileges and modifications or suspensions of privilege, to
22 include direct evidence, or through expert testimony as to
23 Kent McGinley.

24 Now, in regards to that just a brief history. Kent
25 McGinley, who is Dr. McGinley, who's seated right here, is a

1 pathologist at Georgetown Memorial Hospital and Waccamaw
2 Community Hospital and has been for a good number of years.
3 In 2005, if the Court please, October 18th, 2005, he was
4 arrested due to substance abuse. On October 19th, 2005, he
5 requested a leave of absence from Georgetown Hospital. On
6 April the 4th, 2006, a temporary order was issued by the
7 Medical Board of the State of South Carolina in regards to
8 this. The final order was issued June 29th, 2006, and in that
9 final order, Your Honor, it has a long laundry list of things
10 that Dr. McGinley had to accomplish and had to do, which he
11 has done all of.

12 Now, Your Honor, the other Your Honor, Judge Hyman, has
13 already ruled on the issue of the arrest because Mr. McGinley
14 no longer has a criminal record because he participated in PTI
15 and his record has been expunged. So in regards to that, we
16 do, first of all, we need a clarification simply not using the
17 word arrest, but a lot of these documents refer to criminal
18 conduct or a criminal record, and we think that all of that
19 would be covered under this and should not be allowed.

20 Now, the basis, Your Honor, of going further and
21 excluding all of this testimony is that under certain rules
22 that we have cited in our brief they're not applicable in this
23 particular case, bearing in mind that the Plaintiff carries
24 the burden of proof in this case to establish the standard of
25 care, deviation from the standard of care, and they also have

1 to go further and establish the proximate cause.

2 Now, first of all, I would allude to the deposition of
3 the Plaintiff herself in this case who testified in her
4 deposition that she was not aware of any, of any information
5 ever, evidence or otherwise, that Dr. McGinley was impaired on
6 the day he read this slide. I point out to the Court that the
7 slide was read on July the 19th of 2007, which is approximately
8 18 months after that. There are no allegations in the second
9 amended complaint that alleges that Dr. McGinley was impaired
10 at the time he read this slide. I have -- in, in -- in none
11 of the depositions that have been taken in this case has
12 anybody testified to the fact that Dr. McGinley was impaired
13 when he read the slides in 2007. So, therefore, Your Honor,
14 it's the position of Dr. McGinley, pursuant to Rules 401, 402,
15 403, 404, South Carolina Code Sections 42-22-100, 43-53-140,
16 Federal Regulations 42-CFR, Section 264, and Federal Statute
17 42 USC 290dd-2, and in that regard, Your Honor, like I said,
18 the complaint and the complaint contains no allegations that
19 he was impaired or that this problem that he had in any way
20 affected his ability. There's no testimony to that. They
21 can't do it by innuendo. They can't do it by insinuation.
22 They've got to have somebody that's going to testify that he
23 was impaired at the time he read this slide, and they simply
24 do not have that, and on that -- and taking it further, Your
25 Honor, the -- in regards to Rule 404, which deals with

1 character, none of this fits within the parameters of that,
2 the probative value of prior bad acts, even if prior bad act
3 is clear and convincing and falls within an exception, it must
4 be excluded if its probative value is substantially outweighed
5 by the danger of unfair prejudice to the Defendant, and in my
6 opinion, Your Honor, the only -- the sole and only reason that
7 they're seeking to bring this information to the attention of
8 the jury is for the purpose of inflaming the passions of the
9 jury because they have no proof that he was impaired at the
10 time he read this slide. So, therefore, Your Honor, in
11 addition to having the clarification as to whether arrest also
12 includes criminal conduct or crime or that thing in that, we
13 would ask that all of that testimony involving what I have
14 just alluded to be excluded in this case.

15 THE COURT: I got it. Right. All right. Yes?

16 MS. PALMER: Good afternoon. My name's Beth Palmer, and
17 I will be responding to this motion in limine.

18 I earlier gave Ryan a copy of our memo in opposition to
19 this motion.

20 THE COURT: Yes. Yes.

21 MS. PALMER: And I actually meant to give a copy of our
22 motion in limine. So I'm going to give him that now and also
23 give -- Ryan, this was what I meant to give you.

24 MR. MCCUTCHEON: Is this something new?

25 MS. PALMER: Yes. This was filed earlier today.

1 You know, I think you need to take it a step back when you
2 look at what this evidence is. This is evidence of unethical
3 conduct. It's evidence of moral unfitness for the practice of
4 medicine, which is our contention, to be able, to be qualified
5 to be appointed to the medical staff of a hospital you have to
6 be morally fit of character and in matters of professional
7 ethics. That is the state regulation. The hospital's by-
8 laws, which we will bring out, also have many requirements as
9 to character and fitness of professional ethics. This
10 evidence is directly relevant to that. Our cause of action
11 against the hospital is that it knew or should have known that
12 Dr. McGinley was not fit to practice medicine. He was not fit
13 to be a member of the medical staff. So in that regard, this
14 evidence is directly relevant to that. It's relevant and it's
15 probative to the hospital's knowledge and then their
16 corresponding duty to act. So that's one, one way that we
17 believe that this evidence is relevant, is directly relevant
18 to the cause of action that the hospital was negligent in
19 appointing Dr. McGinley to their medical staff, and then once
20 they made that decision to reappoint him, by failing to
21 monitor him and properly ensure that he was rehabilitated.

22 THE COURT: Let me ask you this question. Tell me what
23 is -- first of all, you said let me take a step back, can I,
24 can I ask you to take another little step back for me?

25 MS. PALMER: Absolutely.

1 THE COURT: Because and explain to me a little bit about
2 what occurred. I read it very briefly, but do that for me,
3 please, and what, what are the allegations of proximate, you
4 know, the proximate cause of the injuries. So help me with
5 that a little bit.

6 MS. PALMER: I'd be happy to, Your Honor.

7 THE COURT: Yeah. Because remember, I just got here.

8 MS. PALMER: Yes. Dr. McGinley was arrested in October
9 2005 at the hospital. He was charged with three counts, two
10 counts or three counts, two counts of falsifying
11 identifications. He created false identities, then used those
12 identities to write himself prescriptions for narcotics
13 illegally. He did complete PTI, and those records were
14 expunged, the official records relating to the arrest. That's
15 an issue that Mr. McCutcheon brought up that we will address.
16 During his deposition, he testified that he had done this,
17 meaning falsifying identification to get prescription
18 narcotics, on up to 10 to 20 occasions previously. He
19 requested medical leave. The hospital never suspended him.
20 He requested medical leave. He came back to work in February
21 of '06, we believe, and then the medical board's order came
22 out in June of '06. It is our position that the hospital
23 failed to follow its own by-laws. It failed to consider these
24 acts, failed to take any measure to determine whether he was
25 competent and fit of character to return as a member of the

1 medical staff. This cause of action, negligent credentialing,
2 is the way it's been termed. It's essentially a negligent
3 supervision claim. It's a direct, direct duty owed to
4 patients. The hospital holds itself out as maintaining a
5 staff of highly qualified, ethical physicians. Our client
6 went to that emergency room. That slide that was read by the
7 pathologist, Dr. McGinley, she did not select Dr. McGinley.
8 She had no say in that. This is not a non-delegable duty type
9 of argument or anything like that. We're saying that the
10 hospital had a direct duty to its patients to follow its own
11 by-laws, to follow the state regulations that are there to
12 protect the safety of patients and properly screen those
13 physicians that it was going to appoint to its medical staff,
14 and that it failed to do so, evidence that it failed to do so,
15 what we're -- this evidence represents is what essentially
16 disqualified Dr. McGinley. He -- forgery, fraud, illegal
17 prescription writing, these are all things that the hospital
18 should have considered, not just the fact that he was -- had a
19 drug problem and sought rehabilitation therapy for that.
20 That's one part of it. The other part is his continuous
21 repetitive lying and forgery. That is directly relevant to
22 our cause of action against the hospital.

23 THE COURT: All right. And so tell me what happened to
24 the patient. See, I don't know any of that.

25 MS. PALMER: I apologize.

1 THE COURT: And what, and what -- and you said about the
2 slide?

3 MS. PALMER: Yes. Yes, Your Honor.

4 THE COURT: So what about the slide?

5 MS. PALMER: The -- our client had his gallbladder
6 removed at the hospital. A, Dr. McGinley read the slides
7 taken from that and misdiagnosed cancer. He failed to
8 diagnose the cancer, and for several years our client, who's
9 now deceased, it was not -- he didn't see a doctor. It wasn't
10 caught. It was finally caught I think in 2010, and it was too
11 late to do anything. So it's failure to diagnose is the cause
12 of action against Dr. McGinley. That's the medical negligence
13 claim, and then the separate claim against the hospital is
14 that they had a duty to screen their physicians to only
15 reappoint ethically competent and morally competent physicians
16 and that they failed to do so, and that if they had not
17 reappointed him, a competent pathologist would have read that
18 slide and would have caught it. We've got five experts, two
19 of which are Defendants, that all are going to testify that it
20 is plainly evident on that slide that there was cancer there.

21 MR. MCCUTCHEON: Your Honor, may I respond?

22 THE COURT: Absolutely. Yeah. But let me get a little
23 bit more and then you can. So let me ask you this question,
24 is it the position, and I'll just ask, because we have events
25 in '05. We have events in '06. We have the -- so other

1 than -- I gather that there's going to be the normal, if you
2 will, if it can be normal testimony, that the standard of care
3 is that a pathologist knew or should have known as you read
4 the slide that this was a slide that was presented to the
5 pathologist that would have been indicative of a malignant
6 condition or one that ought to be investigated as being
7 potentially malignant. Yes? Is that the position of the
8 Plaintiff?

9 MS. PALMER: And yes, Your Honor. In 2007 that --

10 THE COURT: Yes. Right. Because he presented to the
11 hospital in 2007.

12 MS. PALMER: Yes, Your Honor.

13 THE COURT: All right. And we've got events in 2005.
14 We've got events in 2006. Did -- it -- I gather the events in
15 2005 involved some drug abuse issues that resulted in some
16 arrests. Then we go to 2006 we've got the medical board
17 taking certain actions in '06. All right.

18 MS. PALMER: Yes, Your Honor.

19 THE COURT: So is it the position of the Plaintiff that
20 by virtue of these occurrences that -- that these occurrences
21 are circumstantial evidence that this particular doctor was,
22 was working or practicing under some impairment on the, on --
23 at the time that he actually opined regarding this particular
24 slide?

25 MS. PALMER: No, Your Honor.

1 THE COURT: Okay.

2 MS. PALMER: That is not, and I understand that is --
3 was Mr. McCutcheon's argument.

4 THE COURT: Okay. All right.

5 MS. PALMER: That there was an absence of evidence.
6 That's not our contention.

7 THE COURT: All right.

8 MS. PALMER: We believe that Dr. McGinley's past
9 behavior, these, these acts, this evidence that we're speaking
10 of, evidences recklessness. I believe it allows you to
11 question whether he even read the slide before he wrote this
12 report. He's got a history of forging medical documents. I
13 think this is very much something that the hospital should
14 have considered before they reappointed him to the medical
15 staff and what I think is important to remember is that these
16 acts, bad acts took place at the end of 2005. The Board's
17 order came out in June '06. It put him -- it suspended some
18 of his licensure privileges, put all these restrictions on him
19 for a period of five years. So at the point that he read our
20 client's slide that was only one year into this five-year
21 probationary period. That is temporally relevant, I believe.
22 It's not so far out in time that it's not something the
23 hospital should have continued to consider, and if they chose
24 to select him back, which they did, or reappoint him, to
25 continue monitoring him after that point, that the duty owed

1 by the hospital is somewhat dependent upon the severity of the
2 actions of the, of the physician.

3 THE COURT: So if you looked at the order, the June '06
4 order, and you looked at the restrictions that were placed
5 upon Dr. McGinley and then you looked a year later into '07 at
6 the time that he reviewed the, I gather the gallbladder
7 tissue, what, what nexus is there between the restrictions
8 placed in June of '06 and the review of the tissue in '07?

9 MS. PALMER: I'm not sure that there's -- the
10 restrictions placed by the Board are something to be
11 considered. When you look at the Board order there's a
12 litany, as Mr. McCutcheon said, a litany of findings, findings
13 that he was a threat to patient safety. Those are all things
14 that the hospital should have considered. If they had
15 properly considered them, he wouldn't have been reappointed.
16 We have found no evidence that they went through with their
17 peer review committee, their credentialing committee and
18 looked at all of this and reviewed it as they're required to
19 do both by state regulation and their own by-laws, and we
20 submit that if they had, if they had properly followed their
21 own procedures and state law, they wouldn't have reappointed
22 him. He would not have read that slide. Somebody else would
23 have, and they would have caught the cancer.

24 MR. MCCUTCHEON: If she's done I want to respond to what
25 she said.

1 MR. DOAR: Your Honor, I want to say something, too, as
2 well.

3 MR. MCCUTCHEON: You're going to get a chance. Are you
4 through?

5 MS. PALMER: Your Honor, would you like --

6 THE COURT: I have one more question, and then, then -- I
7 have one more question.

8 MR. MCCUTCHEON: Okay. Just let me know when.

9 THE COURT: I'm going to say go and then, then you can
10 go.

11 MR. MCCUTCHEON: Thank you.

12 THE COURT: So let me, let me give you an analogy. Let
13 me give you an analogy. Okay? Up until three years ago, if
14 you had a conviction for cocaine use, you lost your driver's
15 license for a period of time, and let's presume that we're
16 back several years ago and somebody is convicted of cocaine
17 use, possession of cocaine, and their driver's license is
18 revoked, but they ignore that, but they drive the automobile.
19 They're driving an automobile and there's an accident, and the
20 basis of the, of the Plaintiff's cause of action against that
21 Defendant is you should never have been on the road. You just
22 shouldn't have been on the road. If you hadn't been on the
23 road, this accident wouldn't have occurred. Is that, is that
24 proximate cause in that wreck case?

25 MS. PALMER: I'm not sure that that's --

1 THE COURT: And why isn't that analogous to this, I
2 guess, would be my question because I'm afraid what I'm
3 hearing is that there's nothing, there's nothing to connect
4 either what was restricted by the medical board or there's no
5 indication that there was any drug abuse going on at this
6 period of time and, and so that, that the cause of action
7 basically is he shouldn't have been driving.

8 MS. PALMER: Your example, I think more analogous --

9 THE COURT: Okay.

10 MS. PALMER: -- example, using your example situation
11 would be --

12 THE COURT: Give me another one.

13 MS. PALMER: -- would be a person that gets arrested for
14 cocaine, goes to the DMV to renew the license. The DMV is
15 supposed to look at their rap sheet to make sure that they are
16 qualified to get the license. The DMV falls short on their
17 job, gives the person a license, they go out, kill someone and
18 then that person sues the DMV for failing to do what it was
19 required by law to do. I know you can't sue the DMV in that
20 respect, but that would be I think a more analogous example
21 that correlates to what we, what we are claiming here.

22 THE COURT: Well, okay. But what if there isn't any
23 evidence other than the person was on the road? In other
24 words, there's no, there's no evidence of proximate -- there's
25 nothing -- there's no proximate cause for the Plaintiff to

1 allege against the Defendant other than you shouldn't have
2 been there. Let me give you a better example here because
3 this is actually happening all the time. People who are
4 undocumented immigrants are getting driver's licenses and
5 they're driving and they're having accidents, and must you
6 still show that there is proximate cause to cause the
7 accident, in other words you did something wrong in your
8 driving, or, or is it sufficient to say you shouldn't have
9 gone, you shouldn't have obtained a driver's license? You
10 shouldn't have been on the road because you didn't have a
11 valid driver's license.

12 MS. PALMER: And I understand that completely, and I
13 think what we're -- this, this is -- started out as a motion
14 concerning the evidence, and what we've moved to is discussing
15 the recognition of this cause of action.

16 THE COURT: Do what now?

17 MS. PALMER: And which is something we would like the
18 opportunity to address. We were preparing a memo for you.

19 THE COURT: Uh-huh.

20 MS. PALMER: This is something that we had prepared for
21 --

22 THE COURT: Sure.

23 MS. PALMER: But we can get that together for you, and we
24 have lots of case law from around the country discussing this.

25 THE COURT: Uh-huh.

1 MS. PALMER: It's been implicitly recognized by our
2 courts so far.

3 THE COURT: Because you know we don't do res ispa in
4 South Carolina. We don't do that.

5 MS. PALMER: I understand that, and you know, going back
6 to your issue of proximate cause, we know that is if there's
7 any evidence that it is an issue for the jury, we believe that
8 there's enough evidence to show that there's a pattern and
9 practice of Mr. -- Dr. McGinley's carelessness, his --

10 THE COURT: Well, I need to know about that. Tell me
11 about that. What do you have?

12 MS. PALMER: It's this evidence, the fact that he up to
13 20 times forged identities to write illegal prescriptions,
14 that, that is evidence that someone is not fit of character to
15 practice medicine in this state. Even if you take -- the
16 medical board serves one purpose of deciding whether or not
17 someone can be licensed in our state. Above and beyond that,
18 a governing board of a hospital is required by law to look
19 beyond and say, "Are they -- are they competent? Are they
20 ethical? Are they worthy of character?" All of these things
21 are imposed upon the hospital above and beyond. Licensure is
22 just one thing to be considered by the board, by a hospital in
23 determining whether or not to credential someone, the reason
24 being is that they hold themselves out to the public as
25 Waccamaw on its website, "We hire only the most qualified

1 physicians." They have a duty to fulfill when they are going
2 through and selecting their physicians. When they fall short
3 on that the public gets hurt. The public, our client got
4 hurt. We believe that there is enough evidence that a jury
5 could conclude, and that they will conclude that Dr. McGinley
6 should never have been practicing medicine. It's a but for
7 causation.

8 THE COURT: Okay. Got it.

9 MS. PALMER: Thank you.

10 THE COURT: Go.

11 MR. MCCUTCHEON: Thank you, ma'am. Thank you, ma'am.

12 First of all, Your Honor --

13 THE COURT: I got to stop you because here's where my
14 head is right now. Let me ask you this question. Is there
15 different issue regarding proximate cause vis-a-vis the
16 hospital as opposed to the doctor specifically?

17 MR. MCCUTCHEON: There would be, Your Honor, but in this
18 case, and I'll speak for Mr. Doar somewhat before he gets up,
19 this state does not --

20 THE COURT: He says, "No, don't do that. Don't do that."

21 MR. MCCUTCHEON: This state does not recognize a cause of
22 action for negligent credentialing.

23 THE COURT: Okay.

24 MR. MCCUTCHEON: So, therefore, ergo, it doesn't matter.

25 THE COURT: Okay. Okay.

1 MR. MCCUTCHEON: But there is, there's a -- there would
2 be a different standard assuming that our state recognizes
3 one, but it doesn't, and so in addition to that, there is a
4 complete failure, if, if not on the issue of what the standard
5 of care is, I have not heard her say one thing about any proof
6 that they have that Dr. McGinley on June, on July the 19th of
7 2007 was impaired nor not practicing medicine. It's proximate
8 cause pure and simple. They don't have it. It's an
9 unwarranted, it's an unwarranted character assassination
10 because they do know that the Board had this long laundry list
11 of stuff that Dr. McGinley had to do and he did every stick of
12 it, and his, and the Board in 2011 released him from all of
13 his recommendations, the recommendations that they had, and
14 they -- and he continues voluntarily to self monitor himself
15 so he doesn't get back. They have no evidence, Your Honor,
16 none, that on July the 19th of 2007 he was impaired. What
17 we've got, Your Honor, is a medical negligence case, pure and
18 simple. They claim he didn't read the slide right. That's
19 it. That's a medical negligence case, and I, and I don't
20 think they ought to be allowed to go into this stuff, and the
21 other problem we're going to have, Your Honor, is if it is
22 then we've got another problem because you can't undo, the
23 horse is already out of the barn if we have to go forward if
24 they're going to proceed with that cause of action against the
25 hospital because we're prejudiced beyond any amount of things.

1 So I don't know what we do from there.

2 THE COURT: Okay.

3 MR. DOAR: Your Honor, I don't know if you want to hear
4 from me, but I'm, I'm anxious.

5 THE COURT: Oh, yes.

6 MR. DOAR: I'm anxious.

7 THE COURT: Absolutely. Of course.

8 MR. DOAR: Your Honor, I would like to pick up on what
9 you said is there a nexus between these two events, and I
10 submit to you there is no nexus. Proximate cause, they cannot
11 prove in this case.

12 I'd like to kind of allude to a few more of the facts if
13 I might. First and foremost, she says something about
14 credentialing. Well, they've never seen the credentialing
15 file because the credentialing of a physician is privileged
16 under the, under the, under the law. So, they've never seen
17 what was considered or was not considered by the credentialing
18 committee at Waccamaw Hospital. There is absolutely no
19 evidence whatsoever that Dr. McGinley was impaired after he
20 was discharged from Talbott Recovery Center in February of
21 2006. Since that time he has been -- he's not fallen off the
22 wagon. He's been on the straight and narrow. At that time
23 when he was discharged from Talbott, which is in Atlanta,
24 Georgia -- he was there, I believe for something like 15 weeks
25 in an inpatient treatment. When he got out of there, they

1 recommended, they, Talbott, recommended that Dr. McGinley go
2 back to work. Okay. The Board of Medical Examiners, which I
3 understand is the highest governing board of physicians in the
4 State of South Carolina, they had his, Mr. McCutcheon has said
5 a whole laundry list of items that Dr. McGinley was required
6 to do for a period of five years, but one of the things they
7 said is return to work at the hospital as of February not to
8 work more than 40 hours a week. Now, the hospital didn't just
9 go out and accept that carte blanche. They entered into a
10 return to practice agreement with Dr. McGinley and that is
11 they did April. So from February they didn't take, they
12 didn't, he didn't go back to work in February. He went back
13 to work in April, and that agreement, and you will have and I
14 can provide that to you, they track pretty much what these
15 others, the Board of Medical Examiners and these other people
16 have said. So as I say to you, there's no evidence of any
17 impairment. The hospital did what they've -- and, and also
18 this professional -- I don't know if you're familiar with the
19 RPP, the Recovering Professionals Program, which is a part of
20 the State of South Carolina, they also monitored, they
21 monitored Dr. McGinley as did the wellness committee of the,
22 of the hospital and the peer review committee of the hospital.
23 So I submit to you that there is -- that the proximate cause
24 is not there. As I understand it, they have to prove but for,
25 and they also have to prove foreseeability, and it's no

1 evidence in this case whatsoever that Dr. McGinley had any
2 kind of prior malpractice problems, prior error problems, and
3 they -- it would certainly not be anything that the hospital
4 could foresee that he was going to have misread a slide, if he
5 did, in fact, misread the slide. So I submit to you that if
6 you grant their motion we are to be, I would certainly think
7 that the hospital should be removed and dismissed from the
8 action.

9 THE COURT: What about Mr. McCutcheon also argued South
10 Carolina does not recognize a negligent credentialing. Talk
11 to me about that.

12 MR. DOAR: Well, Your Honor, there's this case -- let me
13 see if I can pull it out right quick.

14 THE COURT: We'll find it if there's, you know, you're
15 saying there's a case on point that specifically says that
16 South Carolina does not recognize.

17 MR. DOAR: I tell you, we've got so much, so much
18 information in here.

19 THE COURT: Well.

20 MR. DOAR: It's the case of Strickland versus Madden.
21 It's a Court of Appeals case.

22 THE COURT: Right. Right.

23 MR. DOAR: And, I mean, it's -- here's what they say.
24 They say assuming that South Carolina would recognize the
25 doctrine of corporate, they call it corporate negligence, its

1 application would nonetheless require a standard of care to be
2 established for example pursuant to the National Hospital
3 Association, and there and they, and they ended up dismissing
4 the, the cause of action that I think in this case the doctor
5 was drunk and delivered a baby, if I, if I remember the case
6 correctly. It's, for your information, it's in, it's in 448
7 S.E.2d 581. South Carolina, I -- and, and with all due
8 respect to you, Your Honor, I don't think that the Court of
9 Common Pleas, as I understand it, can create new causes of
10 action. The Supreme Court would have to create a new cause of
11 action, and according to this case, Strickland versus Madden,
12 South Carolina has not recognized that corporate negligence
13 cause of action, and, and which would also involve the
14 credentialing matter. So I submit to you that we ought to be
15 out of this case, Your Honor, the hospital that is.

16 THE COURT: Okay. Okay. Yes. Yes, ma'am.

17 MS. PALMER: Thank you, Your Honor.

18 THE COURT: Yes, ma'am.

19 MS. PALMER: When you say that -- you say there's no
20 evidence that he was impaired, we agree with that to the
21 extent you're saying he wasn't -- there's no evidence he was
22 on drugs at the time he read that slide. We do believe his
23 judgment and his ethical capabilities were impaired at that
24 time, and that is --

25 THE COURT: Who testifies to that?

1 MS. PALMER: Well, our -- first of all, five experts are
2 going to say there's no way -- the cancer is right there. He
3 was careless.

4 THE COURT: Okay. All right.

5 MS. PALMER: There's evidence that he didn't even read
6 the slide himself. That's testimony that we will bring out.

7 THE COURT: All right. Now, okay, so tell me -- talk to
8 me about that.

9 MS. PALMER: At first he says he saw no cancer and now he
10 says, he says sees cancer. The report says there are no
11 gallstones in, right below it there are 200 gallstones. I
12 mean, that certainly calls into question his credibility and
13 whether or not he looked at that slide, whether or not he
14 truly did what he is supposed to do as a pathologist.

15 Now, the negligent credentialing, again, you know, we
16 would like to submit additional information for your
17 consideration. The Strickland court did hold that they
18 assumed that the State would recognize this cause of action
19 and then said but in this case there was no evidence to
20 establish standard of care, and they said typically something
21 like JCAHO National Hospital Standards or a hospital's by-
22 laws, that's why I have mentioned the by-laws. The by-laws
23 and the regulations, we believe, establish a standard of care.
24 If I may approach?

25 THE COURT: Uh-huh.

1 MS. PALMER: This is that summary judgment order from the
2 Person case that it was attached to one of our briefs and I
3 didn't realize we were getting to this phase, so.

4 MR. MCCUTCHEON: Summary judgment on what?

5 MS. PALMER: It was attached --

6 MS. THOMAS: It was attached to the order?

7 MS. PALMER: Yes, it is. It's attached to one of our
8 previous memos. I didn't realize we were getting to this
9 today or I would have given it to you. Your Honor, and this
10 is my copy. It's got some highlights on it.

11 THE COURT: Okay.

12 MS. PALMER: But if you would take a look at that. It --
13 the trial court, it recognized specifically this cause of
14 action saying that it is the public policy of the state to
15 protect patients, that hospitals have a duty when they hold
16 themselves out there as employing qualified physicians, and on
17 appeal it was dismissed because the -- it was appealed. Appeal
18 was dismissed as the post-trial motion not being timely filed.
19 So it was -- it has not been decided on appeal directly.

20 MR. MCCUTCHEON: Your Honor, I think Judge Baxley
21 declined to accept that cause of action.

22 THE COURT: Let me look at something else real quick, you
23 all. I need to see that case. Have you all got -- where is,
24 where is that, that case that you were just talking about?
25 The --

1 MR. DOAR: The Strickland case?

2 THE COURT: Yeah.

3 MR. DOAR: Yes, ma'am. I've got it.

4 THE COURT: I don't even have what time it is. Oh, boy.
5 We have like, I don't know, seven minutes for you all to get
6 lunch and for us to get lunch and then be ready to pick a
7 jury. Oh, goodie.

8 MR. DOAR: Well, Judge, if you'll indulge me just a
9 minute. I had it. I don't know what happened to it.

10 THE COURT: Oh, yeah. If you can give me -- if you all
11 can give me a cite I can -- I've got a whiz geek.

12 MR. DOAR: Here it is. I've got it. Now, I've, I've
13 marked a little bit on it. Is that all right?

14 THE COURT: I tell you, wait, you can just give it. I
15 hate -- don't -- I hate for you to take it out. Just give me
16 the cite on it, Mr. Doar, and I can just pull it right up.
17 I'm right where he can do that for me real quick.

18 MR. DOAR: Let's see, the cite, it's 448 S.E.2d 581.

19 LAW CLERK: Thank you.

20 THE COURT: Can I have your last complaint? Can you all
21 help me? Because this file is like really big. Have you all
22 got your -- it's the second amended complaint right here.
23 Isn't that the last one, is the second amended complaint?

24 MS. PALMER: Yes, Your Honor.

25 MR. GOWDOWN: Yes, ma'am.

1 THE COURT: Can we have -- can we hold it? I promise
2 we'll give it back, maybe. All right. I'm going to look at
3 the --

4 MS. PALMER: May I approach?

5 THE COURT: Absolutely. Thank you. Gosh, you all found
6 it so quick. Okay. I'll give it back. We'll give it back.

7 MS. PALMER: Ryan, this is our memo in support of our
8 motion to amend on the cause of action. Starting here it has
9 all the cites of the cases that we've been discussing.

10 MR. DOAR: Your Honor, what was that you were handing up?

11 MS. PALMER: Our memo in support of our motion to amend.
12 It's the filed copy. It has all the citations to the
13 regulations and the cases that we've discussed.

14 THE COURT: All right. This is what we're going to do.
15 I'm not prepared to rule at this moment on, on the motions in
16 limine. So I don't want, I don't want the, the difficulties
17 that the doctor had mentioned in opening.

18 Now, so that's that, and, and the reason is is that even
19 with the quality of argument, which has been extraordinary,
20 I'm not prepared to, to make a determination because I'm still
21 feeling as though I'm a little bit in a vacuum, and, and so
22 I'm, I'm going to have to hear some testimony. I'm -- we're
23 going to have to get in this case for me to comfortably do
24 that, but I don't -- in openings, though, I don't want anybody
25 talking about his conduct.

1 MS. PALMER: Your Honor, if I may offer another --
2 there's a second part to my argument that, that I didn't get
3 to. We, of course, as you've heard, we believe it's directly
4 relevant to the cause of action against the hospital. We also
5 believe that this testimony, this evidence of his forgery, his
6 falsification of documents, his illegal procurement of
7 narcotics, we believe that that is evidence that is probative
8 of his character under Rule 608. I know in the State v.
9 Wilder case, the Supreme Court reversed a trial court that
10 held preparation of false tax returns was not probative of a
11 witness's character. The Supreme Court said that was very
12 probative of a witness's character.

13 THE COURT: What was -- well, what was the underlying
14 cause of action though?

15 MS. PALMER: That was a criminal matter and it was to an
16 eyewitness, an eyewitness on the stand.

17 THE COURT: Was it a conviction?

18 MS. PALMER: No. I don't believe it was. This isn't
19 under the conviction, 609. It's under 608, just a specific
20 instance of conduct probative to character.

21 THE COURT: All right. Well, let's talk about character
22 because here's what happens with character. Character comes
23 into a case in one of two ways, one of three ways. First of
24 all, in a criminal case, if you are claiming self defense and
25 you are the aggressor, then it becomes -- you can bring in

1 character to talk about what was -- what did you know and what
2 was the character, what was the reputation for the victim?
3 The victim was a very violent person. Of course then you can
4 cross examine with regards to specific instances. On cross
5 examination, okay, but you have to -- make the allegations
6 with regards to the victim in terms of reputation and opinion.
7 So move that aside. That's not what we're talking about.
8 When you, when you are inquiring with regards to normal and --
9 a normal and typical case, here's the way that it works. One
10 of two things has to happen. Number one, it has to be an
11 element of the underlying cause of action. This is not an
12 element of the underlying cause of action with regards to
13 malpractice. I mean, he could be a magnificent, wonderful,
14 terrific, you know, ready to be declared, you know, canonized
15 and still commit malpractice. So it's got nothing to do with
16 the underlying cause of action, malpractice. So, so it isn't
17 only the cause of action for malpractice. So the question
18 then gets to be with regards to the malpractice if somebody
19 was then to say, "Oh, this is like the greatest guy ever,"
20 then, then you could certainly cross examine with regards to
21 specific acts. That's a cross examination, specific acts.

22 Now, with regards to a character trait being part of the
23 underlying causes of action it can be proved by reputation or
24 opinion or by specific acts. Now, when you are cross
25 examining someone on the issue of truthfulness and a lack

1 thereof, then, then you can question someone with regards to
2 whether or not the truth, on the issue of truthfulness or lack
3 thereof. You can call into question character, but that's
4 when you get into convictions for crimes involving dishonesty
5 or crimes punishable by longer than a year. So I'm not quite
6 sure where you are, and of course, you know, the 404 stuff
7 comes in no matter what. I mean, it comes in. Obviously,
8 it's flipped if it's a criminal matter opposed to a civil
9 matter, but, but we'd have to talk about that. We'd have to
10 talk about, and one of the issues is is that the most that you
11 have, the most that you have is specific acts because you
12 don't have any convictions, you have the most that you would
13 have would be specific act, not -- ooh, Mr. Doar, you're
14 standing up, and when you stand up what I'm trying to ignore
15 the fact that the alleged cause of action against the hospital
16 potentially involves that. I'm trying to ignore you right now
17 because you're exact, it may, it may. It may be. It probably
18 is, maybe, maybe comes in, in --

19 MR. DOAR: Your Honor, I was just going to, I was just
20 going to --'

21 THE COURT: -- that cause of action that I'm still trying
22 to figure out if there is one.

23 MR. DOAR: They have, they have alleged against the
24 hospital failure to provide Mr. Holliday with a pathologist
25 that was competent in the field of pathology, failing to

1 independently monitor the Defendant McGinley, failing to
2 revoke Defendant's McGinley hospital privileges and in
3 reappointing and continuing to contract with his -- he's an
4 independent contractor.

5 THE COURT: See, here's, here's what just happened.

6 MR. DOAR: But what -- I'm looking for some instruction
7 from you, Your Honor, as to what I can say.

8 THE COURT: I know. I knew, I knew, I knew you were
9 going to jump up. I know because I'm still dealing with you
10 because here's what you just talked about. The first
11 allegation where it talks about, the first one that you just
12 read is trying to establish that there exists a duty between
13 the hospital and the patient for good and safe medical care,
14 which even though he's an independent contractor they would
15 argue is a non-delegable duty of the hospital. That's where
16 it starts to get you in, the hospital, you got a duty to the
17 patient, you in. You see what I'm saying? Under this, the
18 Strickland case, and you all have got me dancing in new, like
19 in new territory. I don't like dancing in new territory, but
20 that's where I am, but there has to be a duty even if there's
21 an injury, doesn't matter if you don't have a duty. So you've
22 got to have a duty. That's what that first allegation alleged
23 that you had a duty. Right? Right. So once you have a duty
24 the way they hook you in is to say you've got a duty, you knew
25 or should have known that this person shouldn't have been,

1 that this, this pathologist wasn't the one that should have
2 been on the job, negligent hiring.

3 MR. DOAR: Well, that's, that's like saying, Your Honor,
4 if he wasn't born the accident would never have happened. I
5 mean, they've got to prove proximate cause as well.

6 THE COURT: No. That's why they made their first
7 allegation because they've given you that duty. That's where
8 we're into the Strickland and kind of never never land a
9 little bit. You see what I'm saying? Because the question --
10 because we don't have -- the Strickland case is trying to take
11 corporate negligence and drag it into the medical field.
12 That's what's happening, and the question is is it there or is
13 it not there? The only way it gets there is if there is a
14 duty of care that the hospital owes to the patient to be sure
15 that they are hiring physicians that ought to be hired or as,
16 I mean, quite frankly. I mean, I don't want to go beyond
17 that.

18 MR. DOAR: Board certified pathologist having practiced
19 since 1996, I mean, I don't know how you get any, any better
20 than that.

21 THE COURT: I know. I know. I know.

22 MR. DOAR: But what I'm saying --

23 THE COURT: Your position is it doesn't exist. We do not
24 have it.

25 MR. DOAR: If I get, in my opening statement if I start

1 talking about independently monitoring and that failing to
2 revoke hospital privileges and all that, does that conflict
3 with your --

4 THE COURT: Mr. Doar, that's why I was trying to ignore
5 you because then, I mean, I think, unfortunately, I've got to
6 make a determination about whether or not there's a cause of
7 action that ought to go forward or not. Okay? I mean, I
8 think that has to happen. I was trying to ignore you for a
9 little bit, but I knew you was going to stop and say, "Wait a
10 minute. I got to know whether there's a cause of action or
11 not because what do I tell this jury? What do they tell the
12 jury? Because if there's not a cause of action then we ought
13 not to talk about it, but if there is, then I need to be
14 prepared." Right?

15 MR. DOAR: Yes, ma'am.

16 THE COURT: I'm so excited you did that, Mr. Doar.

17 MR. MCCUTCHEON: Can I say one more thing, Your Honor?

18 THE COURT: No. I'm just picking on you, Mr. McCutcheon.

19 MR. MCCUTCHEON: The problem, the problem is, Your Honor
20 --

21 THE COURT: Yeah.

22 MR. MCCUTCHEON: -- it's not a threshold problem. It's
23 a, it's a proof problem in this particular case.

24 MS. PALMER: Well, we haven't been there.

25 MR. MCCUTCHEON: It's a proof problem. They can't prove

1 proximate cause.

2 THE COURT: There's a -- whoop, whoop.

3 MR. MCCUTCHEON: Huh?

4 THE COURT: There's a difference. Proximate cause for --
5 assuming arguendo.

6 MR. MCCUTCHEON: Yeah.

7 THE COURT: Assuming arguendo.

8 MR. MCCUTCHEON: That all of this stuff they say is true
9 they can't prove it. They can't prove that he was impaired
10 when he read the slide.

11 THE COURT: Let me -- hold on a second.

12 MR. MCCUTCHEON: Okay.

13 THE COURT: Because here's -- hold on a second because
14 here's what's going through my head. I think that proximate
15 cause could be couched in different terms in terms of the
16 hospital as opposed to the doctor. How about that? That's
17 what's going through my head. Let me, let me tell you why.
18 Can I just -- here's what's going through -- I'm a what -- I
19 should never let lawyers see the sausage being made.

20 MR. MCCUTCHEON: What about on my side?

21 THE COURT: You in better shape than the hospital if the
22 hospital's got a cause of action. Okay. Does that help you?
23 Does that make you feel any better?

24 MR. MCCUTCHEON: You'll -- excuse now -- excuse me?
25 Excuse me?

1 THE COURT: Huh? I think -- I think that the -- I think
2 the proximate cause is in bigger trouble with the -- your,
3 your doc. Sir, I'm scared to death. I'm from Dillon. I'm
4 going to mispronounce your name, and I'm just scared to death
5 I'm going to do it. So please excuse me if I call you the
6 doctor. So please accept that because I'd rather do that than
7 mess up your name because I hate it, unless you want to call
8 me Goldstein and then we're even. So in any event, I think
9 it's a different issue for -- I just think it's a different
10 issue. I really do. I think it's a different issue maybe.
11 Now, let me tell you why. Can I tell you why?

12 MR. MCCUTCHEON: Yes, ma'am.

13 THE COURT: Let me tell you why. I got, and you know I
14 don't, I don't know what these -- I have no idea what these
15 experts are going to say, have no idea the extent to what, to
16 what they're going to do particularly because I haven't
17 looked. I just got here this morning at nine o'clock. Okay.
18 So I don't know, but, but go with me right here. Okay.
19 Arguendo, arguendo, I got five experts testifying, and those
20 five experts tell me that he no way, there's no way that a
21 duly qualified pathologist under any circumstances could have
22 looked at this slide and not seen the big C. It would be
23 inconceivable. Now, that's pretty strong. I never heard an
24 expert to testify that strong. You understand, but it could
25 happen.

1 MR. MCCUTCHEON: Well, it might now.

2 THE COURT: Well, see. I know. I know. That's why I
3 was telling you all --

4 MR. MCCUTCHEON: They might. They might now now that
5 they know what they got to do.

6 THE COURT: I'm -- well, I know. I know. I know. So
7 what if I hear that? What if, what if that is -- and let me
8 tell you why, and we go right through it. It is impossible.
9 A two-week medical student, look at it. It couldn't happen.
10 So then what do I, then what do I do? I'm less concerned,
11 less concerned, to be honest with you, about the substance
12 abuse issues than I am falsifying documents. Ah. Then does
13 that make that more relevant? I don't know. I don't know at
14 this point, and I'm not telling, I'm just telling you that's
15 -- you're watching the sausage being made and that's what's
16 going through my head. See what I'm saying?

17 MR. MCCUTCHEON: Yeah, but the problem, the problem I'm
18 having with it, Your Honor --

19 THE COURT: I know what your problem is.

20 MR. MCCUTCHEON: -- my --

21 THE COURT: What does that do to proximate cause for the
22 abuse and the impairment of my doctor on that occasion?
23 Right?

24 MR. MCCUTCHEON: Well, suppose, suppose, suppose after
25 you hear all of this testimony and this jury over here hears

1 about my guy's stuff --

2 THE COURT: Right.

3 MR. MCCUTCHEON: -- then they're poisoned.

4 THE COURT: Oh, no. I, I can -- I limit those, give them
5 a limited instruction.

6 MR. MCCUTCHEON: Your Honor, come on. I hate to argue
7 with Your Honor, but somebody talking about substance abuse
8 simply because you're going to tell them you can't consider
9 that against the doctor?

10 THE COURT: Oh, you don't, you --

11 MR. MCCUTCHEON: No.

12 THE COURT: -- you're concerned that this jury wouldn't
13 follow that? Oh, Mr. McCutcheon.

14 MR. MCCUTCHEON: No. I don't think so, Your Honor, and
15 I'd, you know, and the problem -- if you've got a problem one
16 with the other --

17 THE COURT: Yes. Yes.

18 MR. MCCUTCHEON: -- the problem I'm having is and maybe I
19 need to move to bifurcate this trial.

20 THE COURT: Well, you're not there yet. So hold up.

21 MR. MCCUTCHEON: Okay.

22 THE COURT: I mean, you're just not there yet.

23 MR. MCCUTCHEON: All right.

24 THE COURT: I'm sharing with you -- I'm sharing with you
25 why I am concerned. Here's -- let me just tell you what's

1 going to happen. Here's what's going to happen. In my mind
2 the determination that we really got to get to this afternoon,
3 first of all I want to get -- I would like to get a jury, and
4 I hate, I hate keeping juries waiting. I just I don't like
5 doing that. So I'd like to get the jury and then we have to
6 continue. I have, I have concerns about two issues, two
7 issues. Is there a cause of action against the hospital,
8 which begins with the question is there a duty, there is -- if
9 there is some language in the Strickland versus Madden case
10 from the Court of Appeals that I have to look at and really
11 give some thought to, and I think that has, that has to be
12 determined before you all make opening statements. Sorry, but
13 it has to. It just does. Doesn't it, Mr. Doar?

14 MR. MCCUTCHEON: Your Honor, might, might I make a
15 suggestion?

16 THE COURT: Yeah.

17 MR. MCCUTCHEON: And let's go ahead and draw the jury.

18 THE COURT: Right, and then send them home and start in
19 the morning.

20 MR. MCCUTCHEON: Because if, if, if these, if these
21 issues aren't ruled on prior to us getting up even for our
22 opening statements --

23 THE COURT: I know. I know.

24 MR. MCCUTCHEON: -- we're, we're not -- okay.

25 THE COURT: I know. That's -- you all are so jumpy.

1 Yes. That was going to be my -- let's pick our jury and let's
2 finish this afternoon and let's start in the morning --

3 MR. MCCUTCHEON: Thank you.

4 THE COURT: -- because I think Mr. Doar -- he's -- he'll
5 be -- it'll all be a sweet memory when he's in Costa Rica.
6 He'll be fine. You know, it's like it was an awful week. It
7 just makes this Mai Tai better. Okay? Chill. So in the
8 event -- the appropriate thing to do so that we don't mess up
9 this trial is to let's pick our jury, let us finish the work
10 that we must do and we're going to get to it because I have to
11 just -- you have to know if there's a cause of action. You
12 can't have an opening unless you are clear about whether
13 there's a cause of action, Mr. Doar. It's impossible. You
14 have to know -- I'm, I'm a little less -- if there's not a
15 cause of action then I can hold off on any mention -- I've got
16 wiggle room, but you can't have it come out in opening without
17 at least affording the opportunity to know that, I don't
18 think. I don't think it's fair, and you guys need to know
19 where you all are.

20 MR. GOWDOWN: Yes.

21 MS. PALMER: Absolutely, Your Honor.

22 THE COURT: But the two issues that I am concerned about
23 is I am looking for authority with regards to the duty of the
24 hospital on credentialing, corporate negligence, if you will,
25 on hospitals, duty, it's duty, it's duty because the case says

1 it doesn't matter, even if the injury is foreseeable if
2 there's no duty. Looking for duty. Looking for duty. Is
3 this a non-delegable duty of a hospital? Because it's --
4 we've got an independent contractor. Is this a non-delegable
5 duty? It meets the definition, but I'm looking for a case,
6 and I'd like it -- I'd love it to be from the South Carolina
7 Supreme Court. We may not have one of those.

8 MS. PALMER: We can get you one from almost every other
9 Supreme Court in this country.

10 THE COURT: Well that's, that's something.

11 MS. PALMER: And the memo that I handed up a minute ago
12 to Ryan, the memo that was in support of our motion to amend,
13 that does contain a good bit. We have some -- I'm going to
14 supplement that and give you some additional authority as well
15 if Your Honor would accept it.

16 THE COURT: Well, sure.

17 MS. PALMER: Okay. It'll take me a bit.

18 THE COURT: But I kind of need to do it this afternoon.

19 MS. PALMER: I understand.

20 THE COURT: You know, and I don't care about -- I don't
21 -- I am not -- care about the stuff being formal. That's just
22 not my deal.

23 MS. PALMER: I can send you a string cite.

24 THE COURT: I'd rather have the information than how it
25 looks.

1 MS. PALMER: Okay.

2 THE COURT: That's not my deal. So all right. The plan
3 this afternoon is let's get a jury, yes, and, and, and then
4 I'm going to send them away and then we'll finish, and we'll
5 do what we need to do. Okay. Okay. Okay. Plan? Plan.

6 MS. PALMER: Thank you, Your Honor.

7 THE COURT: Now, where is the short -- I love this. I
8 need my short non-argumentative statement of the facts. Have
9 you all got one that you've agreed on?

10 MS. PALMER: Yes. I think.

11 THE COURT: Would you like to call Mr. Bellamy to help
12 you do that, Mr. McCutcheon?

13 MR. MCCUTCHEON: I'm, I'm sure Mr., Mr. Bellamy and I
14 could --

15 THE COURT: Yes. Spend the rest of the day.

16 MR. MCCUTCHEON: Your Honor, what I would suggest that
17 you do is, I've got one in my pretrial brief, they've got one
18 in theirs. Why don't you pick which one you want to read?

19 THE COURT: Okay. See, you all --

20 MS. PALMER: Your Honor, I would just put -- we do have
21 a pending motion in limine, but we can handle that.

22 THE COURT: And what is your pending motion? You have
23 another one?

24 MS. PALMER: We have our -- this was Mr. McCutcheon's
25 motion in limine that we've been arguing. We have one as to

1 some distinct evidence issues, but I know the jury's waiting.

2 THE COURT: They have -- I know. Do they have to do with
3 the --

4 MS. PALMER: No, Your Honor.

5 MR. MCCUTCHEON: No.

6 THE COURT: It's some --

7 MS. PALMER: It's certain testimony, certain -- a
8 document or two. It's, it's, it's simple. It's specific.

9 THE COURT: Oh, yeah, yeah, yeah. Oh, that'll be like,
10 that'll be like the amuse-bouche. That'll be like the
11 refresher in between.

12 MS. PALMER: To cleanse your palate from this, yes.

13 THE COURT: I love it. It'll be wonderful. I look
14 forward to it. We -- we'll be -- any problem to us handling
15 that after we get our jury?

16 MS. PALMER: Not at all.

17 THE COURT: Bless your heart. Wonderful.

18 (Voir dire requests discussed, voir dire and jury
19 selection takes place.)

20 THE COURT: Counsel, unless you all have a great
21 objection I would like to have your documents, your case law,
22 what I need to review tonight, and I'd like to review it. I'm
23 a little bit tired. I'd rather do that and be fresh in the
24 morning at nine, and, and argue if that's okay with you all
25 unless you all have great concerns about that.

1 MR. GOWDOWN: No, Your Honor. We have prepared our
2 memo. I'd be happy to hand it up tonight for --

3 THE COURT: Oh, wonderful.

4 MR. GOWDOWN: -- whenever you'd like to look at.

5 THE COURT: Perfect. I mean, you'll give one to Defense?

6 MR. GOWDOWN: And we did e-mail it to counsel.

7 THE COURT: Yeah.

8 MR. MCCUTCHEON: Your Honor, I -- well, I can find
9 another one in here.

10 THE COURT: I got them.

11 MR. MCCUTCHEON: Our memo, our memo's already been filed
12 in all that.

13 THE COURT: I got it. I'll get it and take it with me.
14 I just want to be sure that I have anything else that you
15 wanted to share with me. We got it, negligent credentialing
16 memorandum of authorities.

17 OFF THE RECORD

18 (On the record, January 13, 2015. The following takes
19 place outside the presence of the jury.)

20 THE COURT: Okay. We have a number of matters to handle
21 and how do you all want to do this? Do you all want -- how --
22 well, how do you -- Plaintiffs, how do you all want to do
23 this? How do you all want to drain the swamp this morning?
24 Do you want me to deal with what we dealt with yesterday and
25 then let you argue your motion that we really didn't get to

1 yesterday? How do you all want to, how do you all want to
2 proceed? Tell me that.

3 MR. ROSEN: Your Honor, I think we need to know the
4 answer to --

5 MS. PALMER: Yeah.

6 MR. ROSEN: -- what the case is going to be about.

7 THE COURT: I think so, too. I think so, too, and then
8 you want to just sort of get into those evidentiary issues?

9 MR. ROSEN: Yes, Your Honor.

10 THE COURT: All right. Now, I have read the memos. I
11 have researched --

12 MR. MCCUTCHEON: Your Honor, we -- might we just speak
13 briefly on the issue before you rule?

14 THE COURT: Oh, yeah, yeah, yeah. I was -- that's what I
15 was getting to.

16 MR. MCCUTCHEON: Okay.

17 THE COURT: Any other short, concise argument you all
18 want to make, first of all from the Plaintiff, and then I'll
19 hear from the Defense.

20 MS. PALMER: Thank you, Your Honor.

21 THE COURT: Yes.

22 MS. PALMER: And good morning.

23 THE COURT: And you don't -- you don't -- you do not have
24 to repeat what you told me yesterday because I, I was actually
25 listening and I've read your briefs, yes.

1 MS. PALMER: Okay. Well, I will not repeat myself.

2 At issue is not recognizing some off-the-wall cause of
3 action. I don't want to get caught up in terminology or
4 monikers of what it's called. It is a simple negligence
5 claim, does the hospital owe a duty to patients to properly
6 screen and hire physicians as it's required to do by law, and
7 that's the duty that we're asking for the Court to recognize.

8 THE COURT: Got it. Perfect.

9 MS. PALMER: Thank you.

10 THE COURT: Yes.

11 MS. THOMAS: Your Honor, if I may respond, the motion
12 that we made in limine yesterday was as to Dr. McGinley, and
13 Plaintiffs' counsel told this Court that they, in fact, have
14 several experts, and some of those experts are pathologists,
15 and they are certainly qualified to take the stand and opine
16 that Dr. McGinley breached the standard of care by not seeing
17 malignancy in those slides. We disagree with that, but they
18 are qualified to render that opinion. However, they have
19 named no expert, no psychologist, no psychiatrist, no
20 addiction expert who is qualified to opine that something that
21 happened 18 months prior to Dr. McGinley reading Mr.
22 Holliday's slides had anything to do with an alleged
23 misdiagnosis. So they've -- no expert that they present is
24 qualified to render that opinion, and what Plaintiffs are
25 asking this Court to do is not to allow them to bring a

1 medical negligence case, but allow them to engage in a witch
2 hunt. What they're saying is that because Dr. McGinley made
3 one mistake in his personal life 18 months prior he is forever
4 branded, one strike and you're out, and Your Honor, I would
5 put forward that's why Rule 404 exists, that in general
6 character evidence is not admissible except under certain very
7 narrowly defined circumstances which we don't have here, the
8 reason being that almost always it's more prejudicial than
9 probative, and Your Honor, we would contend that that argument
10 holds true as to the hospital, too, that they have to provide
11 that causal link through expert testimony that something that
12 occurred 18 months earlier caused Dr. McGinley to be impaired
13 or addicted when he read that slide, and that testimony is
14 nowhere. In fact, the evidence remains he was under the
15 monitoring program at the time he read that slide. He never
16 failed a random drug test, never has since he left Talbott
17 Recovery Center. So the only evidence is that he was not
18 impaired at the time that he read that slide, and Your Honor,
19 we would put forward that to allow any testimony from the
20 experts that they call who are not qualified to render that
21 opinion is to allow them to speculate and to invite the jury
22 to speculate, and Your Honor, we feel that any testimony in
23 that regard is so prejudicial, much more prejudicial than
24 probative, and we don't feel that we can un-ring that bell in
25 any way; and so, Your Honor, that's why we would ask that you

1 disallow this testimony.

2 THE COURT: Okay. Thank you. Yes, sir.

3 MR. DOAR: Your Honor, I would just briefly follow up.
4 There is no question that South Carolina today does not
5 recognize the cause of action for corporate negligence
6 regardless of whether my friend calls it off the wall or
7 whatever. I got this brief about the same time you did
8 yesterday afternoon because my office is in Pawleys Island and
9 I live in Georgetown and whatever. So, anyway, I didn't have
10 a chance to do anymore research on it, but looking at the
11 cases that they've cited, and I'm sure you've done that,
12 they're all foreign jurisdictions. There's not one case that
13 they've cited in the, in the brief except Strickland versus
14 Madden and then this Simmons case which I think is very
15 narrow. It involved an ER doctor. It adopted the restatement
16 of torts approach to apparent authority, and I don't think
17 it's really pertinent or authoritative in connection with
18 this, with this situation, and I would also point out, and I
19 say this very respectfully, that the Circuit Court cannot
20 create a new cause of action. As I understand it, that can
21 only be created by the legislature and/or the State Supreme
22 Court. So I would point that out to you.

23 Now, I'd like to very briefly hone in on the proximate
24 cause issue in this case. As I understand it, in a medical
25 malpractice case the Plaintiff has got the burden of proving

1 not only but for, but also the foreseeability test, and I
2 would say but for what in this case, Your Honor, but for the
3 fact that Dr. McGinley --

4 THE COURT: And you're saying even assuming the duty.
5 You're saying even assuming --

6 MR. DOAR: Absolutely.

7 THE COURT: -- the cause of action, even assuming the
8 duty.

9 MR. DOAR: Assuming the duty.

10 THE COURT: Okay.

11 MR. DOAR: We are saying, I mean, but for Dr. McGinley
12 was born that he -- that, that the injury would not or the
13 misread would not have occurred, assuming if there was a
14 misread. Foreseeability, how in the world would the hospital
15 foresee that a doctor who maybe he did have some bad acts in
16 the past, but his bad acts in the past, I submit to you, bad
17 character or alleged bad character was not the proximate cause
18 of the misread like we say -- I think it's more than -- it's
19 about 21 months I think it's something like that, and
20 absolutely no evidence, no evidence that he was impaired when
21 he read the slide, absolutely no evidence that he was even
22 impaired after he left Talbott Recovery Center in February of
23 2006. So we submit, Your Honor, that the case falls on the
24 basis. You don't have to be impaired to make a mistake. Very
25 competent professionals, doctors, lawyers, Indian chiefs make

1 mistakes, and they're not, not, don't have to be impaired. So
2 we would submit, Your Honor, that, that the proximate cause
3 cannot be established in this case, and we believe that
4 frankly by virtue of Dr. McGinley's hundred percent compliance
5 with what he was required to do by a number of agencies that
6 his character, if it was bad in the past, has now been
7 restored. Thank you.

8 THE COURT: Thank you so much, Mr. Doar. All right.
9 Anything else by anyone?

10 All right. You want to -- yes, ma'am.

11 MS. PALMER: Briefly.

12 THE COURT: Yeah.

13 MS. PALMER: Your Honor, with all due respect to
14 Defendants' counsel, these are all arguments that go to the
15 jury or are made at directed verdict stage. They keep saying
16 there's no evidence. Well, there is no evidence in the record
17 at this point. We do have evidence as to all of these items,
18 all of these elements of this cause of action.

19 THE COURT: Thank you. Thank you.

20 MR. DOAR: Well, Your Honor, I would challenge that. I
21 would, I would ask her to disclose at this time what evidence
22 they have that this doctor was impaired anytime after he left
23 Talbott Center in February of 2006.

24 MS. PALMER: Your Honor, I believe that the issue is
25 being missed a bit here. We are not alleging that he was

1 under the influence of drugs when he read this slide. There
2 is no evidence that he was under the influence reading slides
3 at work at any time. Even before the Medical Board, when he
4 was disciplined by the Medical Board, they were not
5 disciplining him for being under the influence while working.
6 There was no evidence that he misread any slide under the
7 influence. That evidence was not before the Medical Board,
8 yet they still found that he was not dedicated to providing
9 competent medical service with compassion and respect for
10 human dignity and that he was guilty of engaging in
11 dishonorable, unethical or unprofessional conduct that is
12 likely to deceive, defraud or harm the public. At the time
13 this order came out he was already back at work at Waccamaw
14 Hospital, and there's no evidence they did anything with this.
15 There's no evidence that they took any steps to determine
16 whether he was -- his character, his morality was
17 rehabilitated. Simply giving him urine tests to detect
18 whether or not he's on drugs does not detect or give them any
19 insight to whether the root of this problem, whether his
20 forgery, his just lying, deceitful conduct was rehabilitated,
21 and that's where we're coming from, not the angle of was he on
22 drugs when he read Mr. Holliday's slide. That's not what
23 we're claiming.

24 THE COURT: Okay. Thank you so much.

25 MR. MCCUTCHEON: I just have one thing, Your Honor, and

1 then I'm going to sit back down. What she just said, what she
2 just said has nothing to do with impairment. Okay. Thank
3 you.

4 THE COURT: Got it. All right. This is how we're going
5 to be proceeding: I'm first going to deal with the cause of
6 action which is alleged for negligent, if you will,
7 credentialing, and which, of course, does arise out of
8 corporate negligence, but as has been described to me it is in
9 the nature of negligent credentialing, and more in the, in the
10 -- perhaps in the nature of negligent supervision in terms of
11 allowing this doctor to continue to work because of the
12 difficulties which have been disclosed, and as I understand
13 the Plaintiff, the Plaintiff does not maintain that at the
14 time of the alleged malpractice that this physician was
15 impaired. However, at the time of the alleged malpractice, he
16 was a person who in the past had abused substances and had
17 engaged in fraudulent activity, and that's not disputed. Now,
18 I find at this time there is not in South Carolina a cause of
19 action for negligent credentialing, for corporate negligence
20 as is alleged in the second amended complaint. There is a
21 12(B)(6) raised by the Defendant hospital. I'm going to grant
22 that motion, 12(B)(6) motion, and with that then this case
23 will then go up in the posture of my having denied that motion
24 and then the Court of Appeals, the Supreme Court, if
25 appropriate, can establish such a cause of action, which is

1 the appropriate vehicle to establish a cause of action for
2 negligent credentialing in the nature I gather of corporate
3 negligence.

4 Now, let me express my concern because I have also and to
5 the extent that it becomes appropriate at some time in the
6 future, I am concerned that the cause of action, if you will,
7 for the negligent credentialing as I am calling it in the
8 nature of corporate negligence again is very much like the
9 individual who gets a driver's license or who doesn't have a
10 driver's license and drives down the road. You still must
11 prove proximate cause, and based on what I've heard, I am
12 concerned about -- additionally about proximate cause, but I
13 don't really -- while I may have concerns about that, there's
14 got to be a cause of action before there's got to be a concern
15 about proximate cause. I'm determining in South Carolina
16 there is no cause of action. So I'm granting the 12(B)(6).
17 Now, that's the first thing.

18 The second thing is the motion in limine with regards to
19 the doctor's addiction issues, fraud issues and the fact that
20 he was under supervision at the time of these events. Let me
21 say at this time I'm going to exclude that testimony. I don't
22 -- I cannot find any nexus between that conduct, that alleged
23 conduct and the alleged malpractice. However, I'm telling you
24 guys be very careful not to open the door because if the door
25 is opened it's coming in, but at this point I don't believe it

1 has any relevance. It could become relevant. So be most
2 careful. I would admonish counsel not to open the door,
3 particularly on the issue of fraud, but certainly on the
4 issue. I could see it happening much more easily on the
5 issues of fraud and identity fraud and the like than perhaps
6 even the addiction issue, but it could certainly happen then.
7 Be careful. I just mothered everybody on this side, be
8 careful not to open the door because that door could get
9 opened. If that door gets opened it's coming in as may be
10 appropriate, but at this point I don't believe it has any
11 relevancy on the issue of whether or not there was malpractice
12 on the date of these alleged events.

13 Now, to the Plaintiff and your concerns evidentially.

14 MR. ROSEN: Your Honor, I don't see any reason to go
15 there yet based on the fact you've dismissed the hospital as I
16 understand it.

17 MR. DOAR: That's going to be our motion, Your Honor, to
18 -- a dismissal.

19 THE COURT: Okay.

20 MR. ROSEN: You granted the 12(B)(6) motion.

21 THE COURT: On that cause of action. Did you allege
22 other causes of action such as respondeat superior, anything
23 else in there?

24 MR. DOAR: No, ma'am. We have a court order declaring
25 Dr. McGinley as an independent contractor. We fought that --

1 that's when they amended their complaint to allege this other
2 stuff.

3 THE COURT: Okay. I don't know.

4 MR. ROSEN: If, if a hospital --

5 THE COURT: I was only dealing with that one thing. I
6 don't -- you know, if it has -- if it does something else then
7 you all, again, you know a lot more. I was very focused on --
8 I had enough to do.

9 MR. ROSEN: I understand. Well, Your Honor, I understand
10 you're late to the case. A lot of judges have been involved
11 in this case for the last two years.

12 THE COURT: Got it.

13 MR. ROSEN: It wasn't fair to drop it on you at the last
14 minute. I understand that.

15 THE COURT: I'm happy with that. That's okay.

16 MR. ROSEN: On the other hand, we spent all day yesterday
17 --

18 THE COURT: Yes, sir.

19 MR. ROSEN: -- picking a jury --

20 THE COURT: Yes, sir.

21 MR. ROSEN: -- to try a case --

22 THE COURT: Yes.

23 MR. ROSEN: -- against Dr. McGinley and the hospital.

24 THE COURT: Yes.

25 MR. ROSEN: And now we don't have the jury for the case

1 just against Dr. McGinley. So this should have been decided
2 before we got here yesterday.

3 THE COURT: Yeah.

4 MR. ROSEN: That's not your fault obviously, but we want
5 a mistrial so we can reschedule this and try the case with a
6 jury and prepare for only the case against Dr. McGinley.

7 THE COURT: Okay. Got you. Who wants to argue? Who
8 wants to jump on that one? Well, you don't want to say
9 anything. Hush.

10 MR. DOAR: No, ma'am. I said my say, Your Honor. Your
11 Honor --

12 MR. MCCUTCHEON: We have no objection, Your Honor.

13 THE COURT: Okay. You have no objection to that?

14 MR. MCCUTCHEON: No, ma'am.

15 THE COURT: I'm not doing it, and let me tell you why
16 because I -- I -- and tell me -- you want to say anything else
17 about that?

18 MR. MCCUTCHEON: No, ma'am.

19 THE COURT: Okay.

20 MR. ROSEN: Your Honor, could I say something about it?

21 THE COURT: Yeah. Because let me tell you what I think I
22 can do. Let me, let me tell you what, what I'm prepared to do
23 and then you speak to that. I'm prepared to tell this jury
24 that this case is, is proceeding against Dr. McGinley and it's
25 on me. It's my determination. You're absolutely to take

1 absolutely no meaning from this whatsoever. This is on me.
2 It's my determination. It's got nothing to do with these
3 lawyers. It's got nothing to do with anything other than the
4 determinations that I have made.

5 MR. ROSEN: Your Honor, thanks, but that doesn't help us
6 very much.

7 THE COURT: Okay.

8 MR. ROSEN: If you allow the mistrial, as the parties
9 have both agreed now, that would give us the opportunity to
10 appeal your decision regarding the hospital and we can find
11 out before there's a big trial whether or not there is such a
12 cause of action. We disagree with your ruling, of course.

13 THE COURT: I understand.

14 MR. ROSEN: And we think you do have the power to let
15 this case proceed forward as a negligence claim, and then if
16 we won, they could appeal, but I understand you've decided to
17 grant a 12(B)(6) motion. So for the sake of judicial economy,
18 which this case sorely needs, it would be much smarter to have
19 this case go up on appeal, have the issue of corporate
20 negligence decided, and then come back and try the whole case.
21 Otherwise, the Plaintiffs are being forced to try this case in
22 two parts, which is onerous, at best, and the jury that was
23 picked was picked for a different case against the hospital
24 and the doctor. So the Plaintiff is not really getting the
25 jury she's entitled to.

1 THE COURT: Let me ask you this.

2 MR. MCCUTCHEON: Yes, ma'am.

3 THE COURT: Let me ask you this question. When you don't
4 object to the mistrial, you doing anything else other than not
5 objecting to the mistrial?

6 MR. MCCUTCHEON: That's all, and, and either way Your
7 Honor wants to go we're prepared to go forward with our side
8 of the case.

9 THE COURT: Yes, sir, Mr. McCutcheon. Because here's
10 what could happen. Here's what could happen, and I want
11 everybody to be clear because what could happen is they could
12 appeal. We could step down. We could, and I don't think
13 declaring a mistrial -- the jury hasn't been sworn so I don't,
14 I don't think it's got -- I don't think declaring a mistrial
15 is even what's necessary at this point, but let's say we stop,
16 you go appeal, here's your problem. The next term of court,
17 two terms of court, they're going to say, "Oh, why isn't this
18 case on the roster," because it isn't stayed. You understand?
19 It would not be stayed. In my mind I don't believe that your
20 appeal is going to stay this case. You see what I'm saying?
21 So the question is is do you want to come back here in 30 days
22 and try the case involving Dr. McGinley because they're not
23 agreeing to it. That's why I asked that question of Mr.
24 McCutcheon, are you agreeing to a stay? You see what I'm
25 saying?

1 MR. ROSEN: We'd be seeking a stay, Your Honor, either
2 from the Circuit Court or the Supreme Court.

3 THE COURT: I know. Well, don't you think it's
4 appropriate to sort of try to work that out now so at least,
5 at least know where you are?

6 MR. ROSEN: I mean, it would be helpful if everybody
7 agreed to a stay. Thank you, Your Honor.

8 THE COURT: I figured that. He's not going to agree to
9 that. I figured that. I figured that. Okay. Then any --

10 MR. ROSEN: Your Honor, you could grant a motion under
11 40(J) to strike for a year.

12 THE COURT: The chief administrative judge has to do
13 that.

14 MR. ROSEN: I'm sorry?

15 THE COURT: I believe the chief administrative judge has
16 to do that, but let me pull that rule and see. Let me look at
17 that rule real quick.

18 All right. We are going to take 15 minutes and we'll be
19 back.

20 MR. ROSEN: Thank you.

21 OFF THE RECORD

22 (On the record. The following takes place outside the
23 presence of the jury.)

24 THE COURT: All right. Okay. Yes. Motions from the
25 Plaintiff?

1 MR. ROSEN: Your Honor, I understand Mr. McCutcheon
2 consents to 40(J) the case?

3 MR. MCCUTCHEON: Yes, ma'am.

4 THE COURT: Okay. All right. It is my understanding
5 that Rule 40(J) is a shall, that when counsel consents -- you
6 have -- it's not been 40(J)'d before; is that correct?

7 MR. MCCUTCHEON: No, ma'am.

8 MR. ROSEN: That's correct.

9 THE COURT: Okay. Okay. And so my understanding is is
10 that when it is done it has to be done by consent, and when it
11 is done by consent, and I'm going to just pull it because I
12 want to put on the record, but my memory is, let's see 40(J),
13 it says a party may strike its complaint from any docket one
14 time as a matter of right provided that all parties adverse to
15 that claim agree in writing that it may be stricken and all
16 further agree that if the claim is restored upon motion made
17 within one year of the date stricken the statute of
18 limitations shall be tolled as to all consenting parties
19 during the time the case is stricken and any unexpired portion
20 of the statute of limitations on the date the case was
21 stricken shall remain and begin to run on the date that the
22 claim is restored. A party moving to restore a case stricken
23 from the docket shall provide all parties notice with ten
24 days, and upon being -- let's see. Now, the question then
25 gets to be I know that it must be restored by the chief

1 administrative judge, and typically requests for a 40(J) are
2 made to the chief administrative judge, but I don't believe
3 that, I don't believe that that is required. I think the, the
4 restoration of it has to be made to the chief administrative
5 judge. So I do believe that I can sign an order. It is a
6 matter of right. You have a consent for the period of one
7 year. Counsel, I would just tell you this, just be mindful
8 that this will not handle the appellate issue. In the event
9 that the case is, is on appeal at the conclusion of a year
10 you'll have to restore it and then move to stay it. So just,
11 just from a procedural standpoint I just think you all need
12 to, need to be mindful of it. It is a matter of right. It is
13 consented to. Are there any -- I just ask, now that the
14 hospital is no longer in, you tell me in the case because that
15 was the remaining cause of action against the hospital, are
16 there any other parties other than the doctor? Nope?

17 MR. MCCUTCHEON: No, ma'am.

18 THE COURT: Okay. Well, I think that you all need to --
19 it has to be done in writing, the consent has to be done in
20 writing. So before I dismiss this jury I think that needs to
21 happen. So I know you all have computers and, and printers
22 and all.

23 MR. ROSEN: We're working on an order right now.

24 THE COURT: That sounds fine, and just if you'll just
25 follow Rule 40(J) we will sign it. Then I will address the

1 jury, but I won't do that until the order is signed, and just
2 bring it, bring it to me, guys, in chambers, ladies, in
3 chambers when you all have it signed.

4 MR. ROSEN: Thank you, Your Honor.

5 THE COURT: And then we'll take it from there, and if
6 you'll just tell the jury just if they'll just bear with us.

7 (Adjourned.)

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C E R T I F I C A T E

I, the undersigned, Grace L. Hurley, Official Court Reporter for the State of South Carolina, do hereby certify that the foregoing is a true, accurate and complete Transcript of Record of the motions held in the case of Nadene Holliday, individually and as Personal Representative of the Estate of David Holliday versus Waccamaw Community Hospital, et al., held in the Court of Common Pleas for Georgetown County, Georgetown County Courthouse, Georgetown, South Carolina, on January 12-13, 2015.

I do hereby certify that I am neither of kin, counsel, nor interest to any party hereto.

Grace L. Hurley, CVR-CM-M
Official Reporter

February 6, 2015.

RETURN TO PRACTICE AGREEMENT

This Return to Practice Agreement (the "Agreement") is entered into between Kent M. McGinley, M.D. (the "Physician") and Waccamaw Community Hospital (the "Hospital") on April 5, 2006.

Introduction. Physician is currently on a voluntary leave of absence under the Hospital's medical staff bylaws. Physician requested reinstatement of his medical staff membership and privileges at the Hospital following his leave of absence. In connection with his reinstatement request, Physician advised the Hospital that he sought evaluation and treatment of alcohol and substance abuse issues during his leave of absence. As a condition of reinstatement of his Hospital medical staff membership and clinical privileges, Physician has agreed to abide by the terms of this Agreement. Hospital is willing to reinstate Physician's medical staff membership and privileges at the Hospital under the terms and conditions set forth in this Agreement.

Agreement. In consideration of the premises and of the mutual covenants herein contained, the parties do hereby agree as follows:

1. Participation in RPP Program. Physician has voluntarily entered into a participant monitoring agreement as of January 23, 2006 (the "Monitoring Agreement") with the South Carolina Recovering Professionals RPP Program, which is operated by the South Carolina Department of Alcohol and Other Drug Abuse services as the approved monitoring program of the South Carolina Board of Medical Examiners (the "RPP Program"). A copy of the Monitoring Agreement and certain other documents related to Physician's participation in the RPP Program are attached to this Agreement as Exhibit A, the terms and conditions of which are hereby expressly incorporated by reference as part of this Agreement.

2. Participation in Pretrial Intervention Program. Physician has also agreed to participate in the Solicitor's pretrial intervention program which may include drug testing, community service, counseling and other requirements based on Physician's individual needs (the "PI Program").

3. Conditions for Reinstatement. As an express condition of Physician's reinstatement of medical staff membership and clinical privileges at the Hospital, Physician agrees to abide by all terms of this Agreement, the Monitoring Agreement and any agreement required for Physician's participation in the PI Program (the "PI Agreement"). Physician shall be an active participant in the activities of the RPP Program and the PI Program including assessment, treatment, monitoring, aftercare activities and any other activities deemed appropriate by the RPP Program and the PI Program. Physician acknowledges and agrees that the Hospital's Impaired Physician Committee (the "IPC") shall be responsible for monitoring Physician's compliance with the terms of this Agreement, the Monitoring Agreement and any

PI Agreement. Physician shall be required to provide a copy of any PI Agreement to the IPC within ten (10) days of Physician entering into a PI Agreement.

4. Reinstatement of Membership and Privileges. Hospital agrees that Physician's medical staff membership and clinical privileges at the Hospital shall be reinstated upon approval of this Agreement by the Hospital's Board of Directors and execution of this Agreement by Physician and an authorized representative of the Hospital.

5. Use of Mood Altering Substances. Physician shall completely abstain from all mood altering substances, drugs, chemicals and other agents while this Agreement is in effect, except as prescribed by a duly licensed practitioner for a legitimate medical purpose. Any prescribed use of any mood altering substance, drug, chemical or other agent must be reported by Physician to the Chairman of the IPC and the Chief Executive Officer within forty-eight (48) hours of initiation. All such medical treatment and prescribing must also be reported directly by the Physician's treating physician to the Chairman of the IPC and the Chief Executive Officer within five (5) days of the date of service.

6. Random Testing. In addition to any monitoring authorized under the Monitoring Agreement or required by the PI Program, Physician agrees to periodic, unannounced blood and urine alcohol and/or drug analysis as may be requested by the IPC, in its sole discretion, to ensure that Physician remains drug and/or alcohol-free. The costs of any such blood and/or drug analyses shall be paid by Physician within thirty (30) days of the date of an invoice from the Hospital.

7. Notification of Additional Evaluation or Treatment. Physician agrees to notify the Chairman of the IPC and the Chief Executive Officer within twenty-four (24) hours of Physician's referral for admission to an inpatient or outpatient treatment program or facility for additional evaluation and/or treatment of any alcohol or substance abuse issues beyond the scope of the treatment services described in Exhibit A.

8. Submission of Documentation to IPC. Physician agrees to submit, on or before the tenth (10th) day of each month, (i) written documentation to the IPC of Physician's participation in the activities of the RPP Program and the PI Program including assessment, treatment, monitoring, aftercare activities and any other activities deemed appropriate by the RPP Program and the PI Program; (ii) written confirmation from his treating physician, Brian Adler, M.D. (telephone #843-650-4006) and his therapists, Margaret Kauffman (telephone # 843-235-8300) and Harold Brown (telephone # 843-237-5785) that Physician is in compliance with all treatment plan requirements including attending scheduled therapy sessions. Physician further agrees to submit documentation from the PI Program of Physician's successful completion of the PI Program within ten (10) days of completion of the PI Program. The documentation to be submitted by Physician under this Section shall be provided by persons and in a format reasonably acceptable to the IPC.

9. Meetings with the IPC. Physician agrees to meet no less frequently than quarterly with the IPC to discuss the status of any ongoing treatment and Physician's continued compliance with the terms of the Monitoring Agreement, any PI Agreement and this Agreement.

10. Release of Information. The IPC shall be entitled to confirm, no less frequently than on a monthly basis, Physician's continued compliance with the terms of the Monitoring Agreement, any PI Agreement and the terms of this Agreement with any third party the IPC deems appropriate, including Physician's treating physician. Physician agrees to execute any necessary authorization or release that may be required by the RPP Program, the PI Program, treatment providers or other third parties to permit the IPC to obtain information related to Physician's compliance with the Monitoring Agreement and this Agreement.

11. Term and Termination. This Agreement shall remain in effect for a period of five (5) years. The Hospital may immediately terminate this Agreement upon written notice of Physician's breach of any term of this Agreement. Physician acknowledges and agrees that any termination of this Agreement by the Hospital may subject Physician to corrective action by the Hospital including, but not limited to, summary suspension of Physician's medical staff membership and clinical privileges at the Hospital.

12. Confidentiality. The terms of this Agreement shall be confidential and may not be released to any third party, except the attorneys and other advisors of the Hospital (including the IPC) or Physician, without the written consent of the other party.

13. Notices. Any notice permitted or required by this Agreement will be considered made on the date personally delivered in writing or mailed by certified mail, postage prepaid, to the other party at the address set forth on the signature page of this Agreement or to such other person or address as either party may designate in writing.

14. Relationship of Parties. At all times during the term of this Agreement, Physician is and shall be an independent contractor and not a servant, agent, or employee of the Hospital. The Hospital and Physician further agree that nothing in this Agreement shall be deemed to create any type of employment, agency, servant, partner, or joint venture relationship between Physician and the Hospital.

15. Modification. This Agreement contains the entire understanding of the parties regarding the conditions for reinstatement of Physician's medical staff membership and clinical privileges following his current leave of absence and will be modified only by a written document signed by each party.

16. Waiver. The waiver by the Hospital or Physician of a breach of this Agreement will not operate as a waiver of any subsequent breach. No delay in acting with regard to any breach of this Agreement will be construed to be a waiver of the breach.

17. Assignment. This Agreement may not be assigned by either party without prior written consent of the other party. This Agreement shall be for the benefit of, and binding upon, the parties hereto and their respective successors and permitted assigns.

18. Governing Law. The interpretation and enforcement of this Agreement will be governed by the laws of the State of South Carolina.

IN WITNESS WHEREOF, the Hospital and Physician have caused this instrument to be executed to be effective as of the date first written above.

Notice Address:

HOSPITAL:

Waccamaw Community Hospital

[REDACTED]
Murrells Inlet, SC [REDACTED]
Attn. CEO

By: [Signature]
Bruce P. Bailey
Its: CEO

PHYSICIAN:

[REDACTED]
Georgetown, SC [REDACTED]

By: [Signature]
Kent M. McGinley, M.D.

*** TX REPORT ***

TRANSMISSION OK

TX/RX NO	0270	
CONNECTION TEL		21700
CONNECTION ID	WCH ADMIN	
ST. TIME	04/05 13:38	
USAGE T	01'44	
PGS. SENT	5	
RESULT	OK	

RETURN TO PRACTICE AGREEMENT

This Return to Practice Agreement (the "Agreement") is entered into between Kent M. McGinley, M.D. (the "Physician") and Waccamaw Community Hospital (the "Hospital") on April 5, 2006.

Introduction. Physician is currently on a voluntary leave of absence under the Hospital's medical staff bylaws. Physician requested reinstatement of his medical staff membership and privileges at the Hospital following his leave of absence. In connection with his reinstatement request, Physician advised the Hospital that he sought evaluation and treatment of alcohol and substance abuse issues during his leave of absence. As a condition of reinstatement of his Hospital medical staff membership and clinical privileges, Physician has agreed to abide by the terms of this Agreement. Hospital is willing to reinstate Physician's medical staff membership and privileges at the Hospital under the terms and conditions set forth in this Agreement.

Agreement. In consideration of the premises and of the mutual covenants herein contained, the parties do hereby agree as follows:

1. Participation in RPP Program. Physician has voluntarily entered into a participant monitoring agreement as of January 23, 2006 (the "Monitoring Agreement") with the South Carolina Recovering Professionals RPP Program, which is operated by the South Carolina Department of Alcohol and Other Drug Abuse services as the approved monitoring program of the South Carolina Board of Medical Examiners (the "RPP Program"). A copy of the Monitoring Agreement and certain other documents related to Physician's participation in the RPP Program are attached to this Agreement as Exhibit A, the terms and conditions of which are hereby expressly incorporated by reference as part of this Agreement.

2. Participation in Pretrial Intervention Program. Physician has also agreed to participate in the Solicitor's pretrial intervention program which may include drug testing, community service, counseling and other requirements based on Physician's individual needs (the "PI Program").

02/16/2006 09:38 FAX 843 652 1700

WCH ADMIN

0003

02/15/2006 15:45 8038965710

SCRP

PAGE 02/03

CONSENT FOR THE RELEASE OF CONFIDENTIAL INFORMATIONName: KENT M^S GINLEY Social Security # [REDACTED]
DOB [REDACTED]I, KENT M^S GINLEYAuthorize RPP/ WACCAMAN COMMUNITY HOSPITAL
(Name of program or person making disclosure)to disclose to WACCAMAN COMMUNITY HOSPITAL RPP _____
(Person or organization to whom disclosure is to be made)

the following information: Treatment data, attendance, test results, assessment results, concerns, and recommendations.

The purpose of this disclosure is: MONITORING
(purpose as specific as possible)

The information will be released in the following form:

☒ Written ☒ Video
☒ Verbal ☒ Electronic
☒ Audio ☐ Other

I understand that my records are protected under the federal regulations governing confidentiality of Alcohol and Drug Abuse Patient Records, 42 CFR, Part 2, and cannot be disclosed without my written consent unless otherwise provided for in the regulations. I also understand that I may revoke this consent at any time except to the extent that action has been taken in reliance on it, and that in any event this consent expires automatically as follows:

90 DAYS POST D/C FROM LPP
(Specification of the date, event or condition upon which this consent expires)[Signature] 2/16/06
(Participant Signature) (Date)
Cathy McGinley 2/16/06
(Witness Signature) (Date)**REVOCACTION OF CONSENT**_____ _____
(Participant Signature) (Date)
_____ _____
(Witness Signature) (Date)

300-A Outlet Pointe Boulevard, Suite 100, Columbia, South Carolina 29210
Telephone 803-896-5700 Toll Free 24hour helpline 1-877-348-2094
Fax (803) 896-5710

PARTICIPANT MONITORING AGREEMENT

I, Kurt McGinnis have chosen to participate in the South Carolina Recovering Professional Program (RPP), a board approved program operating under a memorandum of agreement with the Board of Medical Examiners. RPP is established for South Carolina Health Practitioners whose practice may be impaired by a chemical dependency and is administered by the Lexington/Richland Alcohol and Drug Abuse Council (LRADAC). I acknowledge receipt of the RPP "Participant Handbook" which sets out the terms of participation in RPP. I understand that the RPP agrees to assist me only on these terms, and I agree to abide by them. I have had the opportunity to ask my RPP Recovery Specialist any questions I might have about the terms of participation in RPP. I understand that the terms of participation in RPP include the following and that these and the other terms of participation are explained in more detail in the RPP "Participant Handbook." Any exceptions or modifications to the terms of participation are addressed on an individual basis and must be approved in writing by the RPP Program Director. I further understand and agree that if my initial evaluation is negative, this agreement may be modified or terminated by RPP. I acknowledge receipt of applicable privacy practices.

GENERAL CRITERIA

Please initial each statement.

1. The length of the monitoring program addressing problems with substance abuse/dependency is a minimum of five (5) years. Relapse may result in change of original completion date. RM

2. I understand that I am responsible for the RPP monthly participant fee, which will be determined by my work status. RM

3. I agree to completely abstain from the personal use of mood-altering substances, drugs, chemicals, or other agents, including, but not limited to, alcohol, sedatives, stimulants, narcotics, marijuana, over-the-counter drugs, etc., except as prescribed by my personal or treating physician after consultation with RPP for a documented, legitimate medical purpose. All use of over the counter and prescription medications are to be reported to RPP immediately (examples: Nyquil, Benadryl, other cough medicines and poppy seeds). Copies of all prescription medication must be submitted to RPP. Prescriptions for long term continuing medications must be resubmitted/re-prescribed every 6 months. All documentation regarding any medical treatment needs to be reported to RPP within 24 hours. RM

4. I am required to participate in random witnessed drug screens administered by the National Confederation of Professional Services (NCPS) or as otherwise directed by RPP as part of my monitoring requirements. I am responsible for all costs associated with drug screens. RM

5. If I have voluntarily entered RPP and am anonymous to the board, I will remain anonymous to the board as long as I am compliant with RPP requirements. If I have been referred by the board and elect not to participate, withdraw, or am dismissed from RPP, I will be immediately reported to the board for further action. KA

6. If required by RPP, I agree to undergo a complete medical, psychiatric, and substance abuse evaluation at an approved facility and at a time as designated by RPP. If treatment is recommended by the evaluation team, then I agree to attend a treatment facility approved by RPP for the recommended period of time. I understand that I am responsible for the cost of the evaluation/treatment. If the diagnosis is negative this contract may be terminated or length of monitoring shortened by RPP. KA

7. I understand that I may be required to refrain from practice during treatment. Prior to returning to work, I will have a RPP Return to Work Agreement signed by the treatment provider based on the treatment plan. I understand it may include restrictions on practice or duty assignment which may include no access to "mood altering" medication, no overtime or on call assignments, and where applicable, altering of shift work. KA

8. I will identify all physicians associated with my health care to RPP and report all medications prescribed. I must identify a primary physician who is knowledgeable about my chemical dependency and my participation in RPP. I will refrain from changing personal physicians without prior consultation and approval of RPP. My personal physician is Dr. [illegible] Telephone# [illegible] It is understood and agreed that RPP may contact any of my personal physicians at such time as may be desired. The signing of this agreement shall constitute and act as a release to any and all of my personal physicians (or any other physician I see before or after signing this agreement) to communicate fully with RPP regarding my recovery and compliance with my monitoring agreement or requirements of the Board. KA

9. I understand and agree that the RPP is authorized, upon request, to release any information concerning me to the board investigative staff, and that information may be used in any administrative proceeding in which it may be relevant. KA

10. I understand that any unauthorized use of a mood altering chemical is considered a relapse and will result in a re-evaluation followed by appropriate action as indicated by the level of relapse. KA

11. I will refrain from practice upon receipt of a positive drug screen. I understand and agree that a confirmed drug screen of any mood-altering chemical is considered conclusive evidence of the use of that chemical. KA

12. I understand that participation in Peer Assistance activities is required and I agree to sign a contract with my professional support group (DAAC, PAAC,

PAPIN, SCRIPT), if provided. I will provide or have provided documentation to RPP of my attendance. I will submit or arrange for submission of reports from my professional support group. Frequency shall be determined by the treatment provider in consultation with the RPP and peer assistance organizations. The RPP may make adjustments to frequency as appropriate throughout the monitoring process. KL

13. I understand that Self Help/Therapy group attendance is required. Frequency shall be determined by the treatment provider in consultation with RPP. RPP may make adjustments to frequency as appropriate throughout the monitoring process. Client must obtain a sponsor and maintain an ongoing relationship with him/her. KL

14. I will promptly notify RPP of any changes in address, telephone numbers, practice, hospital privileges, professional status, or compliance with this agreement. Correspondence and copies of reports and notices should be directed to: KL

Recovering Professional Program
300 - A Outlet Pointe Blvd.
Suite 100
Columbia, SC 29210

15. I will notify RPP before accepting or changing any employment. KL

16. I will refrain from applying for a license or registration from the US Drug Enforcement Administration (DEA) or SC Department of Health and Environmental Control (DHEC) or modifying a present DEA or DHEC license of registration without prior approval of RPP. KL

17. I understand I will be required to sign consent forms authorizing RPP to exchange information with others, including: health care providers (including primary physician), treatment facilities, employers and potential employers, peer assistance representatives, licensing boards, and others involved in my recovery as deemed appropriate by RPP. KL

18. I understand that RPP is a South Carolina based program. I further understand that if I leave South Carolina, my case will be transferred to another state as appropriate. KL

19. I am responsible for notifying RPP of out-of-town plans prior to departure. I will arrange a schedule approved by my Recovery Specialist for completion of monitoring requirements while out-of-town. KL

20. I am responsible for maintaining communication with my RPP Recovery Specialist, peer assistance representative, and treatment provider. I am further responsible for timely submission of all required forms to RPP. KL

21. I agree to refrain from instituting legal action of any kind or making any claim

against the Recovering Professional Program (RPP), Lexington/Richland Alcohol and Drug Abuse Council (LRADAC), the South Carolina Department of Labor, Licensing and Regulation, or its professional and occupational licensing boards, their officers, members, representatives, and employees, for slander, libel, defamation of character, malicious prosecution, abuse of process, infliction of emotional distress, harassment, invasion of privacy, false imprisonment, or for any other reason arising out of communications, activities, or conduct relating to or concerning in any way this agreement or its provisions or the enforcement thereof. LM

22. I agree to waive any claim of confidentiality afforded by any local, state, or federal case, statutory, or common law to the extent necessary to carry out this agreement or to protect the public health, safety, or welfare. By executing this agreement, I specifically consent to execute and deliver to the program within ten (10) days of request, an authorization for the release to the program or its designees of any and all records, reports, or other information concerning myself by any and all persons or entities involved, notwithstanding any privilege provided by federal or state law. LM

23. I understand and agree that if I fail to comply with any of the terms of this agreement or other requirements, RPP will report such non-compliance to the licensing board and other interested persons and entities as it may deem appropriate or necessary to protect the profession, my patients/clients, my health or well being or that of my family. LM

24. I understand that no changes in the terms of participation or any RPP agreement or form may be made without written consent from RPP. LM

LM
Participant signature

1/23/06
Date

LM
Witness signature

1-23-06
Date

**SOUTH CAROLINA DEPARTMENT OF LABOR, LICENSING AND
REGULATION
BEFORE THE STATE BOARD OF MEDICAL EXAMINERS OF SOUTH
CAROLINA**

In the Matter of:

**KENT MICHAEL MCGINLEY, M.D.,
Medical License No. 19050,**

OIE # 2006-166
OGC # 06-0038

Respondent.

FINAL ORDER

This matter came before the Board of Medical Examiners (the Board) for Hearing on May 24, 2006, as a result of the Notice and Complaint served upon the Respondent and filed on March 28, 2006. A quorum of Board members was present. The Hearing was held pursuant to S.C. Code Ann. §§40-47-200 and 211, as amended, to determine whether sanctions should be imposed based upon the Memorandum of Agreement and Stipulations signed by the Respondent on April 14, 2006. At the Hearing on May 24, 2006, a Supplement to the Memorandum of Agreement and Stipulations dated May 5, 2006, was entered into evidence as Exhibit 3, without objection. The Respondent appeared at the Hearing and proceeded pro se. The State was represented by Sheridan H. Spoon, Esquire.

The following was admitted into evidence at the Hearing:

1. **Exhibit 1:** Order of Temporary Suspension of Respondent dated April 4, 2006.
2. **Exhibit 2:** Recovering Professional Program Memorandum to Bruce Duke, George Rosen, Larry Atkins, Dr. Prabhu, Sheridan Spoon, and Kathy Meadows, dated May 22, 2006
3. **Exhibit 3:** Supplement to Memorandum of Agreement and Stipulations dated May 5, 2006.

The Respondent was charged with violation of S.C. Code Ann. §§ 40-47-200 (F)(1), (3), (7), (8), (9), (11) and (12) (Supp. 2005). and Regulation No. 81-60 (A) and (C) (Supp. 2005) of the Rules and Regulations of the Board.

FINDINGS OF FACT

Based upon the preponderance of the evidence on the whole record, the Board finds the facts of the case to be as follows:

1. The Respondent is a physician duly licensed to practice medicine in South Carolina.
2. The State alleged that the Respondent violated S.C. Code Ann. §§ 40-47-200 (F)(1), (3), (7), (8), (9), (11) and (12) (Supp. 2005), and Regulation No. 81-60 (A) and (C) (Supp. 2005) of the Rules and Regulations of the Board.
3. Specifically, the State alleged that:
 - A. On or about October 12, 2005, Respondent fraudulently obtained a quantity of Hydrocodone by writing a prescription to a named individual. Respondent then used a fraudulent driver's license, posed as that individual, and filled the prescription at a Georgetown-area Eckerd Pharmacy # 3535.
 - B. On or about October 18, 2005, Respondent was arrested by the Bureau of Drug Control, Department of Health and Environmental Control and was charged with using a false and fraudulent form of identification to obtain a quantity of Hydrocodone, a Schedule III narcotic controlled substance, by fraud, deception, misrepresentation and subterfuge.
 - C. On or about October 19, 2005, Respondent was charged with forgery, pursuant to information that on or about October 12, 2005, Respondent created a fraudulent Mississippi driver's license bearing Respondent's picture, under the alias "Brent Morris." Respondent then used said fraudulent driver's license to unlawfully obtain said prescription.

D. On or about October 19, 2005, Respondent was charged with obtaining a controlled substance by fraud and forgery, pursuant to information that on or about August 15, 2005 Respondent created a fraudulent Louisiana driver's license bearing Respondent's picture, under the alias "Raymond Reed." Respondent then used said fraudulent driver's license to unlawfully obtain a quantity of Hydrocodone, a Schedule III narcotic controlled substance, from a Horry County CVS Pharmacy #5044.

4. The Respondent admitted to the allegations as outlined above.

5. The Respondent testified at the Hearing that he has suffered from migraine headaches most of his life that have worsened over the years. Respondent initially used Stadol nasal spray for relief and progressed to Lortab as the headaches became more severe. This Finding is based upon the testimony of the Respondent as well as the Supplement to the Memorandum of Agreement entered into evidence as Exhibit 3.

6. The Respondent testified that he also dealt with depression which grew worse after his child entered the toddler stage. The Respondent testified that he took Hydrocodone to boost his mood. He also testified that he took other prescription medications on occasion to allow him to sleep. This Finding is based upon the testimony of the Respondent as well as the Supplement to the Memorandum of Agreement entered into evidence as Exhibit 3.

7. The Respondent testified that he became addicted to prescription drugs which eventually resulted in his arrest. This Finding is based upon the testimony of the Respondent as well as the Supplement to the Memorandum of Agreement entered into evidence as Exhibit 3.

8. The Respondent testified that after his arrest, he cooperated fully with law enforcement and voluntarily surrendered his SLED and DHEC controlled substance

privileges. This Finding is based upon the testimony of the Respondent as well as the Supplement to the Memorandum of Agreement entered into evidence as Exhibit 3.

9. The Respondent testified he then immediately referred himself to the Talbott Recovery Center in Atlanta, Georgia, where he completed fourteen weeks of in-patient therapy and successfully passed twenty-one (21) random drug tests. This Finding is based upon the testimony of the Respondent as well as the Supplement to the Memorandum of Agreement entered into evidence and the Discharge Summary from Talbott Recovery Center dated February 14, 2006.

10. The Respondent has successfully completed in-patient therapy with Talbott Recovery Center and is continuing to receive out-patient therapy with Harold Brown, an Addiction Therapist. He is also currently enrolled in the Recovering Professional Program (hereinafter "RPP"). This Finding is based upon the testimony of the Respondent as well as the Supplement to the Memorandum of Agreement entered into evidence as Exhibit 3 and the Memorandum from RPP dated April 12, 2006, entered into evidence as Exhibit 2.

11. All of Respondent's criminal charges were referred to the Pre-Trial Intervention by the Solicitor. Upon successful completion of the program, Respondent will have all of the criminal charges expunged from his record. This Finding is based upon the testimony of the Respondent as well as the letter from Donna E. Elder, Senior Assistant Solicitor with the Fifteenth Judicial Circuit dated January 9, 2006, which was attached to the Supplement to Memorandum of Agreement and Stipulations entered into evidence as Exhibit 3.

12. Respondent testified that he has addressed and overcome his addictions and the behaviors that contributed to his addiction. Respondent is highly desirous of returning to the practice of pathology under appropriate conditions to be determined by the Board. This Finding is based upon the Respondent's testimony.

13. Dr. Coleman of RPP also testified at the Hearing. Dr. Coleman testified that Respondent is in regular attendance at RPP and that he has done most of everything that has been asked of him by RPP. This Finding is based upon the testimony of Dr. Coleman.

14. The Order of Temporary Suspension dated April 4, 2006, was issued by this Board based upon the assumption that Respondent had not enrolled in RPP. However, as evidenced by all of the testimony at the Hearing, this assumption was incorrect. Therefore, the Order of Temporary Suspension dated April 4, 2006, is lifted effective April 12, 2006.

CONCLUSIONS OF LAW

Based upon careful consideration of the facts in this matter, the Board finds and concludes as a matter of law that:

1. The Board has jurisdiction in this matter and, upon finding that a licensee has violated any of the provisions of S.C. Code Ann. §40-47-200, supra, has the authority to order the revocation or suspension of a license to practice medicine or osteopathy, publicly or privately reprimand the holder of a license, or take other reasonable action short of revocation or suspension, such as requiring the licensee to undertake additional professional training subject to the direction and supervision of the Board or imposing restraint upon the medical or osteopathic practice of the licensee as circumstances

warrant until the licensee demonstrates to the Board adequate professional competence. Additionally, the Board may require the licensee to pay a civil penalty of up to ten thousand dollars to the Board and the costs of the disciplinary action.

2. The Respondent has violated S.C. Code Ann. §40-47-200(F)(1), (3), (7), (8), (9), (11) and (12) (Supp. 2005), and Regulation No. 81-60(A) and (C) of the Rules and Regulations of the Board of Medical Examiners, in the following particulars:

A. The Respondent has violated S.C. Code Ann. § 40-47-200(F)(1) in that he has used a false, fraudulent, or forged statement or document or practiced a fraudulent, deceitful, or dishonest act in connection with a licensing requirement.

B. The Respondent has violated S.C. Code Ann. § 40-47-200(F)(3) in that he was addicted to prescription narcotics to such a degree as to render him unfit to practice medicine.

C. The Respondent has violated S.C. Code Ann. § 40-47-200(F)(7) in that he has violated the following Principles of Medical Ethics adopted by the Board; specifically:

(1) Regulation 81-60(A), in that he at the time of the acts outlined above, the Respondent was not dedicated to providing competent medical service with compassion and respect for human dignity;

(2) Regulation 81-60(C), in that at the time of the acts outlined above, the Respondent did not respect the law.

D. The Respondent has violated S.C. Code Ann. § 40-47-200(F)(8) in that he is guilty of engaging in dishonorable, unethical, or unprofessional conduct that is likely to deceive, defraud, or harm the public.

E. The Respondent has violated S.C. Code Ann. § 40-47-200(F)(9) in that he is guilty of the use of a false or fraudulent statement in a document connected with the practice of medicine.

F. The Respondent has violated S.C. Code Ann. § 40-47-200(F)(11) in that he has intentionally violated or attempted to violate, directly or indirectly, or assisted in or abetted the violation of or conspired to violate the medical practice law.

G. The Respondent has violated S.C. Code Ann. § 40-47-200(F)(12) in that he is guilty of violating the Code of Medical Ethics adopted by the Board in accordance with Section 40-47-20.

3. The sanction imposed is consistent with the purpose of these proceedings and has been made after weighing the public interest and the need for continuing services of qualified medical doctors against the countervailing concern that society be protected from professional ineptitude and misconduct.

4. The sanction imposed is designed not to punish the physician, but to protect the life, health, and welfare of the people at large.

NOW, THEREFORE, IT IS ORDERED, ADJUDGED AND DECREED that:

1. The Respondent be, and he hereby is, publicly reprimanded.

2. The Respondent shall pay a fine of Two Thousand and No/100 (\$2000.00) Dollars, as well as the costs of this disciplinary action in the amount of Four Hundred Twenty and No/100 (\$420.00) Dollars, within one (1) year of receipt of this Order. This fine shall not be deemed paid until received by the Board.

3. The Respondent shall comply with the following terms and conditions, for a minimum of five (5) years:

A. The Respondent shall completely abstain from the consumption of legal prescription drugs as well as any illegal drugs. All medical treatment received by the Respondent shall be reported directly to the Board in writing by the treating practitioner within ten (10) days after the date of treatment. The Respondent must inform the treating practitioner of this responsibility, provide a copy of this Order to the treating practitioner, and ensure timely compliance. Failure to inform the treating practitioner of this responsibility shall be considered a violation of this Order.

B. The Respondent must have a written contract with and be an active participant in the activities of the Recovering Professionals Program (RPP), for a minimum of five (5) years. Such contract shall include provisions for any assessment, treatment, monitoring, and aftercare activities, and other activities as RPP shall deem appropriate, including, but not limited to:

- (1) Assessment and treatment requirements of RPP;
- (2) Monitoring and aftercare activities of RPP;
- (3) Participation in Narcotics Anonymous;
- (4) Participation in professional support groups or organizations or equivalents, as approved by RPP;
- (5) Such additional therapeutic activities as deemed appropriate and necessary by RPP.

RPP shall submit regular written reports documenting the Respondent's full compliance with the terms of the contract with RPP and this Order.

C. Within thirty (30) days of the date of this Order, the Respondent must provide to the Board a letter signed by an appropriate representative of RPP

mentioned above verifying that the Respondent has signed a written contract with and become an active participant in the activities of RPP, as required above. Compliance with this paragraph shall not be deemed satisfied until written verification is received by the Board. Failure to comply with this requirement within the prescribed time shall automatically result in the immediate temporary suspension of the Respondent's license to practice until such time as full compliance has been made by the Respondent.

D. The Respondent shall not have prescription writing privileges for a minimum of five (5) years.

E. The Respondent shall comply with all recommendations of continuing care made by Talbot Recovery Center in the Discharge Summary dated February 14, 2006. Specifically:

- 1) Agree to utilize Bill Gibson and Hugh Coleman as monitors.
- 2) Agree to utilize Dr. Brian Adler as primary care physician.
- 3) Agree to random/observed urine/blood monitoring drug screens per Dr. Coleman.
- 4) Return to work at Georgetown Memorial Hospital with return to work date being February 27, 2006. It is suggested that he work no more than 40 hours per week, unless agreed on and cleared by the monitor.
- 5) Utilize Dr. Brian Adler for medication management.
- 6) Utilize Harold Brown for family therapy.
- 7) Utilize Margaret Kauffman for individual therapy.
- 8) Agree to attend daily meetings for 90 days, and then 4-7 per week for the duration of the continuing care agreement.
- 9) Agree to work with a sponsor on a daily basis.

10) Agree to participate in Tabott Recovery Campus continuing care activities with two return visits within the first year of discharge, and then annually for the remainder of the continuing care agreement.

F. The Respondent shall comply with the terms of this Final Order and all state and federal statutes and regulations concerning the practice of medicine.

G. The Respondent shall promptly advise this Board in writing of any changes in address, practice, hospital privileges, professional status, or compliance with this Final Order. Correspondence and copies of reports and notices mentioned herein shall be directed to:

South Carolina Department of Labor,
Licensing and Regulation
Board of Medical Examiners
P.O. Box 11289
Columbia, S.C. 29211

H. Failure by the Respondent to pay the fine imposed or to abide by any of the aforementioned terms and conditions, or if it should be indicated from reliable reports submitted to the Board that the Respondent is otherwise unable to practice with reasonable skill and safety to patients, shall warrant the immediate temporary suspension of his license to practice medicine in this State pending a hearing into the matter and until further order of the Board.

4. The Respondent shall cooperate with the Board, its attorneys, investigators, and other representatives in the investigation of Respondent's practice and compliance with the provisions of this Final Order. It is the Respondent's responsibility to demonstrate compliance with each and every provision of this Final Order. Failure to satisfactorily comply with this requirement will be deemed a violation of this Final Order.

5. If the Respondent is in compliance with all of the conditions as outlined above for no less than five (5) years, to the satisfaction of the Board, the Respondent may request to come before this Board at that time for a determination as to whether any or all of these conditions should be lifted.

6. The Order of Temporary Suspension dated April 4, 2006, is lifted.

7. This Final Order shall take effect upon the service of this Order upon the Respondent.

AND IT IS SO ORDERED.

STATE BOARD OF MEDICAL EXAMINERS

By: Satish M. Prabhu M
Satish M. Prabhu, M.D.
President, Board of Medical Examiners

6 / 29 /, 2006.

**SOUTH CAROLINA DEPARTMENT OF LABOR, LICENSING, AND REGULATION
BEFORE THE STATE BOARD OF MEDICAL EXAMINERS**

In the Matter of:

Kent Michael McGinley, MD,
Medical License No. 19050,
Respondent.

Case No. 2006-166

**ORDER ON THE RESPONDENT'S MOTION
TO BE RELEASED FROM TERMS AND
CONDITIONS
(PUBLIC)**

This matter came before the Board of Medical Examiners (the Board) for hearing on August 3, 2011, as a result of Respondent's Motion to be Released from Terms and Conditions imposed by a previous board order. A quorum of Board members was present. The hearing was held pursuant to provisions of the S.C. Administrative Procedures Act (the APA), S.C. Code Ann. § 1-23-10, *et seq.* (1976, as amended). Paula S. Magargle, Assistant Agency Counsel, represented the State. The Respondent appeared *pro se*.

Upon careful consideration of the evidence and testimony, the Board finds that Respondent has complied with the terms of the 2006 order.

NOW, THEREFORE, IT IS ORDERED, ADJUDGED, AND DECREED that: the Respondent's motion to be released from the terms and conditions of his June 29, 2006 Final Order is granted.

AND IT IS SO ORDERED.

STATE BOARD OF MEDICAL EXAMINERS

BY: *Louis E. Costa II, MD*
Louis E. Costa II, MD.
President of the Board

8/17, 2011

**SOUTH CAROLINA DEPARTMENT OF LABOR, LICENSING AND REGULATION
BEFORE THE STATE BOARD OF MEDICAL EXAMINERS**

In the Matter of:

Kent Michael McGinley, MD
License No. 19050

Case No. 2006-166

Respondent

CERTIFICATE OF SERVICE

I hereby certify that I have this day caused to be served the within Order on the Respondent's Motion to be Released from Terms and Conditions (Public) upon the person hereafter named, by placing the same in an envelope, securely wrapped, in the United States Mail, via first class mail, properly addressed to the said person hereafter named, at the place and address stated below, which is the last known address for the same:

Kent Michael McGinley, MD
77 Fennel Court
Georgetown, SC 29440

**SOUTH CAROLINA DEPARTMENT OF
LABOR, LICENSING & REGULATION**


Jennifer E. Cooper, Administrative Assistant
LLR-Office of Advice Counsel
Post Office Box 11329
Columbia SC 29211 1329

8/18, 2011.



About Us

For more than a half-century, residents of Georgetown and surrounding South Carolina counties have received healthcare services provided by a dynamic, progressive not-for-profit organization known regionally today as Georgetown Hospital System. At Georgetown Memorial Hospital and Waccamaw Community Hospital, our trained professionals adopt a team approach in providing care for you and your family. Whether you are having outpatient testing or are an inpatient, a skilled, caring interdisciplinary team of healthcare providers coordinates the evaluation and administration of your care and treatment. We work hard to make the experience at one of our hospitals as comfortable and convenient as possible...both for our patients and for their family members.

Growth in terms of facilities, medical staff, services and employees has been at the core of Georgetown Hospital System's development. When it opened in 1950, Georgetown Memorial Hospital had 54 beds and a 14-member medical staff. Through the years, beds were added as services and medical staff increased. Today, Georgetown Memorial Hospital has 131 patient beds, and is a full service facility that includes ICU and Step-Down beds, a Cardiac Cath Lab, Endoscopy, Surgical Services, Emergency Department, Labor and Delivery, Pediatrics and several telemetry-equipped medical-surgical nursing units.

In 2002, Georgetown Hospital System opened its second hospital, Waccamaw Community Hospital, to meet the needs of the county's rapidly growing northern service area just south of Myrtle Beach, one of the state's best-known tourist meccas.

Waccamaw Community Hospital, located in Murrells Inlet, recently completed a major expansion adding 56 medical/surgical and acute inpatient rehabilitation beds for a facility total of 167 beds. In Spring 2013 a new Surgery Pavilion opened its doors to patients. The 24,000-square-foot facility includes eight operating rooms, 14 recovery beds, 12 outpatient beds and two endoscopy rooms. Waccamaw Rehabilitation Center, located on the facility's third and fourth floors includes 43 acute inpatient rehab beds.

In 2004, Georgetown Hospital System opened a \$10 million cancer treatment center in Georgetown. Francis B. Ford Cancer Treatment Center offers local cancer patients the opportunity to receive both chemotherapy and radiation therapy without being forced to leave the county. The project was undertaken as a joint effort with Medical University of South Carolina's (MUSC) well-known Hollings Cancer Center.

An advanced Imaging Center at Waccamaw Medical Park - East located in Murrells Inlet across from Waccamaw Community Hospital offers state-of-the-art open MRI and breast imaging capabilities. A Breast Health Center within the building offers a variety of imaging capabilities designed for routine breast screening and diagnostic purposes, including MRI Breast Coil technology that provides technologists with breast specific MRI capabilities and stereotactic breast biopsy services. In addition, a complete educational resources library is available at the center. The Breast Health Center offers digital mammography for a first time to women in Horry and Georgetown counties.

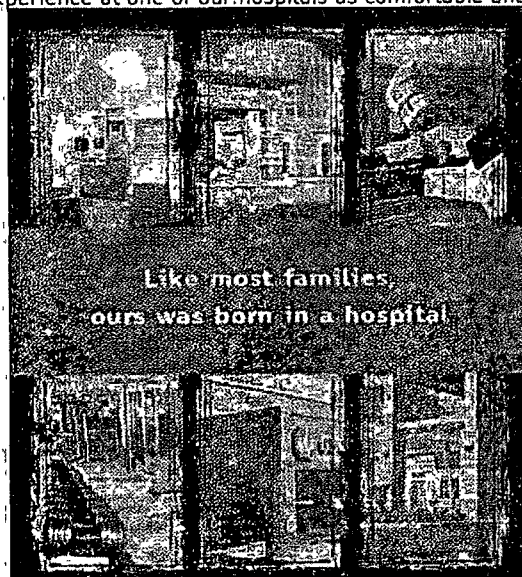
Also located at Waccamaw Medical Park - East, NextStep Wound Healing Center was added to the NextStep Rehabilitation Services family of programs in 2006. Our NextStep Wound Healing Center takes a multi-disciplinary approach to wound management and offers comprehensive treatments using leading edge techniques such as Hyperbaric Oxygen Therapy (HBO).

In early 2012, Georgetown Hospital System expanded the Waccamaw Community Hospital campus to include a new 90,000 square foot medical office building. The new facility, Waccamaw Medical Park - West includes physician offices, an endoscopy suite, NextStep Rehabilitation Services, NextStep Pain Management Center, and NextStep Neuro Rehabilitation Center which includes MUSC Health neurosurgeons.

The Georgetown Hospital Family also includes a variety of other services located at sites throughout Georgetown County and surrounding areas:

- HealthPoint Center for Health and Fitness in Pawleys Island near Litchfield
- NextStep Pediatric Outpatient Rehabilitation Services in Myrtle Beach and Georgetown
- NextStep Adult Outpatient Rehabilitation Services in Georgetown, Murrells Inlet and Myrtle Beach
- NextStep Pain Management Services in Murrells Inlet and Georgetown

Learn more about Georgetown Hospital System's facilities.





Mission, Vision & Values

Our Mission

Georgetown Hospital System is committed to providing high quality healthcare to the citizens of Georgetown County and surrounding areas. Our mission is to continuously improve the care we are able to render to exceed the expectations of our patients and customers.

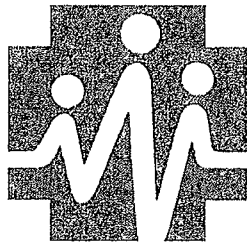
Our Vision

Georgetown Hospital System will achieve recognition as a leader in continuous quality improvement in healthcare and will be recognized as a superior healthcare provider, employer and resources center for health services in Georgetown and surrounding counties. This delivery of care will ultimately result in the improved health status of our community.

Our Values

Georgetown Hospital System expects the very highest standard in human behavior. Toward that end, we will respect the following principles:

- We will be dynamic in our efforts to meet and exceed the expectations of our customers through continuous improvement.
- We are a team and treat each other with respect. Our reputation and vitality are determined by our actions.
- Customer satisfaction is our primary focus
- Our integrity and ethics will not be compromised.
- We will continuously review, upgrade and change technology to meet the needs of our patients and customers
- We will ensure healthcare availability to all members of our community regardless of age, race or station.
- We will utilize our resources in a cost effective manner in an effort to contribute to the survival and continued growth of the facility.



WACCAMAW
COMMUNITY HOSPITAL

A member of the Georgetown Hospital Family

WACCAMAW COMMUNITY HOSPITAL

**APPOINTMENT AND REAPPOINTMENT
PROCEDURES FOR
MEDICAL STAFF MEMBERSHIP
AND CLINICAL PRIVILEGES**

**WACCAMAW COMMUNITY HOSPITAL
APPOINTMENT AND REAPPOINTMENT PROCEDURES
FOR MEDICAL STAFF MEMBERSHIP AND CLINICAL PRIVILEGES**

**ARTICLE I
GENERAL PROVISIONS**

Section 1. Purpose. These Appointment and Reappointment Procedures are established by the Board (i) to define the requirements for appointment and reappointment to the Medical Staff, and (ii) to grant initial, renewed or modified Clinical Privileges. These Appointment and Reappointment Procedures are intended to supplement the core criteria for Medical Staff membership set forth in the applicable provisions of the Medical Staff Bylaws.

Section 2. Definitions. The defined terms used in these Appointment and Reappointment Procedures are set forth in the attached Exhibit A.

**ARTICLE II
APPOINTMENT AND REAPPOINTMENT PROCEDURES**

Section 1. Appointment and Reappointment Requirements

A. Pre-Application.

(1) Practitioners seeking initial Medical Staff membership and/or Clinical Privileges, shall be provided a pre-application form reviewed by the MEC and approved by the Board and shall be required to complete a pre-application form that includes the following

(a) A description of the Board's qualifications set forth in the Medical Staff Bylaws that are used to review applications for Medical Staff membership and Clinical Privileges;

(b) A description of the Medical Staff application review procedure;

(c) A request that the Practitioner describe the nature and extent of the Medical Staff appointment and Clinical Privileges desired; and

(d) A request that the Practitioner provide proof that the Practitioner meets each of the basic objective criteria and applicable qualifications prior to receiving an Medical Staff application form

(2) The Practitioner shall complete the pre-application form and submit it to the Hospital's Medical Staff Office for review and consideration by the MEC.

(3) The MEC shall review the pre-application form and determine whether the Practitioner meets the applicable qualifications for Medical Staff membership and Clinical Privileges. The MEC shall also review the pre-application form to determine whether the Medical Staff membership and Clinical Privileges requested by the Practitioner are consistent with any exclusive Hospital contract for the furnishing of Hospital-Based Services

(4) If the Practitioner meets the applicable qualifications for Medical Staff membership and Clinical Privileges and the pre-application form is consistent with the Hospital's contracts for the furnishing of Hospital-Based Services based on the foregoing determination by the MEC, then the Practitioner shall be forwarded an application for Medical Staff membership and Clinical Privileges for completion and consideration in accordance with these Appointment and Reappointment Procedures

(5) If the Practitioner fails to meet the applicable qualifications for Medical Staff membership and Clinical Privileges or the Practitioner's requested Medical Staff membership and Clinical Privileges are not consistent with any exclusive Hospital contract for Hospital-Based Services, then the Practitioner shall be notified of the determination that the Practitioner is not eligible to receive or submit a Medical Staff application. A determination that the Practitioner is not eligible to receive or submit a Medical Staff application is not an Adverse Action and does not entitle the Practitioner to a hearing or appellate review under the Corrective Action and Fair Hearing Procedures.

B Application.

(1) If a determination is made that the Practitioner is eligible to apply for Medical Staff membership and Clinical Privileges, or for re-appointment and/or Clinical Privileges, the following information shall be submitted to the Practitioner:

(a) The appropriate Medical Staff application form materials, including a description of the Board's qualifications used to review Medical Staff applications and re-applications;

(b) A copy of the Medical Staff Bylaws, the Rules and Regulations, these Appointment and Reappointment Procedures and the Corrective Action and Fair Hearing Procedures; and

(c) A release and indemnification statement pertaining to all individuals and entities who participate in, or provide information as part of the Medical Staff application process

(2) Application for Medical Staff membership and/or Clinical Privileges shall be presented in writing, on the prescribed form, which will state the qualifications and references of the Practitioner. Practitioners must include an application fee in an

amount determined by the Board when requesting Medical Staff membership in any Medical Staff category. A Medical Staff application will not be processed until the application fee is received by the Hospital.

(3) A Practitioner may be requested to appear before the Medical Staff committee assigned responsibility for the review of the credentials of Practitioners for interview in conjunction with an application for Medical Staff membership.

(4) The Practitioner shall be required to sign a release and indemnity statement releasing from civil liability those reviewing or providing information relative to credentialing, Medical Staff membership, and Privileges.

(5) The Practitioner must provide a statement regarding his/her past medical history, including physical impairment, mental problems, current or past, and substance abuse, current or past

(6) The Practitioner must sign a statement that the Practitioner agrees, if accepted for membership to the Medical Staff, to be bound by, the Hospital's mission, the Medical Staff Bylaws, the Rules and Regulations, these Appointment and Reappointment Procedures, the Corrective Action and Fair Hearing Procedures, other Medical Staff policies and procedures and Hospital policies

(7) The Practitioner shall provide information to the Medical Staff committee assigned responsibility for the review of the credentials of Practitioners regarding

(a) Voluntary or involuntary termination of the Practitioner's medical staff membership or voluntary relinquishment, reduction or loss of privileges at any other hospital or health care facility;

(b) Any pending challenge to, voluntary or involuntary relinquishment of, or loss of the Practitioner's license from the Licensing Board,

(c) Any pending challenge, voluntary or involuntary relinquishment of, or loss of the Practitioner's South Carolina controlled substance license or DEA controlled substance registration; and

(d) Final judgments or settlements involving the Practitioner.

(8) Each application for appointment or reappointment to the Medical Staff, or an application for modification of appointment status or Clinical Privileges, must contain a request for the specific Clinical Privileges desired by the Practitioner.

(9) In addition to the above requirements, a Practitioner seeking re-appointment to the Medical Staff, or modifications of appointment status or Clinical Privileges, shall receive the above-referenced application materials at least ninety (90) days prior to the expiration of any current appointment period. The Practitioner shall

then be required to submit the completed application at least sixty (60) days prior to the expiration of any current appointment period.

(a) Failure, without good cause, to return the application form, with any required application fee in an amount determined by the Board within the required time frame under this Section, or to inadequately complete the application form, shall constitute a voluntary resignation from the Medical Staff, and shall result in automatic termination of Medical Staff membership and Clinical Privileges effective at the expiration of the Practitioner's current appointment period.

(b) A Practitioner whose Medical Staff membership or Clinical Privileges is terminated for failure to submit a complete application form as required under this Article, shall be entitled to the hearing and appellate review rights set forth in the Corrective Action and Fair Hearing Procedures for the sole purpose of resolving the issue of good cause.

C. Burden of Proof The Practitioner shall have the burden of producing adequate information that forms a basis for a proper evaluation of the Practitioner's competence, professional conduct, ethics, character. The Practitioner shall also have the burden of establishing by clear and convincing evidence that the Practitioner meets all qualifications of the Medical Staff as set forth in the Medical Staff Bylaws, the Rules and Regulations, these Appointment and Reappointment Procedures, any other Medical Staff policies and procedures and Hospital policies.

D Verification of Information.

(1) The Medical Staff committee assigned responsibility for the review of the credentials of Practitioners (or assigned Medical Staff secretary) shall review the application and determine that the application is complete and in compliance with all application requirements

(2) If additional information is required, the Medical Staff application will be returned to the Practitioner who is responsible for ensuring that all necessary information is provided, and that the application and all reference responses are complete.

(3) Once the application and all reference responses are determined to be complete, the MEC (or assigned Medical Staff secretary) shall verify and investigate all information submitted as part of the application process, including but not limited to the following:

(a) Education and training,

(b) Licensure and certifications;

- (c) References and other professional affiliations;
- (d) Data Bank reports; and
- (e) Exclusion or sanction by federal health care programs, including Medicare and Medicaid programs.

(4) In the case of a Practitioner seeking reappointment to the Medical Staff, a recommendation is required from the Department Chairperson of the Practitioner's assigned clinical department and the Chairperson of the Medical Staff committee assigned responsibility for the review of the credentials of Practitioners concerning the reappointment of the Practitioner and the Clinical Privileges to be granted and documentation that the Practitioner has met the meeting attendance and continuing education requirements under the Medical Staff Bylaws

(5) A Practitioner's failure to adequately complete the application form, the withholding of requested information, or the providing of false or misleading information shall, in and of itself, constitute a basis for denial or revocation of Medical Staff appointment.

(6) Following the receipt and verification of all information submitted as part of the application process, and the determination that the requested information is complete and accurate, the application shall be forwarded to the Department in which the Practitioner would be assigned based on clinical specialty for review and consideration

E Department Action

(1) Upon receipt of a Practitioner's complete application for initial appointment or reappointment, the Chairperson of the Department in which the Practitioner is, or would be assigned, shall review the application and supporting documentation. The Chairperson, at the Chairperson's discretion, may conduct a personal interview with the Practitioner. The Department Chairperson may request additional information if he or she deems such information necessary.

(2) The Department Chairperson shall transmit, within thirty (30) days of receipt of a Practitioner's complete application, to the Medical Staff committee assigned responsibility for the review of the credentials of Practitioners, on the prescribed form, a written report and recommendations as to the Medical Staff appointment and, if appointment is recommended, as to the Medical Staff category and department, Clinical Privileges to be granted and any special conditions to be attached to the Medical Staff appointment or exercise of Clinical Privileges. A Department Chairperson may also recommend that the MEC defer action on a Practitioner's application. The reason for each recommendation shall be stated and supported by reference to the completed application and any other documentation considered by the Department Chairperson, all of which shall be transmitted with the report to the Medical Staff committee assigned responsibility for the review of the credentials of Practitioners

F. Committee Review of Credentials.

(1) If the MEC is the committee assigned the responsibility for the review of the credentials of Practitioners under the Medical Staff Bylaws, then the provisions of this Section shall not apply and the report of the Department Chairperson shall be transmitted to the MEC for consideration of the Practitioner's application.

(2) The members of the Medical Staff committee assigned responsibility for the review of the credentials of Practitioners shall review the Practitioner's Medical Staff application, the supporting documentation, the Department Chairperson's report and recommendations and such other information available to it that may be relevant to consideration of the Practitioner's qualifications for the Medical Staff category or Clinical Privileges requested.

(3) The Chairperson of the Medical Staff committee assigned responsibility for the review of the credentials of Practitioners shall transmit, within thirty (30) days of receipt of the Department Chairperson's report under this Article, to the MEC on the prescribed form a written report and recommendation as to the Medical Staff appointment or reappointment and, if appointment or reappointment is recommended, as to the Medical Staff category and department, Clinical Privileges to be granted and any special conditions to be attached to the Medical Staff appointment or the exercise of Clinical Privileges. The Chairperson to the Medical Staff committee assigned responsibility for the review of the credentials of Practitioners may also recommend that the MEC defer action on the Practitioner's application. The reason for each recommendation shall be stated and supported by references to the completed application and any other documentation considered by the Medical Staff committee assigned responsibility for the review of the credentials of Practitioners, all of which shall be transmitted with the report to the MEC. Any minority view shall be reduced to writing, supported by reasons and references and transmitted with the majority report of the Medical Staff committee assigned responsibility for the review of the credentials of Practitioners.

G. MEC Action.

(1) In conducting the Medical Staff application review, the MEC shall initially

(a) Examine the Medical Staff application for evidence of character, professional competence, qualifications, prior experience, and ethical standing of the Practitioner,

(b) Determine, through information obtained from references and other sources available to the MEC, including but not limited to the reports of to the Medical Staff committee assigned responsibility for the review of the credentials of Practitioners and the appropriate Department Chairperson, whether the Practitioner meets all of the required qualifications, and

(c) Determine the Hospital's present ability to provide adequate facilities or supportive services for the Practitioner and the Practitioner's patients

(2) Based upon this review, the MEC shall formulate a recommendation regarding appointment or reappointment, assigned clinical department, and Clinical Privileges within thirty (30) days of receipt of the report from Medical Staff committee assigned responsibility for the review of the credentials of Practitioners or the Department Chairperson, if the MEC is the committee assigned responsibility for the review of the credentials of Practitioners.

(3) The MEC shall submit its written recommendation with all necessary supporting documentation as follows that will allow the Board to take informed action:

(a) "Deferral Recommendation," which means an initial decision by the MEC to defer for further consideration by the MEC, without recommendation to the Board at this time, of Practitioner's application, to be followed within forty-five (45) days with a subsequent recommendation for appointment or reappointment with specified Clinical Privileges, or for rejection for Medical Staff membership and Clinical Privileges;

(b) "Favorable Recommendation," which means action by the MEC that is favorable to the Practitioner, the recommendation is promptly forwarded, together with the application form and its accompanying information and reports, to the Board, or

(c) "Adverse Recommendation," which means a recommendation by the MEC for an Adverse Action; the recommendation is promptly forwarded, together with the application form and its accompanying information and reports, to the CEO (or designee).

(4) Within seven (7) days after the MEC submits an Adverse Recommendation to the CEO (or designee), the CEO (or designee) shall provide the Practitioner with Special Notice of the Adverse Recommendation in accordance with the Corrective Action and Fair Hearing Procedures. The Medical Staff application and its accompanying information and information of any Practitioner receiving an Adverse Recommendation shall be held by the CEO (or designee) until the Practitioner has exercised, or has been deemed to have waived, the Practitioner's hearing and appellate review rights under the Corrective Action and Fair Hearing Procedures.

H. Board Action on Favorable Recommendations by the MEC.

(1) The Board is ultimately responsible for all decisions regarding
- Medical Staff appointment and reappointment, and the determination of Clinical Privileges, taking into consideration the documents and information concerning the

MEC's preliminary recommendations and other supporting documentation or information

(2) Upon receipt of a Favorable Recommendation from the MEC, the Board has the authority to follow, reject, or modify the MEC's Favorable Recommendation to include any of the following actions:

(a) Accept the Favorable Recommendation of the MEC;

(b) Defer the consideration of the Favorable Recommendation of the MEC for further consideration or to request additional information or clarification, without action at this time, to be followed within forty-five (45) days with a subsequent recommendation for appointment or reappointment with specified Clinical Privileges, or for rejection for Medical Staff membership,

(c) Refer the Favorable Recommendation back to the MEC for further consideration; or

(d) Take action contrary to the Favorable Recommendation of the MEC.

(3) If the Board accepts the Favorable Recommendation of the MEC and approves the Practitioner's Medical Staff application and request for Clinical Privileges, then the CEO (or designee) shall send the Practitioner Special Notice of the Board's decision that includes the following information

(i) The Medical Staff category to which the Practitioner is appointed,

(ii) The clinical department to which the Practitioner is assigned;

(iii) The Clinical Privileges that the Practitioner may exercise, and

(iv) Any special conditions attached to the Medical Staff Appointment, clinical department assignment, or Clinical Privileges granted.

(4) If the Board takes action contrary to a Favorable Recommendation of the MEC, (in which case the Practitioner had no reason to request a hearing at that time), then the CEO (or designee) shall send the Practitioner Special Notice of the Board's decision that includes the reasons for the Board's decision. The Special Notice shall also advise the Practitioner that the Board's decision entitles the Practitioner to the hearing and appellate review rights set forth in the Corrective Action and Fair Hearing Procedures.

I MEC Inaction Or Delay

(1) If the MEC does not issue a recommendation to the Board or the CEO (or designee) within (i) thirty (30) days after the MEC receives the report of the Medical Staff committee assigned responsibility for the review of the credentials of Practitioners or the Department Chairperson under this Article, or (ii) forty-five (45) days of the MEC's Deferral Decision under this Article, and if the Practitioner so requests in writing, the Board may take one of the following actions on its own initiative:

(a) "Deferral Decision," which means action by the Board to defer a Practitioner's application for further consideration, to be followed within forty-five (45) days with a subsequent recommendation for appointment or reappointment with specified Clinical Privileges, or for rejection for Medical Staff membership,

(b) "Favorable Decision," which means action by the Board that is favorable in all aspects of the application; or

(c) "Adverse Decision," which means action by the Board that is adverse to the Practitioner.

(2) If the Board issues a Favorable Decision, then the Favorable Decision shall become effective as the final decision of the Board. The CEO (or designee) shall send the Practitioner Special Notice of the Board's Favorable Decision including.

(i) the Medical Staff category to which the Practitioner is appointed;

(ii) the clinical Department to which the Practitioner is assigned;

(iii) the Clinical Privileges that the Practitioner may exercise, and

(iv) any special conditions attached to the Medical Staff Appointment, clinical department assignment, or Clinical Privileges granted

(3) If the Board issues an Adverse Decision, then the CEO (or designee) shall provide the Practitioner with Special Notice within seven (7) days of the Board's action, to include the reasons for the Board's Adverse Decision. Any such Special Notice of an Adverse Decision shall also advise the Practitioner of the hearing and appellate review rights in the Corrective Action and Fair Hearing Procedures

J. Provisional Medical Staff Extension or Advancement.

(1) A Practitioner's appointment to the Provisional Medical Staff may be extended by the MEC for one (1) extension period of up to twelve (12) additional months upon written request of the Practitioner at least sixty (60) days prior to the expiration of the Practitioner's initial appointment

(2) If an extension is not granted by the MEC under this Section, then the Practitioner shall be considered for advancement to the Practitioner's requested Medical Staff category at the end of the Provisional Medical Staff appointment period. At least sixty (60) days prior to the expiration of the Practitioner's Provisional Medical Staff appointment, the Practitioner must submit the following information to the MEC

(a) A signed statement from the Practitioner's assigned Department Chairperson, that the Practitioner meets the applicable qualifications, has discharged the responsibilities and obligations, and has not exceeded or abused the Prerogatives for the Practitioner's requested Medical Staff membership category,

(b) A signed statement from the Practitioner's assigned Department Chairperson, that the Practitioner has satisfactorily demonstrated the ability to exercise the requested Clinical Privileges; and

(c) A signed statement from the Practitioner's assigned Department Chairperson, that the Practitioner has cooperated with the Medical Staff, officers and committees of the Medical Staff and Hospital personnel.

(3) If the MEC fails to approve a Practitioner's request for extension of the Practitioner's Provisional Medical Staff appointment or fails to approve a Practitioner's request for advancement to the requested Medical Staff membership category under this Article, then the CEO (or designee) shall send the Practitioner Special Notice of the MEC's adverse recommendation and the Practitioner shall be entitled to the hearing and appeal rights set forth in the Corrective Action and Fair Hearing Procedures

K Immunity From Legal Action. As a condition of applying for appointment or reappointment to the Medical Staff, for any advancement in Medical Staff category for particular Clinical Privileges, or for any modified, enlarged, or additional Clinical Privileges, the Practitioner

(1) Authorizes Hospital representatives to solicit and act upon information, including otherwise privileged or confidential information, provided by third parties bearing on the Practitioner's credentials, and agrees that any information so provided shall not be required to be disclosed to the Practitioner if the third party providing such information does so on the condition that it be kept confidential,

(2) Authorizes third parties to release information, including otherwise privileged or confidential information, as well as reports, records, statements, recommendations, and other documents in their possession, bearing on the Practitioner's credentials to any Hospital representative, and consents to the inspection and procurement by any Hospital representative of such information, records and other documents;

(3) Authorizes the Hospital and Hospital representatives to release such information, when requested by the Practitioner, to other hospitals, health care facilities, and their agents, that solicit such information for the purpose of evaluating the Practitioner's professional qualifications pursuant to the individual's request for appointment, reappointment, or clinical privileges at other hospitals or healthcare facilities,

(4) Agrees to appear for a personal interview at a reasonable time, during normal business hours, if requested by an appropriate Hospital representative,

(5) Agrees to meet the following terms and conditions and undergo a physical and/or mental examination at any time, at the request of the MEC, in order to review the Practitioner's health status and determine any impairment that interferes with the Practitioner's ability to provide quality patient care:

(a) The examination shall be conducted by a physician approved by the MEC and the Practitioner,

(b) If the MEC and Practitioner cannot agree on a physician to conduct the examination, the MEC and the Practitioner shall each choose a physician and those two physicians shall select the physician to perform the examination;

(c) The request of the MEC to undergo a physical and/or mental examination shall be supported by a statement of the reasons for such request, and

(d) If the Practitioner or the MEC wishes to appeal either the request or the physician approved or disapproved for such examination, such appeal shall be made to the Board's Joint Conference Committee, which shall hear the matter promptly, and the decision of which shall be final with respect to such matter

(6) Agrees to the reporting by any Hospital representative of information to the Data Bank which such Hospital representative believes in good faith is required by law to be reported;

(7) Agrees that if the Practitioner is subject to any Adverse Action or recommendation for an Adverse Action under these Appointment and Reappointment Procedures, the Practitioner:

(a) Will follow and exhaust the hearing and appellate review rights afforded by the Corrective Action and Fair Hearing Procedures as a prerequisite to any other action available to the Practitioner, if any; and

(b) Acknowledges that the Practitioner has the burden of demonstrating by clear and convincing evidence that the Practitioner meets the standards for appointment or reappointment to the Medical Staff, or for the Clinical Privileges requested.

(8) Releases, indemnifies and holds harmless from all liability.

(a) All members of the Medical Staff committees, persons engaged to assist such Medical Staff committees or the Board, the Board, the CEO (or designee) and all other Hospital representatives, officers, employees or agents, for any and all acts, omissions, or proceedings undertaken or performed in connection with the evaluation of the Practitioner's Medical Staff application, and the Practitioner's credentials, if such acts, omissions or proceedings are committed or undertaken substantially in accordance with the standards for Professional Review Actions in the Corrective Action and Fair Hearing Procedures, and

(b) All individuals and organizations who provide information in their possession, including otherwise privileged or confidential information, to the Hospital, Medical Staff or other Hospital representatives concerning the Practitioner's competence, professional ethics, character, health and emotional stability when such communication is intended to aid in the evaluation of the qualifications, fitness or character of the applicant and does not know the information provided to be false

ARTICLE III

CLINICAL PRIVILEGES

Section 1. Exercise of Clinical Privileges. A Practitioner shall be entitled to exercise only those Clinical Privileges or specified services specifically granted to the Practitioner by the Board. Regardless of the level of Clinical Privileges granted, each Practitioner must obtain consultation when necessary for the safety of a patient or when required by the Rules and Regulations, or other policies of the Medical Staff, any of its clinical departments, or the Hospital. Said Clinical Privileges and services must be

within the scope of the license, certificate, or other legal credential authorizing the Practitioner to practice in South Carolina and consistent with any restrictions thereon. The granting of Clinical Privileges shall be conditioned on acceptance of the obligations of such Privileges, including participating in emergency room on-call schedule and other rotational and administrative obligations.

Section 2. Delineation of Clinical Privileges

A. 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 Medical Staff member for modification of Privileges must be supported by documentation of additional training and/or experience supportive of the request. Modification of Privileges must be considered and approved by the Chairperson of the Department to which the Practitioner is a member, the Medical Staff committee assigned responsibility for the review of the credentials of Practitioners, the MEC and the Board.

B. Bases For Privileges Determination. Requests for Clinical Privileges shall be evaluated on the basis of the Practitioner's background, education, training, experience, health, ability, and judgment, demonstrated competence, adherence to professional ethics, reputation, ability to work well with others, references and other relevant information, including an appraisal by the Department to which the Practitioner is or would be assigned. The bases for determinations made in connection with periodic reappointment, and applications for additional Privileges shall include the observation of members of the Active Medical Staff and the documented results of the patient care audit and other quality review evaluations conducted at the Hospital including, but not limited to, the reports of appropriate Medical Staff committees. Clinical Privileges determinations shall also be based on pertinent information concerning physical and mental capabilities and clinical performance obtained from other sources, especially other health care institutions. All criteria set forth in the applicable qualifications of the Medical Staff Bylaws shall also be considered for determination of Clinical Privileges.

C. Procedure. All requests for Clinical Privileges shall be processed pursuant to the procedures pertaining to appointment and reappointment set forth in these Appointment and Reappointment Procedures. The Practitioner shall have the burden of producing adequate information for a proper evaluation of the Practitioner's qualifications and competence for the Clinical Privileges requested as required.

D. Resumption of Privileges After Interruption. Any Practitioner whose practice is interrupted for a period of greater than ninety (90) days (other than for reasons related to professional conduct, patient care or an Adverse Action) shall be subject to the leave of absence reinstatement provisions in the Medical Staff Bylaws.

E Special Conditions for Podiatric and Dental Privileges.

(1) Dentists and podiatrists shall exercise Clinical Privileges as designated on an individual basis and within the scope of their licensure

(2) Surgical procedures performed by podiatrists and dentists shall be under the overall supervision of the Chief of Surgery (or designee)

(3) A member of the Active Medical Staff shall 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 shall determine the risk and effect of the proposed surgical procedure on the total health status of the patient.

(4) Dentists shall be responsible for the part of their patients' history and physical examination that relates to dentistry in accordance with the Medical Staff Bylaws, the Rules and Regulations, Medical Staff policies and procedures and Hospital policies.

(5) Podiatrists shall be responsible for the part of their patients' history and physical examination that relates to podiatry in accordance with the Medical Staff Bylaws, the Rules and Regulations, Medical Staff policies and procedures and Hospital policies

(6) Dentists and podiatrists may write orders and prescribe medications within the limits of their licensure, the Medical Staff Bylaws, the Rules and Regulations, Medical Staff policies and procedures and Hospital policies

F. Special Conditions for Oral Surgery Privileges

(1) Oral surgeons shall exercise Clinical Privileges as designated on an individual basis and within the scope of their licensure.

(2) Surgical procedures performed by oral surgeons shall be under the overall supervision of the Chief of Surgery (or designee)

(3) If an oral surgeon successfully completes a postgraduate program in oral and maxillofacial surgery at a program that is accredited by a nationally recognized accrediting body approved by the United States Department of Education, then the oral surgeon may be considered for Clinical Privileges to perform the medical history and physical examination for their patients to assess the medical, surgical and anesthetic risk of any proposed operative and other procedures in accordance with their licensure, the Medical Staff Bylaws, the Rules and Regulations, Medical Staff policies and procedures and Hospital policies

(4) Oral surgeons may write orders and prescribe medications within the limits of their licensure, the Medical Staff Bylaws, the Rules and Regulations, Medical Staff policies and procedures and Hospital policies.

G Telemedicine Privileges.

(1) Telemedicine involves the use of electronic communication or other communication technologies to provide or support care from a remote location.

(2) Any Practitioner who prescribes, renders a diagnosis or otherwise provides clinical treatment to Hospital patients through the use of telemedicine must obtain Clinical Privileges to provide telemedicine services at the Hospital in accordance with these Appointment and Reappointment Procedures

(3) The scope of services that may be appropriately provided by telemedicine shall be determined by the Board based on accepted quality standards and the recommendations of the MEC

Section 3. Procedures for Delineation of Clinical Privileges for Other Licensed Individuals

A. Any licensed individual who is not a Practitioner, but who wishes to provide independent patient care services at the Hospital must apply for, and be granted, specific Clinical Privileges.

B. The requirements for delineation of Clinical Privileges for licensed individuals who are not Practitioners shall be determined by the Board.

Section 4. Temporary Privileges Pending Application.

A Status of Application. Upon receipt of an application for Medical Staff membership from an appropriately licensed Practitioner, the CEO (or designee), after reviewing and considering the recommendation of the Chairperson of the Medical Staff committee assigned responsibility for the review of the credentials of Practitioners, may, upon the basis of information then available which may reasonably be relied upon as to the competence and ethical standing of the Practitioner, and with the written concurrence of. (i) the Department Chairperson where the Practitioner will be assigned, and (ii) the Chief of Staff, grant temporary admitting and Clinical Privileges to the Practitioner for a period of ninety (90) days with subsequent renewal not to exceed the pendency of the Medical Staff application. Only Practitioners with a pending application for Active Medical Staff or Limited Active Medical Staff membership shall be eligible for Temporary Privileges under this Section. In exercising such Temporary Privileges, the Practitioner shall act under the supervision of the Department Chairperson to which the Practitioner is assigned and shall be subject to the conditions specified in this Section

B. General Conditions. Temporary Privileges shall be granted only when the information available reasonably supports a favorable determination regarding the Practitioner's qualifications, ability, judgment and competence to exercise the Privileges requested, and only after the Practitioner has satisfied all existing Hospital and Medical

Staff requirements regarding professional liability insurance. Special requirements of supervision and reporting may be imposed by the applicable Department Chairperson. Temporary Privileges shall be immediately terminated by the CEO (or designee) upon notice of any failure by the Practitioner to comply with such special conditions. Before Temporary Privileges are granted, the Practitioner must acknowledge in writing that the Practitioner agrees to abide by the terms of the Medical Staff Bylaws, the Rules and Regulations, the Appointment and Reappointment Procedures, any Medical Staff policies and procedures and Hospital policies that apply to exercise of such Temporary Privileges, in all matters relating to the exercise of Temporary Privileges.

C Termination The CEO (or designee) may at any time, upon the recommendation of either the Chief of Staff or the Department Chairperson where the Practitioner with Temporary Privileges is assigned, terminate a Practitioner's Temporary Privileges effective as of the discharge from the Hospital of the Practitioner's patient(s) then under the Practitioner's care in the Hospital. Where the well-being of a patient is determined to be compromised by continued treatment by the Practitioner, the immediate termination of Temporary Privileges may be imposed by any person entitled to impose summary suspensions under the Corrective Action and Fair Hearing Procedures. In the event of any such termination, the Practitioner's patients then in the Hospital shall be assigned to another Practitioner by the Chief of Staff. The wishes of the patient shall be considered, where feasible, in selection of a substitute Practitioner.

D Rights of the Practitioner A Practitioner shall not be entitled to the hearing or appellate review rights afforded by the Corrective Action and Fair Hearing Procedures because the Practitioner's request for Temporary Privileges is refused or because all or any portion of a Practitioner's Temporary Privileges are terminated or suspended.

Section 5. Temporary Privileges for Locum Tenens Coverage.

A Approval of Temporary Privileges for Locum Tenens Coverage. The CEO (or designee), after reviewing and considering the recommendation the Department Chairperson where the locum tenens Practitioner will be assigned and the Chief of Staff, may grant a Practitioner serving as a locum tenens for a member of the Active Medical Staff Temporary Privileges to admit and attend to patients or provide on-call coverage for a period not to exceed a total of ninety (90) cumulative days of coverage in a twelve (12) month period, unless, upon demonstration of good cause by the sponsoring Active Staff member, the CEO (or designee), in consultation with the Department Chairperson and the Chief of Staff, grant an extension for a period up to, but not to exceed, an additional ninety (90) days. The Active Medical Staff member sponsoring the locum tenens Practitioner shall be responsible for recording, monitoring, and reporting to the Department Chairperson the total number of days of coverage provided by the locum tenens Practitioner.

B General Conditions. Temporary Privileges shall be granted only when the information available reasonably supports a favorable determination regarding the

Practitioner's qualifications, ability, judgment and competence to exercise the Privileges requested, and only after the Practitioner has satisfied all existing Hospital and Medical Staff requirements regarding professional liability insurance. Special requirements of supervision and reporting may be imposed by the applicable Department Chairperson. Temporary Privileges shall be immediately terminated by the CEO (or designee) upon notice of any failure by the Practitioner to comply with such special conditions. Before Temporary Privileges are granted, the Practitioner must acknowledge in writing that the Practitioner agrees to abide by the terms of the Medical Staff Bylaws, the Rules and Regulations, the Appointment and Reappointment Procedures, any Medical Staff policies and procedures and Hospital policies that apply to exercise of such Temporary Privileges, in all matters relating to the exercise of Temporary Privileges.

C. Specific Conditions. All of the following conditions shall be satisfied prior to the time of the commencement of the locum tenens coverage and the exercise of temporary privileges under this Section:

(1) The locum tenens Practitioner's credentials are approved by the Department Chairperson where the locum tenens Practitioner will be assigned and the Chief of Staff,

(2) The locum tenens Practitioner is duly licensed to practice medicine in South Carolina, maintains a current federal and state controlled substance license and registration, and is not excluded, suspended or under sanction with any federal healthcare program including Medicare or Medicaid,

(3) The locum tenens Practitioner is sponsored by an Active Medical Staff member in good standing;

(4) The Active Medical Staff member sponsoring the locum tenens Practitioner submits to the Chairperson of the Medical Staff committee assigned responsibility for the review of the credentials of Practitioners a written request for specific Temporary Privileges for the locum tenens Practitioner. Such a request must include an outline of the training and background of the locum tenens Practitioner and at least two (2) letters of recommendation. The request and supporting documentation shall be forwarded by the Chairperson of the Medical Staff committee assigned responsibility for the review of the credentials of Practitioners to the Chief of Staff, and

(5) The locum tenens Practitioner executes and submits to the CEO (or designee) a statement acknowledging and consenting to the submission of the locum tenens Practitioner's name for approval of Temporary Privileges. In addition, the locum tenens Practitioner must document or demonstrate satisfaction of all applicable qualifications of Medical Staff membership set forth in the Medical Staff Bylaws, including a Data Bank inquiry. The locum tenens Practitioner shall also provide to the Hospital's Medical Staff office, prior to the commencement of each period for which Temporary Privileges are approved, verification of sufficient malpractice insurance coverage, valid licenses, verification that Privileges, if any, granted upon initial request,

are unchanged, and information regarding malpractice activity since the last coverage period. The Hospital's Medical Staff office shall verify the status of the Practitioner's state licensure, insurance, Data Bank reports and the Practitioner's status with federal healthcare programs, including Medicare and Medicaid; and

(6) The Active Medical Staff member sponsoring the locum tenens Practitioner must arrange for another Active Medical Staff member, who may or may not be in the same specialty as the sponsoring Active Medical Staff member, to be available in his absence to act as advisor to the locum tenens Practitioner, and assume responsibility for assuring that the locum tenens Practitioner properly completes all patient care, appropriate charts and insurance forms

D Termination The CEO (or designee) may at any time, upon the recommendation of either the Chief of Staff or the Department Chairperson where the Practitioner with Temporary Privileges is assigned, terminate a Practitioner's Temporary Privileges effective as of the discharge from the Hospital of the Practitioner's patient(s) then under the Practitioner's care in the Hospital. Where the well-being of a patient is determined to be compromised by continued treatment by the Practitioner, the immediate termination of Temporary Privileges may be imposed by any person entitled to impose summary suspensions under the Corrective Action and Fair Hearing Procedures. In the event of any such termination, the Practitioner's patients then in the Hospital shall be assigned to another Practitioner by the Chief of Staff. The wishes of the patient shall be considered, where feasible, in selection of a substitute Practitioner.

E Rights of the Practitioner A Practitioner shall not be entitled to the hearing or appellate review rights afforded by the Corrective Action and Fair Hearing Procedures because the Practitioner's request for Temporary Privileges is refused or because all of any portion of a Practitioner's Temporary Privileges are terminated or suspended.

Section 6. Temporary Privileges for the Care of Specific Patients.

A. Grant of Temporary Privileges Upon a Practitioner's submission of a written request for Temporary Privileges to provide care to specific patients, the CEO (or designee), after reviewing and considering the recommendation of the Department Chairperson where the locum tenens Practitioner will be assigned and the Chief of Staff, may grant a Practitioner Temporary Privileges for the care of up to two (2), but not more than (2), specific patients at the Hospital during any twelve (12) month period.

B. General Conditions Temporary Privileges under this Section shall be granted only when the information available reasonably supports a favorable determination regarding the Practitioner's qualifications, ability, judgment and competence to exercise the Privileges requested, and only after the Practitioner has satisfied all existing Hospital and Medical Staff requirements regarding professional liability insurance. Special requirements of supervision and reporting may be imposed by the applicable Department Chairperson. Temporary Privileges shall be immediately

terminated by the CEO (or designee) upon notice of any failure by the Practitioner to comply with such special conditions. Before Temporary Privileges are granted, the Practitioner must acknowledge in writing that the Practitioner agrees to abide by the terms of the Medical Staff Bylaws, the Rules and Regulations, the Appointment and Reappointment Procedures, any Medical Staff policies and procedures and Hospital policies that apply to exercise of such Temporary Privileges, in all matters relating to the exercise of Temporary Privileges.

C Termination. The CEO (or designee) may at any time, upon the recommendation of either the Chief of Staff or the Department Chairperson where the Practitioner with Temporary Privileges is assigned, terminate a Practitioner's Temporary Privileges effective as of the discharge from the Hospital of the Practitioner's patient(s) then under the Practitioner's care in the Hospital. Where the well-being of a patient is determined to be compromised by continued treatment by the Practitioner, the immediate termination of Temporary Privileges may be imposed by any person entitled to impose summary suspensions under the Corrective Action and Fair Hearing Procedures. In the event of any such termination, the Practitioner's patients then in the Hospital shall be assigned to another Practitioner by the Chief of Staff. The wishes of the patient shall be considered, where feasible, in selection of a substitute Practitioner.

D Rights of the Practitioner. A Practitioner shall not be entitled to the hearing or appellate review rights afforded by the Corrective Action and Fair Hearing Procedures because the Practitioner's request for Temporary Privileges is refused or because all of any portion of a Practitioner's Temporary Privileges are terminated or suspended.

Section 7. Temporary Privileges in Emergency Situations.

A In the case of an emergency, as defined in this Section, the CEO (or designee), in consultation with the Chief of Staff (or in the Chief of Staff's absence, the Chairperson of the affected Department) may grant Temporary Privileges to a Practitioner who is not a member of the Medical Staff upon the following conditions:

(1) Approval of such Temporary Privileges as is necessary to provide a medical or surgical service that is otherwise unavailable at the Hospital to treat a patient in an emergent condition;

(2) Prior to permitting the Practitioner to exercise Temporary Privileges under this Section, the Hospital's Medical Staff office shall make every effort to, if reasonable under the circumstances, (i) make an inquiry concerning the Practitioner's credentials to the Data Bank and (ii) verify the status of the Practitioner's state licensure and current competence (a documented telephone call is acceptable);

(3) Prior to permitting the Practitioner to exercise Temporary Privileges under this Section, if reasonable under the circumstances, the Practitioner must execute and submit to the Hospital a statement acknowledging and consenting to the

submission of the Practitioner's name for approval of Temporary Privileges. In addition, the Practitioner must represent in writing that the Practitioner

(a) Has read all of the applicable qualifications of Medical Staff membership set forth in the Medical Staff Bylaws, the Rules and Regulations and these Appointment and Reappointment Procedures related to Temporary Privileges in emergency situations;

(b) Satisfies all Medical Staff member general qualification requirements set forth in the Medical Staff Bylaws;

(c) Agrees to be bound by the terms of the Medical Staff Bylaws, the Rules and Regulations, and these Appointment and Reappointment Procedures that apply to the exercise of Temporary Privileges; and

(d) Agrees to provide to the Hospital, within a reasonable time upon conclusion of the emergency, documentation confirming satisfaction of the general qualification requirements set forth in the Medical Staff Bylaws.

(4) The Practitioner considered for Temporary Privileges under this Section is sponsored by an Active Medical Staff member in good standing who agrees, prior to authorization of emergency coverage, to act as advisor for the Practitioner and to be responsible for assuring that the Practitioner properly completes all patient care, appropriate charts and insurance forms, and

(5) When the emergency condition no longer exists as determined by the Chief of Staff (or designee) and upon Special Notice to the Practitioner from the CEO (or designee), the Temporary Privileges of the Practitioner related to such emergency shall expire unless the Chief of Staff and CEO (or designee), in consultation with the sponsoring Active Medical Staff member and the Practitioner with Temporary Privileges, determine that the expiration of such Temporary Privileges would not be in the best interest of the patient attended by the Practitioner. If a determination is made to extend the Temporary Privileges of a Practitioner under this Section beyond the emergency, the Chief of Staff and CEO (or designee), and appropriate Department Chairperson shall expedite the review of the Practitioner's eligibility for standard locum tenens coverage under this Article and make such determination as soon as is reasonably prudent.

B. Emergencies

(1) An "emergency" means a condition in which there is a danger of serious or permanent harm or death to a patient or a patient's unborn fetus if treatment is delayed or in which the life of the patient or the patient's unborn fetus is in immediate danger and any delay in administering treatment would add to that danger

(2) In the case of an emergency, any Practitioner who is a member of the Medical Staff, including any Practitioner who is granted Temporary Privileges and

whose Temporary Privileges are current at the time of the emergency, to the degree permitted by the Practitioner's license and regardless of the Practitioner's Hospital department, Medical Staff status, or Clinical Privileges, shall be permitted to do and assist as necessary to do everything possible to save the life of a patient or provide appropriate treatment, and shall be permitted to use every facility or service of the Hospital necessary, including calling for necessary or desirable consultations. When an emergency situation ceases, the patient's attending Practitioner will resume care of the patient or request an appropriate consultation if the Practitioner does not have Clinical Privileges appropriate to the patient's condition. If the patient has no attending Practitioner, then the patient will be assigned to an appropriate Practitioner based on the emergency on-call rotation for appropriate treatment and disposition.

Section 8. Temporary Privileges for Educational Purposes

A. Approval of Temporary Privileges for Educational Purposes. Practitioners who are in their third year or training in a residency program are eligible for Temporary Privileges for educational purposes within the scope of their licensure and training. The CEO (or designee), after reviewing and considering the recommendation of the Department Chairperson where the Practitioner will be assigned and the Chief of Staff, may grant a Practitioner Temporary Privileges to attend to patients for a period not to exceed a total of ninety (90) cumulative days of coverage in a twelve (12) month period, unless, upon demonstration of good cause by the Practitioner, the CEO (or designee), in consultation with the Department Chairperson and the Chief of Staff, grant an extension for a period up to, but not to exceed, an additional ninety (90) days. An Active Medical Staff member shall be assigned by the Chief of Staff to act as an advisor to the Practitioner exercising Temporary Privileges under this Section and assume responsibility for assuring that the Practitioner properly completes all patient care, appropriate charts and insurance forms.

B. General Conditions. Temporary Privileges under this Section shall be granted only when the information available reasonably supports a favorable determination regarding the Practitioner's qualifications, ability, judgment and competence to exercise the Privileges requested, and only after the Practitioner has satisfied all existing Hospital and Medical Staff requirements regarding professional liability insurance. Special requirements of supervision and reporting may be imposed by the applicable Department Chairperson. Temporary Privileges shall be immediately terminated by the CEO (or designee) upon notice of any failure by the Practitioner to comply with such special conditions. Before Temporary Privileges are granted, the Practitioner must acknowledge in writing that the Practitioner agrees to abide by the terms of the Medical Staff Bylaws, the Rules and Regulations, the Appointment and Reappointment Procedures, any Medical Staff policies and procedures and Hospital policies that apply to exercise of such Temporary Privileges, in all matters relating to the exercise of Temporary Privileges.

C. Termination. The CEO (or designee) may at any time, upon the recommendation of either the Chief of Staff or the Department Chairperson where the

Practitioner with Temporary Privileges is assigned, terminate a Practitioner's Temporary Privileges effective as of the discharge from the Hospital of the Practitioner's patient(s) then under the Practitioner's care in the Hospital. Where the well-being of a patient is determined to be compromised by continued treatment by the Practitioner, the immediate termination of Temporary Privileges may be imposed by any person entitled to impose summary suspensions under the Corrective Action and Fair Hearing Procedures. In the event of any such termination, the Practitioner's patients then in the Hospital shall be assigned to another Practitioner by the Chief of Staff. The wishes of the patient shall be considered, where feasible, in selection of a substitute Practitioner.

D Rights of the Practitioner. A Practitioner shall not be entitled to the hearing or appellate review rights afforded by the Corrective Action and Fair Hearing Procedures because the Practitioner's request for Temporary Privileges is refused or because all or any portion of a Practitioner's Temporary Privileges are terminated or suspended.

ARTICLE IV ADOPTION AND AMENDMENT

Section 1. These Appointment and Reappointment Procedures are hereby adopted by the Board for use by the Medical Staff.

Section 2. These Appointment and Reappointment Procedures shall be periodically reviewed and amended by the Board when necessary in accordance with the Hospital Bylaws.

Secretary of the Board
Waccamaw Community Hospital
Murrells Inlet, South Carolina

Date

EXHIBIT A DEFINITIONS

"Adverse Action" means a Professional Review Action that recommends or results in the reduction, restriction, suspension, revocation, denial or failure to renew the Clinical Privileges or Medical Staff membership of a Practitioner for a period of more than thirty (30) days.

"Appointment and Reappointment Procedures" means the specific requirements and procedures adopted by the Board for appointment and reappointment to the Medical Staff and granting Clinical Privileges to Medical Staff members.

"Board" means the governing body of Waccamaw Community Hospital.

"CEO (or designee)" means the chief executive officer appointed by the Board to act on its behalf in the overall management of the Hospital

"Clinical Privileges" or "Privileges" means the permission granted to a Practitioner by the Board to render specific professional diagnostic, therapeutic, medical, dental, podiatric, or surgical services

"Corrective Action and Fair Hearing Procedures" means the substantive and procedural rights and requirements for taking corrective action against Practitioners and reviewing Adverse Actions

"Data Bank" means the National Practitioner Data Bank established by the HCQIA.

"DEA" means the United States Department of Justice Drug Enforcement Administration that is responsible for issuing controlled substance registrations.

"Ex Officio" means service as a member of a body by virtue of an office or a position previously held and, unless otherwise expressly provided, means without voting rights

"HCQIA" means the Health Care Quality Improvement Act of 1986 as may be amended from time to time

"Hospital" means Waccamaw Community Hospital

"Hospital-Based Services" means the services offered by the Hospital in the clinical specialties of anesthesia, emergency medicine, pathology or radiology.

"Hospital Bylaws" means the duly adopted corporate bylaws of the Hospital as may be amended from time to time

"Licensing Board" means the South Carolina Board of Medical Examiners or any successor created to license physicians and osteopaths in South Carolina

"MEC" means the executive committee of the Medical Staff.

"Medical Staff" means all duly licensed physicians, osteopaths, and podiatrists who are appointed to the Medical Staff and granted Clinical Privileges by the Board to attend patients at the Hospital

"Practitioner" means, unless otherwise limited, any physician, osteopath, dentist or podiatrist applying for, or obtaining, Medical Staff membership or Clinical Privileges at the Hospital

"Prerogative" means the rights and responsibilities granted by virtue of Medical Staff category, or otherwise, to a Medical Staff member and exercisable subject to the conditions imposed in these Medical Staff Bylaws, the Rules and Regulations, in other Medical Staff policies and procedures and Hospital policies.

"Professional Review Action" means an action or recommendation of a Professional Review Body that is taken or made in the conduct of a Professional Review Activity, which is based on the competence or professional conduct¹ of an individual Practitioner (which conduct affects or could affect adversely the health or welfare of a patient or patients), and which affects (or may affect) adversely the Medical Staff membership, Clinical Privileges of the Practitioner. Such term includes a formal decision of a Professional Review Body not to take an action or make a recommendation described in the previous sentence and also includes Professional Review Activities related to a Professional Review Action

"Professional Review Activity" means an activity of the Hospital with respect to an individual Practitioner to accomplish any one or more of the following: (a) to determine whether the Practitioner may have Clinical Privileges or Medical Staff membership at the Hospital, (b) to determine the scope or condition of such Clinical Privileges or Medical Staff membership; or (c) to change or modify such Clinical Privileges or Medical Staff membership

"Professional Review Body" means the Board, the CEO (or designee) or any committee of the Hospital which conducts Professional Review Activity, and includes any

¹ A Professional Review Action is not considered to be based on the competence or professional conduct of a Practitioner if the action is primarily based on

- 1 the Practitioner's association, or lack of association, with a professional society or association,
- 2 the Practitioner's fees or the Practitioner's advertising or engaging in other competitive acts intended to solicit or retain business,
- 3 the Practitioner's participation in prepaid group health plans, salaried employment, or any other manner of delivering health services whether on a fee-for-service or other basis,
- 4 a Practitioner's association with, supervision of, delegation of authority to, support for, training of, or participation in a private group practice with, as a member or members of a particular class of health care practitioner or professional, or
- 5 any other matter that does not relate to the competence or professional of a Practitioner

committee of the Medical Staff, individual, or entity with the authority to recommend an Adverse Action when assisting the Board in a Professional Review Activity including, without limitation, the Credentials Committee, the MEC, any Ad Hoc Committee and the Chief of Staff.

"Rules and Regulations" means the rules and regulations adopted by the Medical Staff and approved by the Board to govern certain aspects of Medical Staff membership and the exercise of Clinical Privileges

"Special Notice" means written notification by hand delivery, receipt acknowledgement requested or sent by certified or registered mail, return receipt requested

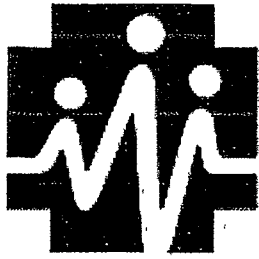
"Staff Year" means the fiscal year of the Hospital

**WACCAMAW COMMUNITY HOSPITAL
APPOINTMENT AND REAPPOINTMENT PROCEDURES
FOR MEDICAL STAFF MEMBERSHIP AND CLINICAL PRIVILEGES**

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WACCAMAW
COMMUNITY HOSPITAL

A member of the Georgetown Hospital Family

**WACCAMAW COMMUNITY HOSPITAL
MEDICAL STAFF BYLAWS**

Revised: January 22, 2004
 April 21, 2005
 October 20, 2005 (Rules & Regulations and Appointment Procedures)
 September 20, 2007
 November 18, 2010

WACCAMAW COMMUNITY HOSPITAL MEDICAL STAFF BYLAWS

PREAMBLE

The Hospital is a non-profit corporation established and operated in accordance with the provisions of Section 501©(3) of the Internal Revenue Code and the regulations thereunder, and Section 12-6-540 of the Code of Laws of South Carolina, as amended (the "South Carolina Code"), and is incorporated under the South Carolina Non-Profit Corporation Act of 1994 in Article I, Chapter 31, Title 33 of the South Carolina Code (the "Act").

The Hospital is responsible for the quality of medical care delivered in the Hospital. The Board hereby delegates to the Medical Staff the responsibility of striving to assure that quality medical care is provided in the Hospital. The Medical Staff shall in turn support and further the mission of the Hospital. The cooperative efforts of the Board, the Hospital's administration and the Medical Staff are necessary to fulfill the Hospital's obligations to its patients and the communities it serves.

In order to fulfill the Medical Staff's responsibilities, the Board and the Medical Staff establish and implement the provisions of these Medical Staff Bylaws and the Rules and Regulations, subject to the approval of the Board. These Medical Staff Bylaws are adopted in order to provide for the organization of the Medical Staff and to provide a framework for the discharge of its responsibilities in matters involving the quality of medical care at the Hospital and the orderly resolution of those purposes. These Medical Staff Bylaws provide the professional and legal structure for Medical Staff operations, Medical Staff relations with the Board and relations with Practitioners to, and members of, the Medical Staff.

ARTICLE I

PURPOSES AND RESPONSIBILITIES

Section 1. Definitions The defined terms used in these Medical Staff Bylaws are set forth in the attached Exhibit A.

Section 2. Purposes. The purposes of the Medical Staff are to:

A. Strive toward assuring that patients admitted to, or treated in any of the facilities, departments or services of the Hospital, shall receive the best possible care, that no patient is denied necessary emergency treatment, and that no assignment or treatment of patients within the Hospital is made on the basis of race, color, religion, age, ancestry, national origin, or ability to pay,

B. Be the organizational structure through which individual Practitioners may obtain Medical Staff membership, Prerogatives and Clinical Privileges at the Hospital to provide clinical services to patients;

C. Serve as the primary means for accountability to the Board for a high level of professional performance of all Practitioners authorized to practice in the Hospital through the appropriate delineation of the Clinical Privileges that each Practitioner may exercise in

the Hospital and a periodic review and evaluation of each Practitioner's performance in the Hospital;

D. Be accountable for the appropriateness of the professional performance and ethical conduct of each member of the Medical Staff that affects the Hospital or its patients, and for reporting the results of continuing performance improvement activities conducted in accordance with the Hospital's continuing performance improvement plan;

E. Provide a means through which the Medical Staff may participate in the Hospital's policy-making and planning processes by formulating and submitting recommendations,

F. Provide an appropriate educational setting that will maintain scientific standards and that will foster continuing medical education and that will lead to continuous advancement in professional knowledge and skills;

G. Maintain and recommend amendments to the Medical Staff Bylaws, the Rules and Regulations and policies and procedures for the governance and proper functioning of the Medical Staff as approved by the Board;

H. Provide a forum for discussion of Hospital and Medical Staff issues and concerns with the Board and the CEO (or designee);
Assure qualification and competence of Practitioners through a credentialing procedure, including mechanisms for appointment and reappointment to the Medical Staff and the delineation of Clinical Privileges in accordance with the Appointment and Reappointment Procedures and making recommendations to the Board concerning appointments and reappointments to the Medical Staff, Medical Staff membership category and department assignments, Clinical Privileges, and corrective action;

I. Enforce compliance with the Medical Staff Bylaws, the Rules and Regulations, policies and procedures of the Medical Staff, the Hospital Bylaws, the Appointment and Reappointment Procedures, the Corrective Action and Fair Hearing Procedures and other Hospital policies;

J. Participate in the Hospital's performance improvement initiatives by supervising and conducting all required and necessary activities for assessing and improving the effectiveness and efficiency of medical care provided in the Hospital, and

K. Initiate and pursue Professional Review Action with respect to Practitioners when warranted in accordance with these Medical Staff Bylaws and the Corrective Action and Fair Hearing Procedures

Section 3. Responsibilities of the Medical Staff The specific responsibilities of each individual member of the Medical Staff are to:

A Render specific professional, diagnostic, therapeutic, medical, podiatric and surgical services at the level of quality and efficiency equal to, or greater than, that generally recognized and accepted among Practitioners and other physicians, in a manner consistent with generally recognized and accepted standards of professional ethics, licensure, education, and expertise, and in an economically efficient manner, taking into account patient needs, available Hospital facilities and resources, and utilization standards in effect in the Hospital,

B Discharge such Medical Staff, clinical service, department, committee, and Hospital functions for which the Practitioner is responsible by appointment, election, or otherwise, including but not limited to, participation in the Hospital's Emergency Department "on call" system to the full extent authorized by Medical Staff membership and Clinical Privileges, and as required by the Hospital, these Medical Staff Bylaws, the Rules and Regulations, the Appointment and Reappointment Procedures, other Medical Staff policies and procedures, Hospital policies and federal or state law;

C. Support the mission of the Hospital and not discriminate against Hospital patients based on their ability to pay;

D. Abide by the Medical Staff Bylaws, the Rules and Regulations, the Appointment and Reappointment Procedures, the Corrective Action and Fair Hearing Procedures, all other Medical Staff policies and procedures and Hospital policies;

E. Prepare and complete the medical and other required records for all patients the Medical Staff member or Practitioner admits or in any way provides care to in the Hospital in accordance with applicable Hospital licensing or accreditation requirements; and

F Satisfy the continuing medical education requirements established by the Medical Staff.

ARTICLE II MEDICAL STAFF MEMBERSHIP

Section 1. Nature of Medical Staff Membership.

A The relationship between the Hospital and the Medical Staff is a privilege in the nature of a license granted to the Practitioner to use the Hospital's facilities for the purpose of rendering specific professional, diagnostic, therapeutic, medical, podiatric or surgical services in the Hospital in a manner consistent with licensure, education, and expertise but is not a right nor an employment relationship

B Membership on the Medical Staff or the exercise of Privileges shall be extended only to Practitioners who continuously meet the applicable qualifications, standards, and requirements set forth in these Medical Staff Bylaws, the Rules and Regulations and the Appointment and Reappointment Procedures, other Medical Staff policies and procedures and Hospital policies Membership on the Medical Staff shall confer on the appointee or

member only such Clinical Privileges and Prerogatives as have been granted by the Board in accordance with these Medical Staff Bylaws and the Appointment and Reappointment Procedures.

C. No Practitioner shall admit or provide services to patients in the Hospital unless the Practitioner is a member of the Medical Staff and has been granted Privileges in accordance with these Medical Staff Bylaws and the Appointment and Reappointment Procedures.

Section 2. General Qualifications. Every Practitioner who seeks or enjoys Medical Staff membership must, at the time of application and continuously thereafter, demonstrate to the satisfaction of the Medical Staff and the Board the following general qualifications:

A. Experience, background, training, demonstrated ability, availability, and physical and mental health status, in order to demonstrate to the Medical Staff and the Board that the Practitioner will provide care to patients at the generally recognized and accepted professional level of quality and in an economically efficient manner, taking into account patients' needs, the available Hospital facilities and resources, and utilization standards in effect at the Hospital;

B Current licensure without restriction by the Licensing Board,

C Current Controlled Substance License and Registration, including:

(1) A currently valid and unrestricted South Carolina controlled substances license issued by the South Carolina Department of Health and Environmental Control, if required for the practice of the Practitioner's specialty, or Practitioner is eligible at the time of application for such license

(2) A currently valid and unrestricted DEA controlled substance registration, if required for the practice of the Practitioner's specialty, or Practitioner is eligible at the time of application for such registration.

D. Current certification and/or, if required, re-certification, without restriction, by the appropriate specialty board(s), recognized by the American Board of Medical Specialties, applicable to the Practitioner's Clinical Privileges, or to be eligible at the time of application for such certification and/or re-certification and to obtain such certification and/or re-certification within five (5) years of becoming a member of the Medical Staff.

Notwithstanding the above, a Practitioner shall be exempt from the certification and re-certification requirements of this Section if the Practitioner has been in good standing on the active medical staff of another accredited acute care hospital that is located within a reasonable distance to the Hospital for a period of at least the five (5) years immediately preceding the time of application, without interruption

E Professional liability insurance coverage is not less than the minimum amount, if any, as determined by resolution or policy of the Board, or other evidence of financial

responsibility as the Board may establish or require. Such evidence of insurance will be shown through presentation of a current certificate of insurance from an insurance company licensed and approved to do business in South Carolina.

F. A history of performance of a sufficient number of procedures, the management of a sufficient number of cases, and/or sufficient patient care contact in the Hospital or other health care facilities or settings so that Medical Staff and the Board may properly assess the Practitioner's competency for Clinical Privileges, whether being requested or already granted.

G. A willingness and capability, based on evidence of performance:

(1) To work with and relate to patients, other Medical Staff members, members of other health disciplines, Hospital management and employees, visitors and the community in general, in a cooperative, professional manner that is essential for maintaining a Hospital environment appropriate to quality patient care; and

(2) To participate equitably in the discharge of Medical Staff obligations appropriate to the Practitioner's assigned Medical Staff membership category.

H. Adherence to applicable ethical codes of conduct such as the Principles of Ethics adopted by the Licensing Board, the Code of Ethics adopted by the American Medical Association and the "Statement of Principles" of the American College of Surgeons which govern the professional conduct of members of the Medical Staff.

I. Absence of any significant physical, mental, or behavioral impairment that interferes with the Practitioner's ability to render quality care to patients.

J. The practice of a branch of health care, or a specialty, which is consistent with the purposes, philosophy, policies, contracts and resources of the Hospital

K. The absence of any significant Adverse Actions, or other adverse actions, as confirmed by a query to the Data Bank as required by the HCQIA.

L. Participation in continuing medical education in accordance with requirements established from time to time by the Medical Staff, as described in the Rules and Regulations

M. Attendance at Medical Staff meetings in accordance with these Medical Staff Bylaws.

N. The absence of exclusion, suspension or sanction from any federally-funded health benefit programs, including the Medicare or Medicaid programs

Section 3. Effect Of Other Affiliations

A. No Practitioner is automatically entitled to membership on the Medical Staff or to the exercise of particular Clinical Privileges merely because the Practitioner is licensed to practice in this or any other state, or because the Practitioner is a member of any professional organization, or the faculty of a medical school, or because the Practitioner had, or presently has, medical staff membership or clinical privileges at another health care facility or in another practice setting.

B. No Practitioner is automatically entitled to appointment, reappointment to the Medical Staff or particular Clinical Privileges merely because the Practitioner had, or presently has, Medical Staff membership or those particular Clinical Privileges at this Hospital

C. No Practitioner is automatically entitled to appointment, reappointment to the Medical Staff or particular Clinical Privileges merely because the Practitioner, or an entity Practitioner is affiliated with, had, or presently has, a contractual relationship with the Hospital to provide professional services at the Hospital.

Section 4. Non-Discrimination. No aspect of Medical Staff membership or particular Clinical Privileges shall be denied or qualified on the basis of age, sex, race, creed, color, disability, or national origin.

Section 5: Leave of Absence

A. A Practitioner may obtain a voluntary leave of absence from the Medical Staff by submitting written notice to the Chief of Staff of the exact period of time required for the leave, which may not exceed six (6) months, with the option for renewal by the MEC for an additional six (6) months, for purposes of.

- (1) armed services obligations;
- (2) obtaining further professional training,
- (3) medical treatment or rehabilitation, or
- (4) other personal reasons

A Practitioner may not obtain a leave of absence for reasons related to professional competence or conduct or while the Practitioner is under investigation for reasons related to professional competence or conduct. If a leave of absence is granted by the Board on the recommendation of the Executive Committee, all staff obligations, responsibilities, clinical privileges, and rights will be immediately suspended until a request for reinstatement is received, with the exception that all outstanding medical records and patient care obligations must be completed immediately. Administration will notify applicable hospital departments of physician's leave of absence.

B. A Practitioner may seek reinstatement at any time during, or at least sixty (60) days prior to, the expiration of the leave of absence by submitting a written request to the Chief of Staff. Any written request for reinstatement must be accompanied by a detailed, written summary of relevant professional activities performed during the leave of absence period.

C. The Chief of Staff shall transmit the written request and recommendation to the MEC. The MEC's recommendation of acceptance or rejection of the same shall be transmitted to the Board at its next meeting. The Board shall grant or deny the Practitioner's written request for reinstatement. A denial of a Practitioner's timely and complete request for reinstatement following an approved leave of absence shall entitle the Practitioner to the hearing and appellate review rights set forth in the Corrective Action and Fair Hearing Procedures.

D. Subject to any additional requirements in this Section, if a Practitioner requests a leave of absence for purposes of armed services obligations, if otherwise qualified to do so, reinstatement will become automatic upon written notice of the Practitioner that armed services obligation has been completed.

E. Subject to any additional requirements in this Section, if a Practitioner requests a leave of absence for the purpose of obtaining further professional training, reinstatement will become automatic upon the written request of the Practitioner; provided, any additional written request for modified, enlarged, or additional Clinical Privileges will be processed by the MEC and the Board as if the Practitioner was making application for the first time.

F. Subject to any additional requirements in this Section, if a Practitioner requests a leave of absence for the purpose of medical treatment or rehabilitation, a reinstatement will become effective only after the following conditions have been met:

(1) The written request for reinstatement is accompanied by a detailed, written summary of relevant medical treatment and rehabilitation activities accomplished during the leave of absence period, and

(2) Subject to Board approval, the Practitioner enters into a written "return to practice" agreement with the Chief of Staff and CEO (or designee) which shall provide for any necessary monitoring, reporting, and announced/unannounced testing that may be required, upon the recommendation of the Practitioner's treating physician(s) or the Licensing Board.

G. Failure to (i) request reinstatement at least sixty (60) days prior to the expiration of a leave of absence, (ii) provide the detailed, written summary of relevant professional activities performed during the leave of absence period noted above, or (iii) meet any other condition required by this Article for reinstatement shall constitute, in the absence of a showing of good cause, a voluntary resignation from the Medical Staff, and shall result, in the absence of such showing, in the automatic termination of Medical Staff membership effective at the expiration of the Practitioner's leave of absence.

(1) A Practitioner whose Medical Staff membership or Clinical Privileges is so terminated, shall be entitled to the hearing and appellate review rights set forth in the Corrective Action and Fair Hearing Procedures for the sole purpose of resolving the issue of good cause

(2) Any subsequent request or application for Medical Staff membership that is received from a Practitioner following a termination under this Section shall be processed by the MEC and the Board as if the Practitioner was making application for the first time.

H: If the Practitioner's leave of absence period includes no professional medical activity for at least six (6) months, the MEC may require proof of competency through one or more of the following

(1) additional continuing medical education;

(2) a self-query to the Data Bank; or

(3) appropriate monitoring by a qualified Practitioner on the Active Medical Staff, assigned by the appropriate Department Chairperson, for a period of time to ensure continuing quality of care.

H. If a Practitioner's leave of absence extends beyond the expiration date of the Practitioner's current appointment or reappointment, then the Practitioner's request for reinstatement must be processed as an initial application for Medical Staff membership and request for Clinical Privileges.

Section 6. Modification of Appointments or Clinical Privileges.

A A Practitioner must submit a written request to the Medical Staff secretary to modify the Practitioner's Medical Staff category, Department assignment or Clinical Privileges. For purposes of this Section, a modification request includes any request by a Practitioner, prior to reappointment, to: (i) obtain additional Clinical Privileges; (ii) relinquish or decrease Clinical Privileges, (iii) change Medical Staff category; or (iv) change Departments.

B Any request for modification requires review by the MEC. If the requested modification would result in a reduction in the duties of a Practitioner under these Medical Staff Bylaws, the Rules and Regulations, other Medical Staff policies and procedures or Hospital policies, as determined by the MEC, then the MEC may require the Practitioner to furnish justification for the requested modification prior to considering the Practitioner's request. The MEC shall submit a recommendation to the Board, which may include a recommendation that a change in Medical Staff category or Department assignment of a current Medical Staff member, or the granting of additional Privileges to a current Medical Staff member, be made subject to an observation period.

C All modifications of a Practitioner's Medical Staff category, Department assignment or Clinical Privileges are effective upon approval by the Board and valid until the next reappointment period.

D. Any Adverse Action on a request or modification to a Practitioner's Medical Staff category, Department assignment or Clinical Privileges by the MEC or the Board shall entitle the Practitioner to the hearing and appellate review rights set forth in the Corrective Action and Fair Hearing Procedures.

Section 7. Ability to Waive Medical Staff Rights. Nothing in these Medical Staff Bylaws shall be deemed to prevent any Practitioner from entering into an agreement with the Hospital to forego or otherwise waive any rights available under these Medical Staff Bylaws, the Appointment and Reappointment Procedures, or the Corrective Action and Fair Hearing Procedures.

Section 8. Procedures for Appointment and Reappointment. The specific mechanisms for evaluating applications for initial appointment and reappointment and for conducting periodic reappraisals for reappointment to the Medical Staff are set forth in the Appointment and Reappointment Procedures. The Board is responsible for granting appointment and reappointment to the Medical Staff.

Section 9. Procedures for Granting or Renewing Clinical Privileges. The specific mechanisms for evaluating requests for initial Clinical Privileges and for conducting periodic reappraisals for renewal of Clinical Privileges are set forth in the Appointment and Reappointment Procedures. The Board is responsible for granting Clinical Privileges

ARTICLE III MEDICAL STAFF CATEGORIES

Section 1. Categories of the Medical Staff. There are seven (7) categories of membership on the Medical Staff: Active, Provisional, Active II, Call Coverage, Consulting, Courtesy, and Honorary

A. Active Medical Staff

(1) Qualifications for Active Medical Staff The Active Medical Staff shall consist of Practitioners who

(a) Meet the applicable qualifications as members of the Medical Staff as set forth in these Medical Staff Bylaws; must admit to the Hospital a minimum of 13 patients per Medical Staff year, or are otherwise involved in the care of 13 patients per Medical Staff year,

(b) Provide timely continuous care to their patients,

(c) Regularly admit patients to, or are otherwise regularly involved in, the care of patients in the Hospital;

(d) Have completed, unless specifically exempted, at least one (1) year of satisfactory performance on the Provisional Medical Staff,

(e) Assume responsibility for participation in emergency on-call services and consultation assignments; and

(f) Have a primary office or primary residence located within Georgetown or Horry County to provide timely, continuous care to Hospital patients. A primary office is defined as an office that is fully staffed with both physician and ancillary staff at least four (4) days per week.

(2) Prerogatives of Active Medical Staff. The Prerogatives of an Active Medical Staff member shall be to.

(a) Admit patients, without limitation, unless otherwise provided in the Hospital or Medical Staff Bylaws, the Rules and Regulations, Medical Staff policies and procedures or Hospital policies.

(b) Notwithstanding the Prerogatives of Active Medical Staff members to admit patients, Practitioners who furnish Hospital-Based Services and Practitioners who are podiatrists and who are on the Active Medical Staff shall not be entitled to admit patients at the Hospital;

(c) Exercise such Clinical Privileges as are granted to the Practitioner,

(d) Vote on all matters presented at general and special meetings of the Medical Staff and of the Medical Staff department and committees of which the Practitioner is a member;

(e) Hold office at any level in the Medical Staff organization and sit on or be chairperson of any committee.

(3) Obligations of Active Medical Staff. An Active Medical Staff member, unless otherwise specified in these Medical Staff Bylaws, must.

(a) Contribute to the organizational and administrative affairs of the Medical Staff, including service in Medical Staff or department offices and on Hospital and Medical Staff committees, performing the duties of any office or position to which the Practitioner is elected or appointed;

(b) Actively participate in the quality evaluation and monitoring activities of the Medical Staff,

(c) Discharge the recognized functions of Medical Staff membership by engaging in the Medical Staff's continuing medical education programs, attending service or charity patients as required, and giving consultation to other Medical Staff members consistent with the Practitioner's delineated Privileges, absent a conflict of interest;

(d) Attend regular and special meetings of the Medical Staff and of the department and committees of which the Practitioner is a member, being present and voting at not less than fifty percent (50%) of the meetings held in each category;

(e) Provide Emergency Department on-call coverage and consultation to the full extent authorized by the Practitioner's Medical Staff category and Privilege delineation, and

(f) Discharge the obligations as stated above.

(4) Duration of Appointment and Reappointment. An Active Medical Staff member's appointment shall be effective for a period not to exceed the time period established to meet the Hospital's licensing or accreditation requirements but may be renewed pending consideration if the Practitioner's reappointment application is submitted prior to the expiration of the Active Staff member's appointment.

B Provisional Medical Staff.

(1) The Provisional Medical Staff shall consist of all Practitioners who are otherwise qualified for Medical Staff membership in a requested category and meet the applicable qualifications set forth in these Medical Staff Bylaws and (i) approved for initial Medical Staff membership, or (ii) granted initial Clinical Privileges

(2) Duration of Provisional Medical Staff Appointment. All appointments to the Provisional Medical Staff shall be for a period of twelve (12) months. A Practitioner's Provisional Medical Staff appointment may only be extended according to the requirements set forth in the Appointment and Reappointment Procedures

(3) Effect on Medical Staff Membership or Exercise of Privileges Except as limited by this Section, a Practitioner on the Provisional Medical Staff (i) must demonstrate all of the applicable qualifications, (ii) may exercise all of the Prerogatives, (iii) must fulfill all of the obligations of the Practitioner's requested Medical Staff category, and (iv) may exercise all of the Clinical Privileges granted to the Practitioner

(4) Review During Provisional Period During the Provisional Medical Staff appointment period, a Practitioner's performance will be evaluated by the appropriate assigned Medical Staff performance improvement committee or body.

(5) Prerogatives of Provisional Medical Staff. Provisional Medical Staff members are not eligible to hold office in the Medical Staff organization, to vote at general and special meetings of the Medical Staff or for Medical Staff-wide office, to chair any committee, or to serve on the MEC, but may:

- (a) Admit patients in the same manner as a member of the Practitioner's requested Medical Staff category;
- (b) Exercise such Clinical Privileges as are provisionally granted to the Practitioner,
- (c) Vote on all matters presented at meetings of the Medical Staff department and committees to which the Practitioner is assigned; and
- (d) Serve as a member of Medical Staff committees.

(6) Obligations of Provisional Medical Staff. Each member of the Provisional Staff is required to discharge the same responsibilities as those members in the Practitioner's requested Medical Staff category. Failure to fulfill any required obligations shall be grounds for the denial of the request for Clinical Privileges, denial of appointment to the requested Medical Staff category or immediate termination of the Practitioner's Provisional Medical Staff membership and Clinical Privileges. The CEO (or designee) shall provide the Practitioner so affected with Special Notice of the proposed action and the Practitioner shall be entitled to the hearing and appellate review rights set forth in the Corrective Action and Fair Hearing Procedures.

(7) Advancement from Provisional Medical Staff. The requirements for advancement from the Provisional Medical Staff are set forth in the Appointment and Reappointment Procedures

C. Active II Medical Staff.

(1) Qualifications for Active II Medical Staff. The Active II Medical Staff shall meet the following qualifications.

(a) The Active II Medical Staff shall consist of Practitioners who are otherwise eligible for Active Medical Staff membership but do not have more than twelve (12) cases at the Hospital in any Staff Year,

(b) For purposes of these Active II Medical Staff provisions, cases shall mean any combination of inpatient or outpatient admissions, procedures and surgeries, however, any admission and subsequent procedure or surgery during a single episode of care or encounter shall be counted as one (1) case;

(c) The number of cases Active II Medical Staff members can attend or admit in any Staff Year under this Section shall be prorated for any Practitioner

whose initial appointment to the Active II Medical Staff is made prior to the beginning of a new Staff Year;

(d) Active II Medical Staff members shall maintain full active medical staff membership and clinical privileges, without restriction or limitation, at another acute care hospital located in either Georgetown or Horry County ;

(e) Be located within a reasonable distance to the Hospital to provide timely continuous care to Hospital patients;

(f) Be a (i) solo practitioner; or (ii) member of a group practice which has at least as many members of the group practice on the Active Medical Staff as the total number of members of the group practice on the Active II Medical Staff and the Call Coverage Medical Staff (and based on at least equal representation of practice specialties on the Active Medical Staff and the Active II Medical Staff and the Call Coverage Medical Staff within a multi-specialty group); and

(g) Active II Medical Staff members may also seek appointment to the Call Coverage Medical Staff

(2) Prerogatives of the Active II Medical Staff. The Prerogatives of an Active II Medical Staff member shall be to:

(a) Admit or attend patients in the Hospital within the limitations provided in this Section and under the same conditions as specified for Active Medical Staff members;

(b) Exercise such Clinical Privileges as are granted to the Practitioner, and

(c) Attend meetings of the Medical Staff and the department of which the Practitioner is a member and any Medical Staff or Hospital education programs. Active II Medical Staff members shall not be eligible to hold office or vote in the Medical Staff organization.

(3) Failure to Comply with Case Limitations If the Hospital cases of an Active II Medical Staff member in any Staff Year exceed twelve (12) or the prorated number of cases for initial appointments, as required by this Section, then

(a) The CEO (or designee) shall send the Practitioner Special Notice that the Practitioner's admitting Privileges shall be automatically suspended for the remainder of the current Staff Year five (5) days after the date the Special Notice is hand delivered or mailed by the Hospital.

(b) The suspension of a Practitioner's admitting Privileges under this Section shall be lifted at the beginning of the next Staff Year

(c) If the Practitioner wishes to request reinstatement of the Practitioner's admitting Privileges, then the Practitioner must submit and timely pursue a written request for modification of the Practitioner's Medical Staff category from Active II Medical Staff to Active Medical Staff under these Medical Staff Bylaws

(d) If the Practitioner submits and timely pursues a request for modification of Medical Staff category in compliance with of this Section, then the Practitioner's admitting Privileges shall be reinstated and the Practitioner's Active II Medical Staff membership shall remain in effect pending consideration of the modification

(4) Obligations of the Active II Medical Staff. The obligations of the Active II Medical Staff shall be to discharge the basic responsibilities for Medical Staff membership, including participation in performance improvement activities, and, further, to retain responsibility within the Practitioner's area of professional competence for the care and supervision of each patient in the Hospital for whom the Practitioner is providing services, or to arrange a suitable alternative for such care and supervision.

(5) Duration of Appointment and Reappointment. An Active II Medical Staff member's appointment shall be effective for a period not to exceed the time period established to meet the Hospital's licensing or accreditation requirements but may be renewed pending consideration if the Practitioner's reappointment application is submitted prior to the expiration of the Active II Medical Staff member's appointment.

D. Call Coverage Medical Staff.

(1) Qualifications for Call Coverage Medical Staff The Call Coverage Medical Staff shall meet the following qualifications:

(a) The Call Coverage Medical Staff shall consist of Practitioners who are otherwise eligible for Active Medical Staff membership but who are members of a group practice and requesting Call Coverage Medical Staff membership and Clinical Privileges for the sole purpose of providing call coverage to a member of their group practice who is on the Active Medical Staff;

(b) Call Coverage Medical Staff members shall maintain full active medical staff membership and clinical privileges, without restriction or limitation, at another acute care hospital located in either Georgetown or Horry County;

(c) Have a primary office or primary residence located within Georgetown or Horry County to provide timely, continuous care to Hospital patients,

(d) Call Coverage Medical Staff members may also seek appointment to the Active II Medical Staff, and

(e) The Active Medical Staff member for whom call coverage is being provided must certify the coverage relationship with the Call Coverage Medical Staff member in writing and immediately notify the Hospital if the relationship with the Call Coverage Medical Staff member changes.

(2) Prerogatives of the Call Coverage Staff. The Prerogatives of a Call Coverage Medical Staff member shall be to:

(a) Admit or attend patients in the Hospital for the sole purpose of providing call coverage within the limitations provided in this Section and under the same conditions as specified for Active Medical Staff members;

(b) Exercise such Clinical Privileges as are granted to the Practitioner for the sole purpose of providing call coverage within the limitations provided in this Section; and

(c) Attend meetings of the Medical Staff and the department of which the Practitioner is a member and any Medical Staff or Hospital education programs. Call Coverage Medical Staff members shall not be eligible to hold office or vote in the Medical Staff organization

(3) Obligations of the Call Coverage Medical Staff. The obligations of the Call Coverage Medical Staff shall be to discharge the basic responsibilities for Medical Staff membership, including participation in performance improvement activities, and, further, to retain responsibility within the Practitioner's area of professional competence for the care and supervision of each patient in the Hospital for whom the Practitioner is providing services, or to arrange a suitable alternative for such care and supervision.

(4) Duration of Appointment and Reappointment. A Call Coverage Medical Staff member's appointment shall be effective for a period not to exceed the time period established to meet the Hospital's licensing or accreditation requirements but may be renewed pending consideration if the Practitioner's reappointment application is submitted prior to the expiration of the Call Coverage Staff member's appointment

E Consulting Medical Staff.

(1) Qualifications for Consulting Medical Staff. A Consulting Medical Staff member must.

(a) Possess specialized skills not otherwise available through a member of the Active Medical Staff and needed at the Hospital in a specific project or on an occasional basis in consultation when requested by a member of the Medical Staff. An exception to this qualification can be allowed if all members of the Active medical Staff possessing the same core privileges request such exception, allowing such Consulting Medical Staff privileges for an individual practitioner. Such an exception would be in effect for no more than twenty-four (24) months and would

be subject to Medical Executive Committee approval in each case. If the patient care contacts, consultations or procedures of a Consulting Medical Staff member over any twelve-month period are not occasional, as defined by the Department to which the Consulting Medical Staff member is assigned and approved by the MEC and the Board, then the Consulting Medical Staff member shall be sent Special Notice by the CEO and required to promptly apply for, and timely pursue, a written request for modification of the Practitioner's Medical Staff category from Consulting Medical Staff to Active Medical Staff under these Medical Staff Bylaws;

(b) Agree to fulfill the obligations of Active Medical Staff membership concerning participation in performance improvement, quality evaluation and monitoring activities at this Hospital, and

(c) Provide evidence of attendance at continuing medical education programs.

(2) Prerogatives of Consulting Medical Staff. A Consulting Medical Staff member may exercise such Clinical Privileges as are granted to the Practitioner. Consulting Medical Staff members are not eligible to admit patients to the Hospital, to hold office in the Medical Staff organization, or to vote at meetings of the Medical Staff, department or committees.

(3) Condition for Reappointment to Consulting Medical Staff. Each member of the Consulting Medical Staff is required to discharge the responsibilities as specified in these Medical Staff Bylaws and must perform a minimum of six (6) patient contacts per reappointment period to be eligible for reappointment to the Consulting Medical Staff.

(4) Duration of Appointment and Reappointment. A Consulting Medical Staff member's appointment shall be effective for a period not to exceed the time period established to meet the Hospital's licensing or accreditation requirements but may be renewed pending consideration if the Practitioner's reappointment application is submitted prior to the expiration of the Consulting Medical Staff member's appointment.

F. Courtesy Medical Staff.

(1) Qualifications for Courtesy Medical Staff. The Courtesy Medical Staff shall consist of Practitioners who meet the applicable qualifications of Medical Staff membership under these Medical Staff Bylaws but who do not have a hospital practice with the exception that they are not required to be Board Certified or be on the staff of a hospital in Georgetown or Horry County.

(2) Prerogatives of Courtesy Medical Staff. Members of the Courtesy Medical Staff are not eligible to admit patients to the Hospital or to exercise Clinical Privileges in the Hospital. Courtesy Medical Staff may not hold office in the Medical Staff organization or to vote at meetings of the Medical Staff, departments or committees. They

may, however, attend Medical Staff education programs and meetings of the Medical Staff, departments or committees.

(3) Duration of Appointment and Reappointment. A Courtesy Medical Staff member's appointment shall be effective for a period not to exceed the time period established to meet the Hospital's licensing or accreditation requirements but may be renewed pending consideration if the Practitioner's reappointment application is submitted prior to the expiration of the Courtesy Medical Staff member's appointment

G Honorary Medical Staff

(1) Qualifications for Honorary Medical Staff. The Honorary Medical Staff shall 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.

(2) Prerogatives of Honorary Medical Staff. Honorary Medical Staff members are not eligible to admit patients to the Hospital or to exercise Clinical Privileges in the Hospital. They may, however, attend Medical Staff education programs. Honorary Staff members shall not be eligible to vote or to hold office in this Medical Staff organization. If an Active Staff member is additionally appointed to the Honorary Medical Staff, the Practitioner shall not lose the rights, Privileges or obligations of an Active Medical Staff member.

ARTICLE IV PRACTITIONER HEALTH PROGRAM

Section 1. Establishment of Health Program The Medical Staff, subject to the approval of the Board, shall establish a program to address issues related to Practitioner health, including physical and mental illness and impairment (the "Health Program")

Section 2. Purpose The purpose of the Health Program is to provide assistance and rehabilitation to Practitioners who suffer from physical or mental illness or impairment, rather than corrective action discipline, to the extent permitted by applicable law and consistent with the Hospital's obligations to its patients and personnel. The Health Program is intended to educate the Hospital administration and the Medical Staff on the prevention of physical and mental illness and facilitate the confidential diagnosis, treatment and rehabilitation of Practitioners who suffer from a potential impairment condition

Section 3. Effect of Health Program Participation on Corrective Action Notwithstanding any other provision of this Article, if at any time while a Practitioner is participating in the Health Program, it is determined that the Practitioner is unable to safely perform the Clinical Privileges granted, then appropriate corrective action shall be initiated under these Medical Staff Bylaws

ARTICLE V MEDICAL STAFF OFFICERS

Section 1. General Officers of the Medical Staff

A. Identification

The general officers of the Medical Staff are the

- (1) Chief of Staff,
- (2) Vice-Chief of Staff, and
- (3) Secretary/Treasurer.

B. Qualifications

(1) Each general officer must be a member of the Active Medical Staff at the time of nomination and election, must remain a member in good standing continuously during the officer's term of office, and must be willing and able to faithfully discharge the duties of the office held. Failure to maintain such status shall immediately create a vacancy in the office involved. The Chief of Staff and the Vice Chief of Staff must be Practitioners with demonstrated competence in their fields of practice and demonstrated qualifications on the basis of training, experience, and ability to direct the medico-administrative aspects of Hospital and Medical Staff activities. No individual may hold two (2) general Medical Staff offices concurrently, and no individual may serve simultaneously as a general Medical Staff officer under this Article and as a Department Chairperson under these Medical Staff Bylaws.

C. Nominations.

(1) By Nominating Committee. The Medical Staff Nominating Committee shall be appointed by the MEC and may include up to three (3) of the most recent past Chiefs of Staff who are still on the Active Medical Staff and available to serve. The MEC shall designate a member to serve as the chair of the Medical Staff Nominating Committee. The Medical Staff Nominating Committee shall convene sixty (60) days prior to the annual Medical Staff meeting and submit one or more qualified nominees for each office and for each member of the MEC that is to be selected from the Medical Staff at large to the Medical Staff Secretary. Any nominee for general Medical Staff office must be contacted by the Medical Staff Nominating Committee and agree to serve prior to submission of the nominee's name for consideration. The list shall be mailed by the Medical Staff Secretary to all Medical Staff members eligible and qualified to vote for general Medical Staff officers at least thirty (30) days prior to the annual Medical Staff meeting.

(2) By Petition. Nominations may also be made by petition signed by at least twenty (20%) percent of the members of the Medical Staff who are eligible to vote for

general Medical Staff officers This petition must be filed with the Medical Staff Secretary at least fifteen (15) days prior to the annual Medical Staff meeting and be accompanied by evidence of the candidate's qualifications and willingness to be nominated. As soon thereafter as reasonably possible, the names of these additional nominees shall be reported to the Medical Staff.

(3) By Other Means

(a) If before the election, any of the individuals nominated for an office shall refuse, be disqualified from, or otherwise be unable to accept nomination, then the Medical Staff Nominating Committee shall submit one or more substitute nominees at the annual Medical Staff meeting

(b) Nominations shall also be accepted from the floor at the time of the annual Medical Staff meeting. Individuals nominated in this manner must indicate a willingness to serve at the time of nomination or before the vote.

D. Election. Medical Staff officers shall be elected at the annual Medical Staff meeting each year Only Medical Staff members accorded the Prerogative to vote for general Medical Staff officers under these Medical Staff Bylaws shall be eligible to vote. Voting shall be by secret written ballot, if requested by any Medical Staff member present, and absentee ballots and voting by proxy shall not be permitted. A nominee shall be elected upon receiving over fifty percent (50%) of the votes cast by active Medical Staff members present and eligible to vote. If no candidate for the office receives a majority vote on the first ballot, a run-off election shall be held promptly between the two (2) candidates receiving the highest number of votes

E. Exceptions. The Vice-Chief shall, upon completion of a term of office in that position, immediately succeed to the office of Chief of Staff

F Term Of Elected Office. Each Medical Staff officer shall serve a one (1) year term, commencing on the first day of the Staff Year following the election Each Medical Staff officer shall serve until the end of the term and until a successor is elected, unless the Medical Staff officer shall resign or be removed from office prior to the end of the term. The Secretary/Treasurer shall serve no more than two (2) consecutive terms in the same office

G Removal Of General Medical Staff Officers Except as otherwise provided, removal of a general Medical Staff officer may be by a two-thirds (2/3) majority vote of the members of the Medical Staff eligible to vote for Medical Staff officers A regular or special-called meeting must be held to carry out this vote, at which absentee or proxy ballots shall not be accepted

Permissible bases of removal of a general Medical Staff officer include, without limitation.

(1) Failure to perform the duties of the position held in a timely and appropriate manner,

(2) Failure to continuously satisfy the qualifications of the position; or

(3) A determination that removal is in the best interests of the Medical Staff or the Hospital.

H. Resignation From Office. Any general Medical Staff officer may resign at any time by giving written notice to the MEC. Such resignation shall not be contingent upon formal acceptance and shall take effect on the date of receipt or at any later time specified in the notice.

I. Vacancies In Elected Office. If there is a vacancy in the office of Chief of Staff, the Vice-Chief shall serve out the remaining term and shall subsequently succeed to a full term as Chief of Staff as provided in this Section. Vacancies in offices other than that of Chief of Staff shall be filled by a special election conducted as reasonably soon after the vacancy occurs as possible, following the election procedures in this Section for election of Medical Staff officers.

J. Duties Of General Medical Staff Officers

(1) Chief Of Staff. The Chief of Staff shall serve as the chief medical officer of the Hospital and as the principal elected official of the Medical Staff. As such, the Chief of Staff shall:

(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 and needs of the Medical Staff to the Board, the CEO (or designee), and other officials of the Medical Staff,

(c) Develop and implement, in cooperation with the Department Chairpersons, appropriate committees of the Medical Staff and the Board, and subject to the approval of the MEC, methods for retrospective patient care audits on-going monitoring of practice, credentials review, delineation of Privileges and specified services, continuing education, and utilization review,

(d) Unless otherwise expressly provided, appoint the membership and chairpersons of Medical Staff committees, subject to approval of the MEC,

(e) Be responsible for the enforcement of Medical Staff Bylaws, the 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,

(f) Upon termination or suspension of a Practitioner's Medical Staff Membership or Clinical Privileges, including Temporary Privileges, assign another Practitioner to assume the care of the affected Practitioner's patients in the Hospital at the time of termination or suspension,

(g) Call, preside at, and be responsible for the agenda of all general meetings of the Medical Staff and the MEC;

(h) Serve as Chairperson of the MEC;

(i) Serve as an Ex-Officio member, who may vote when needed to resolve a matter, of all other Medical Staff committees;

(j) Present the roster of general Medical Staff Officers and Department Chairpersons for the upcoming Staff Year to the Board at each year's October meeting for approval. The Board will approve/confirm these officers upon recommendation from the MEC; and

(k) Attend and represent the Medical Staff at meetings of the Board.

(2) Vice-Chief Of Staff The Vice-Chief of Staff shall:

(a) Be responsible for the Medical Staff Bylaws review and revision responsibilities of the Medical Staff;

(b) Be a member of the MEC;

(c) In the absence, temporary or permanent, of the Chief of Staff, assume all the duties and have the authority of the Chief of Staff, and

(d) Perform such additional duties as may be assigned by the Chief of Staff or the MEC

(3) Secretary/Treasurer. The Secretary/Treasurer shall.

(a) Be responsible for giving proper notice of all Medical Staff meetings, regular or special, on order of the appropriate authority,

(b) Be a member of the MEC,

(c) Be responsible for the accurate and complete minutes for all Medical Staff and MEC meetings,

(d) Be responsible for communicating nominees for Medical Staff officers to the Medical Staff at least thirty (30) days prior to the annual Medical Staff meeting;

(e) Communicate to the Medical Staff all applicants for membership on the Medical Staff; and

(f) Perform such other duties as may be assigned by the Chief of Staff or the MEC

(4) Immediate Past Chief Of Staff The Immediate Past Chief of Staff shall

(a) Serve as a member of the MEC; and

(b) Serve as Chief of Staff, in the absence of the Chief of Staff and Vice Chief of Staff;

ARTICLE VI MEDICAL STAFF COMMITTEES

Section 1. Functions of the Medical Staff. The functions of the Medical Staff are as specified in this section, but not limited to those stated. The Medical Staff functions shall be accomplished as indicated in these Medical Staff Bylaws through assignment to the Medical Staff as a whole, to departments, to Medical Staff committees, to Medical Staff officers or other individual Medical Staff members, or to interdisciplinary Hospital committees with participation of Medical Staff members. A list of all Medical Staff standing committees are retained in the Medical Staff policy and procedures manual. Those functions are to:

A Govern, direct, and coordinate the Medical Staff organization and its various functions,

B Provide leadership and implement appropriate policies for the process measurement, assessment and improvement of the Medical Staff components of the Hospital's performance improvement program, including, without limitation, the

(1) Clinical processes involved in the:

(a) Medical assessment and treatment of patients,

(b) Use of antibiotics and other medications,

(c) Use of blood, blood components and tissue,

(d) Use of operative and other procedures,

(e) Efficiency of clinical patterns and utilization review activities, and

(f) Significant departures from established patterns of clinical practice

(2) Patient care processes related to

(a) Education of patients and families,

(b) Coordination of care with other Practitioners and Hospital personnel relevant to an individual patient's care and fulfillment of consultation requirements; and

(c) Accurate, timely and legible completion of Hospital medical records that include clinically pertinent information

(3) Communication and use of performance improvement findings, when relevant to a Practitioner, in consideration of any application for appointment or reappointment to the Medical Staff and requests for Clinical Privileges.

(4) Development and use, with other appropriate Hospital personnel, of autopsy requirements including the:

(a) criteria to identify when an autopsy should be performed;

(b) mechanisms to document permission to perform an autopsy,

(c) review and monitoring of autopsy reports; and

(d) system to notify the attending Practitioner and other appropriate individuals when an autopsy is performed

C. Conduct, coordinate and evaluate the effectiveness of clinical studies, including without limitation:

(1) Monitoring mortality and morbidity, and

(2) Special studies of the inputs, processes and outcomes of care

D. Evaluate and monitor compliance with the Medical Staff Bylaws, the Rules and Regulations, other policies and procedures of the Medical Staff and Hospital policies;

E. Coordinate and perform investigations of the credentials of any Practitioner's application for appointment or reappointment to the Medical Staff or requesting Clinical Privileges and make recommendations on such applications, including

(1) Investigate the credentials of all Practitioners seeking Medical Staff appointment,

(2) Make recommendations on applications for initial or reappointment to the Medical Staff, requests for Clinical Privileges, and modifications of Medical Staff category or Clinical Privileges; and

(3) Make recommendations on written criteria for granting specific Clinical Privileges

F Monitor and evaluate the care provided in, and develop clinical policies for the services offered at the Hospital

G. Conduct, coordinate and act on credentials investigations and recommendations regarding grants of clinical privileges, corrective action, and specified services for other licensed professionals who have delineated clinical privileges at the Hospital;

H. Provide and evaluate continuing education opportunities responsive, when appropriate, to performance improvement program findings, the type and nature of care offered at the Hospital and to new state-of-the-art developments pertinent to clinical practice in the Hospital;

I Supervise the Hospital's professional library services;

J. Develop and review policies and practices on, and maintain surveillance over, the completeness, timeliness, and clinical pertinence of patient medical and related records;

K. Prevent, investigate, and control Hospital-acquired infections and monitor the Hospital's infection control program;

L. Participate in planning 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, and

M Direct Medical Staff organizational activities, including Medical Staff Bylaws review and revision, Medical Staff officer and committee nominations, liaison with the Board and Hospital administration, and review and maintenance of Hospital accreditation.

Section 2. Principles Governing Committees

A MEC and Other Committees There shall be a MEC and such other standing and special committees of the Medical Staff responsible to the MEC as may from time to time be necessary and desirable to perform the Medical Staff functions listed in this Article and elsewhere in these Medical Staff Bylaws

B MEC Requirements

(1) Purpose of the MEC The MEC is empowered to act for the Medical Staff and to coordinate all activities and policies of the Medical Staff and its departments and

committees The MEC shall meet on a monthly basis and make available for review by members of the Medical Staff, eligible to attend general Medical Staff meetings, the minutes of such monthly meetings

(2) Composition of the MEC Except for the Hospital's initial year of operation, the MEC shall consist of the Chief of Staff, Vice-Chief of Staff, Secretary/Treasurer (to serve as Chairperson of the Hospital performance improvement committee), the Department Chairpersons, and the Immediate Past Chief of Staff for a total of eight (8) members. The Department Chairpersons, at their discretion, may appoint a pro-tem Practitioner on a case-by-case basis to sit as the departmental representative of the MEC in the Department Chairperson's absence The CEO (or designee) shall be an Ex-Officio member of the MEC

(3) Officers of the MEC. The Chief of Staff shall serve as the chairperson and presiding officer of the MEC. The Vice Chief shall serve as the vice chairperson of the MEC to act in the chairperson's absence. The Secretary/Treasurer shall serve as the secretary and recording officer of the MEC .

(4) Functions of the MEC The MEC functions include, but are not limited to.

(a) Reviewing and acting on reports of Medical Staff committees, departments and other assigned activity groups;

(b) Reviewing the credentials of applicants for Medical Staff membership and delineated Clinical Privileges,

(c) Making recommendations regarding the mechanism designed to review credentials and delineate individual Clinical Privileges to the Board,

(d) Making recommendations for Medical Staff membership and delineated Clinical Privileges to the Board (subject to any applicable state law),

(e) Organizing the Medical Staff's organization performance improvement activities and establishing a mechanism designed to conduct, evaluate and revise such activities, ensuring that the findings, conclusions, recommendations and actions taken to improve organizational performance are communicated to appropriate Medical Staff members;

(f) Adopting Medical Staff policies and procedures, subject to Board review and approval,

(g) Ensuring there are mechanisms by which Medical Staff membership and Clinical Privileges may be terminated, as outlined in these Medical Staff Bylaws and the Corrective Action and Fair Hearing Procedures, and

(h) Ensuring there are mechanisms designed for use in corrective actions, as outlined in these Medical Staff Bylaws and the Corrective Action and Fair Hearing Procedures

C Substitution. The MEC may, at any time it deems it necessary and desirable for the proper discharge of the functions required of the Medical Staff by these Medical Staff Bylaws and the Hospital Bylaws and Hospital policies, by resolution establish, eliminate, or merge standing or special committees, change the functions of a Medical Staff committee, or assign the function to the Medical Staff as a whole.

D Hospital Joint Conference Committee. The Chairperson of the Georgetown Hospitals, with the approval of and after consultation with the Board, may appoint a Hospital Joint Conference Committee consisting of an equal number of Board members and Active Medical Staff members. The Chief of Staff, the Vice-Chief of Staff and the Secretary/Treasurer shall be appointed to serve as the Active Medical Staff members of the Hospital Joint Conference Committee. The Chairperson of Georgetown Hospitals shall act as the Chairperson of the Hospital Joint Conference Committee. The Hospital Joint Conference Committee shall serve as a forum for the discussion of matters of administrative and medical policies and procedures of concern to the Board and the Medical Staff.

E. Representation on Hospital Committees. Medical Staff functions and responsibilities relating to liaison with the Board and Hospital administration which require participation of, rather than direct oversight by the Medical Staff, may be discharged by Medical Staff representation on such committees as are established to perform such functions.

F. Action Through Sub-Committees. Any standing committee may elect to perform any of its specifically designated functions by constituting any number of its members as a sub-committee for that purpose, reporting such action to the MEC in writing. Any such subcommittee may include individuals in addition to members of the standing committee. Such additional members are appointed by the committee chairperson after consultation with the Chief of Staff and with the CEO (or designee) when administrative staff appointments are to be made.

G Composition. Medical Staff committees that may be established pursuant to this Article to perform one or more of the Medical Staff functions required by these Medical Staff Bylaws will be composed of members of the Active, and/or Provisional, Medical Staffs, and may include, where appropriate representation from Hospital departments as are appropriate to the function(s) to be discharged. The CEO (or designee) shall serve as an Ex Officio member of all Medical Staff committees.

H Appointment of Committees. Unless otherwise specifically provided, the Chief of Staff shall appoint the members and chairperson of any Medical Staff committee. Hospital personnel serving on Medical Staff committees shall be appointed by the CEO (or designee).

I. Term and Removal Unless otherwise specifically provided, a Medical Staff committee chairperson and member shall serve a one (1) year term, except one serving ex-officio, and that one (1) year term shall commence the first day of the Staff Year and expire the last day of the Staff Year, unless the chairperson or member sooner resigns or is removed from the committee or the Medical Staff. A Medical Staff committee member, other than one serving Ex-Officio, may be removed by the Chief of Staff upon a majority vote of the MEC.

J. Vacancies A vacancy on any committee shall be filled for the unexpired portion of the term in the same manner in which original appointment was made. Any Ex-Officio member of a Medical Staff committee shall automatically lose such position if the Ex-Officio member no longer holds the designated position which is the basis of the Ex-Officio membership.

K. Meetings. A Medical Staff committee established to perform one or more of the Medical Staff functions required by these Medical Staff Bylaws shall meet as often as is necessary to discharge its assigned duties. Unless otherwise indicated in these Medical Staff Bylaws, Roberts Rules of Order will be adopted as the principal parliamentary authority governing fair and orderly procedure in all Medical Staff committee meetings.

ARTICLE VII MEDICAL STAFF CLINICAL DEPARTMENT AND DEPARTMENT CHAIRPERSONS

Section 1. Designation

A. Current Clinical Departments The current clinical departments of the Hospital are Family Practice, Hospital-Based Services, Medicine and Surgery (the "Department(s)").

(1) The Family Practice Department consists of Practitioners practicing in the specialties listed below and other appropriate specialties as designated by the MEC.

Family Practice
General Practice

(2) The Hospital-Based Services Department consists of Practitioners practicing in the specialties defined as Hospital-Based Services, except for the clinical specialty of anesthesia, and listed below and other appropriate specialties as designated by the MEC.

Emergency Medicine
Pathology

Radiology

(3) The Medicine Department consists of Practitioners practicing in the specialties listed below and other appropriate specialties as designated by the MEC:

- Gastroenterology
- Internal Medicine and Internal Medicine subspecialties
- Neurology
- Oncology
- Pediatrics
- Physical Medicine and Rehabilitation
- Psychiatry
- Pulmonology

(4) The Surgery Department consists of Practitioners practicing in the specialties listed below and other appropriate specialties as designated by the MEC:

- Anesthesiology
- General Surgery
- Neurosurgery
- Obstetrics and Gynecology
- Ophthalmology
- Oral Surgery
- Orthopedics
- Otorhinolaryngology
- Plastic Surgery
- Podiatry
- Urology

B Affiliation With Departments. Each member of the Medical Staff shall be assigned membership in one (1) Department. The exercise of Clinical Privileges by members assigned to a Department are subject to the authority of the Department Chairperson, these Medical Staff Bylaws, the Rules and Regulations, the Appointment and Reappointment Procedures, the Corrective Action and Fair Hearing Procedures, other Medical Staff policies and procedures and Hospital policies

C Functions of Clinical Departments Each Department will

(1) Coordinate the professional services of those Practitioners assigned to the Department with those of the other Department, clinical units of the Hospital and Hospital and Medical Staff services,

(2) Recommend minimum requirements for the Clinical Privileges that may be exercised by Practitioners assigned to the Department and monitor the exercise of Privileges actually delineated for the Department's members,

(3) Monitor, on a continuing and concurrent basis, the performance of the Practitioners assigned to the Department for adherence to Medical Staff policies and procedures and Hospital policies, including requirements for: obtaining alternate coverage and consultation; adherence to sound principles of clinical practice generally, unexpected clinical occurrences, and patient safety;

(4) Meet as needed on a regular basis, to review the clinical work of the Department and other business to be transacted and make recommendations and provide written reports to the MEC; and

(5) Conduct or participate in and make recommendations for continuing medical education programs.

D Designation And Qualifications Of Department Chairpersons Each Chairperson shall be a member of the Active Medical Staff and of the Department the Chairperson is to head and remain in good standing throughout the Chairperson's term, and must be qualified by training, experience, interest and current demonstrated ability in at least one of the clinical specialties within the Department, and shall be willing and able to faithfully discharge the functions of the office of Department Chairperson Failure to maintain such status shall immediately create a vacancy in the office involved.

E Method Of Selection Of Chairpersons

(1) The Department members shall nominate persons for Department Chairperson at least ten (10) days before the last Department meeting held before the end of the Staff Year

(2) Election of the Department Chairperson will be made by majority vote of those voting members present at the last regular or special meeting of the Department held before the end of the Staff Year. A quorum of fifty percent (50%) of Department members is needed for such a meeting

F Term Of Office A Department Chairperson shall serve a one (1) year term coinciding with the Staff Year, commencing on election and continuing until a successor is chosen, unless the Department Chairperson sooner resigns or is removed from office Department Chairpersons are eligible for re-election, but may not serve more than two (2) consecutive terms

G. Resignation A Department Chairperson may resign at any time by giving written notice to the MEC. Such resignation shall not be contingent on formal acceptance and shall take effect on the date of receipt or at any later time specified in the notice

H Removal A Department Chairperson may removed from office by a two-thirds (2/3) majority vote of the applicable constituent group eligible to vote and subject to the approval of the MEC and the Board A regular or special-called meeting must be held to carry out a vote to remove a Department Chairperson, at which absentee or proxy ballots will not be accepted Permissible grounds for removal include, but are not limited to

(1) Failure to perform the duties of the position held in a timely and appropriate manner,

(2) Failure to continuously satisfy the qualifications for the position; or

(3) A determination that such removal is in the best interests of the Medical Staff or the Hospital.

I. Vacancies. An unexpected vacancy in the position of a Department Chairperson will be filled by the MEC through the appointment of an acting Department Chairperson after considering the recommendations of the members of the department concerned. The acting Department Chairperson will serve pending a special election conducted in the same manner as provided for in this Section for the regular election of a Department Chairperson.

J. Responsibilities, Authority And Reporting Obligations Of Department Chairpersons.

(1) Responsibility And Authority. A Department Chairperson shall have the responsibility and authority to do everything necessary to carry out the functions delegated to the Chairperson and the Department by the Board, by the MEC, by these Medical Staff Bylaws, the Rules and Regulations, Medical Staff policies and procedures and Hospital policies.

(2) Reporting Obligations. Each Department Chairperson will report.

(a) At all regularly scheduled MEC meetings on the Department's activities;

(b) Whenever necessary or requested to, to the Chief of Staff or other Practitioner fulfilling the duties of these Medical Staff Bylaws, on matters of immediacy, especially where action to coordinate clinical services to maintain quality or to assure patient safety are at issue, and

(c) To the CEO (or designee) on issues relating to Department needs requiring Hospital action

K. Specific Duties And Obligations. Each Department Chairperson shall.

(1) Be accountable to the MEC for all professional and administrative activities within the Department,

(2) Be accountable for the quality of patient care rendered by members of the Department,

(3) Be responsible for the effective conduct of the patient care review, evaluation, and monitoring functions delegated to the Department;

(4) Make recommendations for criteria for Clinical Privileges that are relevant to the care provided by Practitioners assigned to the Department,

(5) Develop and implement Department programs and recommend policies of operation of the Department, in cooperation with the Chief of Staff and consistent with these Medical Staff Bylaws, Medical Staff policies and procedures and Hospital policies, for retrospective patient care audit, on-going monitoring of practice, credentials review and Privileges delineation, continuing medical education and utilization review,

(6) Be a member of the MEC, give guidance on the overall medical policies of the Hospital, and make specific recommendations and suggestions regarding the Department;

(7) Interview, as necessary, initial applicants for Medical Staff membership and Privileges who would be assigned to the Department based on their specialty, and make a written report including recommendations on the applicants to the Medical Staff committee assigned responsibility for the review of the credentials of Practitioners;

(8) Interview, as necessary, any Practitioner assigned to the Department wishing to modify Medical Staff category, Privileges or Department assignment and make a written report including recommendations regarding the requested modification to the Medical Staff committee assigned responsibility for the review of the credentials of Practitioners;

(9) Maintain continuing review of the professional performance of all Practitioners assigned to the Department and report thereon to the Medical Staff committee assigned responsibility for the review of the credentials of Practitioners at time of reappointment to the Medical Staff, along with recommendations,

(10) Appoint such committees as are necessary to conduct the functions of the Department including departmental quality assessment and performance improvement committees, subject to approval by the MEC;

(11) Enforce the Hospital and Medical Staff Bylaws, the Rules and Regulations, the Appointment and Reappointment Procedures, the Corrective Action and Fair Hearing Procedures and Medical Staff or Hospital policies and procedures within the Department, including, when appropriate, initiation of corrective action and investigation of clinical performance and obtaining consultations;

(12) Implement actions taken by the MEC and by the Board within the Department,

(13) Participate in every phase of administration of the Department through cooperation with the nursing service and the Hospital administration in matters affecting patient care, including personnel, supplies, special regulations, standing orders and techniques;

(14) Perform such other duties commensurate with office of Department Chairperson as may from time to time be reasonably requested by the Chief of Staff, the MEC, the CEO (or designee) or the Board; and

(15) Upon request, review a Practitioner's request for a leave of absence, the Practitioner's current health status, and, if applicable, the recommendation from the attending physician regarding the Practitioner's ability to return to active practice, and make recommendations regarding the Practitioner's return to the Chief of Staff

ARTICLE VIII MEETINGS

Section 1. Medical Staff Year. For purposes of the business of the Medical Staff, the business year will commence on the first day of the Staff Year and expire on the last day of the Staff Year.

Section 2. Medical Staff Meetings.

A. Regular Meetings

(1) Regular meetings of the Medical Staff will be held at least annually before the beginning of the new Staff Year

(2) The MEC may authorize the holding of additional general Medical Staff meetings by resolution. The resolution authorizing any such additional meeting shall require notice specifying the place, date, and time for the meeting, and that the meeting can transact any business as may come before it.

B. Special Meetings

(1) A special meeting of the Medical Staff may be called by the Chief of Staff, but must be called by the Chief of Staff at the written request of the Board, the MEC, or fifty-one percent (51%) of the Active Medical Staff.

(2) The meeting shall be held at the time and place designated in the meeting notice. The notice shall stipulate that no business shall be transacted at any special meeting except that business stated in the notice

C. Order of Business and Agenda The order of business at a regular meeting shall be determined by the Chief of Staff. The agenda shall include at least, but is not limited to

(1) Reading and acceptance of the minutes of the last regular and all special meetings held since the last regular meeting,

- (2) Old business and status report on pending business,
- (3) New business and status report on pending business;
- (4) The election of officers and of representatives to Medical Staff and Hospital committees, when required by these Medical Staff Bylaws, and
- (5) Administrative reports from the Departments, committees, and the CEO (or designee). These reports may include overall results of patient care audit and other quality review, evaluation and monitoring activities of the Medical Staff and on the fulfillment of the other required Medical Staff functions.

Section 3. Department and Committee Meetings.

A. Regular Meetings Departments and committees may, by resolution, provide the time for holding regular meetings and no notice other than such resolution is then required. Department and committee meetings will be held as needed on a regular basis, but not less than on an annual basis.

B. Special Meetings A special meeting of any Department or committee may be called by the applicable Department or committee Chairperson or the Chief of Staff, but must be called by the applicable Department or committee Chairperson or the Chief of Staff at the written request of the Board, the Chief of Staff, or one-third (1/3) of the group's current members. No business shall be transacted at any special meeting except that stated in the meeting notice.

Section 4. Notice of Meetings Written notice stating the place, day, and hour of any general Medical Staff meeting, of any special meeting, or of any regular committee meeting not held pursuant to resolution shall be delivered either personally or by mail to each person entitled to be present at the meeting, or placed in the Practitioner's box in the Hospital's medical records department, not less than three (3) days nor more than eight (8) days before the date of such meeting. Notice of department or committee meetings may be given orally. If mailed, the notice of the meeting shall be deemed delivered forty-eight (48) 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 shall constitute a waiver of notice of such meeting.

Section 5. Quorum.

A. General Staff Meetings The presence of forty percent (40%) of the members of the Medical Staff eligible to vote or attend regular or special staff meetings shall constitute a quorum. The affirmative vote of a majority is necessary for the transaction of all business other than the amendment of these Medical Staff Bylaws and the Rules and Regulations.

B. Department and Committee Meetings

(1) A quorum for an individual department meetings will be determined by that department. Should a department not take special action to develop a quorum specific to their department, then fifty percent (50%) of the voting members of the department, but not less than two (2) members shall constitute a quorum at any meeting of such department.

(2) Fifty percent (50%) of the voting members of a committee, but not less than two (2) members, shall constitute a quorum at any committee meeting.

Section 6. Participation of Hospital Administration The CEO (or designee) shall be invited to attend participate Ex-Officio in all Medical Staff meetings.

Section 7. Manner of Action. Except as otherwise specified, the action of a majority of the members present and voting at a meeting at which a quorum is present shall 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 each member entitled to vote at the meeting.

Section 8. Minutes. Minutes of all meetings shall be prepared by the secretary of the meeting so appointed or his/her designee and shall include a record of attendance and the vote taken on each matter. The meeting minutes shall be approved and signed by the chairperson and/or the presiding member, made available to members of the group meeting for review, and forwarded to the MEC. A permanent file of minutes of each meeting shall be maintained.

Section 9. Attendance Requirements.

A. Generally Each member of the Medical Staff must attend the Medical Staff and department meetings required for members in the Practitioner's Medical Staff category and the meeting of committees on which the Practitioner serves, being present and voting at not less than fifty percent (50%) of each Medical Staff, department and committee meeting held, unless excused by reason of illness or a medical or personal emergency by the chairperson or presiding member of the applicable meeting.

B. Absence from Meetings Unless excused for good cause, failure to meet the attendance requirements of this Section shall be grounds for initiation of corrective action under these Medical Staff Bylaws, and including, in addition, removal from committee participation or the Medical Staff.

ARTICLE IX CORRECTIVE ACTION

Section 1. Informal Interviews and Investigations Nothing in this Article or the Corrective Action and Fair Hearing Procedures shall prevent any Professional Review Body from conducting an informal investigation of a Practitioner, including actions involving the professional competence or conduct of a Practitioner, or undertaking corrective

counseling, including issuing a letter of warning, admonition or reprimand, which shall be documented in the Practitioner's file and may serve as a basis to initiate a corrective action under this Article.

Section 2. Initiation

A. A Department Chairperson, a Medical Staff Officer, the CEO (or designee) or the Board may submit a written request for investigation to the Chief of Staff (the "Request") at any time when such person has reason to believe that the competence or professional conduct, or other behavior or conduct not related to the competence or professional conduct, of a Practitioner has been or is reasonably likely to be detrimental to patient care, disruptive to Hospital operations, or otherwise deviates from the Practitioner's responsibilities and applicable qualifications set forth in these Medical Staff Bylaws, the Rules and Regulations, other Medical Staff policies and procedures or Hospital policies. The Request must identify the specific acts, activities or conduct which constitute the grounds for the Request.

B. The Request shall be processed in accordance with the procedures set forth in the Corrective Action and Fair Hearing Procedures.

Section 2. Summary Suspension and Automatic Suspension.

A. Summary Suspension. The requirements and procedures for summary suspensions are set forth in the Corrective Action and Fair Hearing Procedures.

B. Automatic Suspension. The requirements and procedures for automatic suspensions are set forth in the Corrective Action and Fair Hearing Procedures.

ARTICLE X ADOPTION AND AMENDMENT

Section 1. Medical Staff Responsibility The Medical Staff may recommend to the Board proposed changes or amendments to the Medical Staff Bylaws, the Rules and Regulations, and related policies, procedures and manuals.

Section 2. Medical Staff Action

A. Recommendations for substantive amendments to these Medical Staff Bylaws and the Rules and Regulations shall be approved by the affirmative vote of two-thirds (2/3) majority vote of the Medical Staff members eligible and qualified to vote on Medical Staff Bylaws cast at a regular or special-called meeting of the Medical Staff provided a quorum of forty percent (40%) of the Medical Staff members eligible and qualified to vote are in attendance at the meeting. The vote may include absentee voting by personal delivery to the appropriate medical staff secretary. Absentee votes may be accepted up to the time of the meeting. Absentee ballots will not be counted to constitute a quorum. Each Medical Staff member who is eligible and qualified to vote will be

provided a period of no less than twenty-one (21) days to review the proposed documents or amendments to be approved.

B. The MEC shall have the power to recommend amendments to the Board to the Medical Staff Bylaws and the Rules and Regulations that are, in the MEC's judgment: technical; legal; modifications or clarifications by the Hospital's licensing or accrediting bodies, reorganization or renumbering; or amendments needed because of punctuation, spelling, or other errors of grammar or expression. Such amendments need not be circulated or approved by the Medical Staff.

Section 3. Periodic Review. These Medical Staff Bylaws shall be periodically reviewed by the Medical Staff and recommend amendments, if necessary, in accordance with this Article to reflect the Hospital's current practices regarding the Medical Staff organization and functions

Section 4. Adoption of Recommendations and Board Approval. These initial Medical Staff Bylaws and the Rules and Regulations and any future amendments thereof shall become effective upon approval by the Board. The MEC shall also approve these initial Medical Staff Bylaws. Thereafter, the Medical Staff or the MEC may recommend amendments to the Medical Staff Bylaws and the Rules and Regulations to the Board. The Board may approve all or certain portions of the Medical Staff Bylaws and the Rules and Regulations. Neither body may unilaterally amend the Medical Staff Bylaws or Rules and Regulations without first submitting the proposed amendment to the Joint Conference Committee as set forth in Section 5 of this Article.

Section 5. Joint Conference Committee Consideration. If at any time the Board proposes to take an action to disapprove any amendment to the Medical Staff Bylaws or Rules and Regulations recommended by the MEC or the Medical Staff under this Article, then the Chairperson of the Board shall convene a Hospital Joint Conference Committee to undertake bilateral consideration of the proposed amendment and make a recommendation to the Board. Any recommendations by the Hospital Joint Conference Committee under this Section shall be submitted to the Board in writing based upon a super majority vote of at least two-thirds (2/3) of the Joint Conference Committee members.

ARTICLE XI CODE OF CONDUCT

Section 1. Principal Objectives. The principal objectives of this code are aimed at ensuring high standards of patient care and preserving a professional work environment. It provides a channel through which code of conduct behavior can be reported and appropriately recorded. A single incident may or may not be sufficient for action, but each individual report may help identify a pattern that requires intervention. The code of conduct establishes a clear review or verification process. It establishes a process to notify a

physician that a report has been made, and provide the physician with an opportunity to respond to the report.

Furthermore, this code includes a means of monitoring whether the physician's conduct improves. Proposed corrective actions should be commensurate with the behavior. Codes of conduct, therefore, allows for self-correction, as well as structured rehabilitation. Suspension of responsibilities or privileges is to be held as a mechanism of final resort if the behavior persists despite adequate attempts at intervention. In addition, codes of conduct establish which individuals will be involved in the various stages of the process (from reviewing reports to notifying physicians and monitoring conduct after intervention), and provides guidelines for confidentiality. Finally, this ensures individuals who report physician conduct issues are duly protected.

Section 2. Definition. Personal conduct, whether verbal or physical, that negatively affects or that potentially may affect patient care or employee safety, or which may create a hostile work environment for employees or colleagues, constitutes disruptive behavior. (This includes but is not limited to conduct that interferes with one's ability to work with other members of the health care team.) However, criticism that is offered in good faith with the aim of improving patient care should not be construed as disruptive behavior. This criticism should be directed to supervisor level or management, and not staff level, and should not be conducted in public areas or in the presence of patients.

For the purposes of this code of conduct, a hostile work environment may be created by conduct or behavior that is directed at a specific person or persons that causes substantial emotional distress, especially if said conduct has the purpose or effect of creating an intimidating, hostile or offensive work environment. Behaviors that engender a hostile or offensive work environment may include, but are not limited to, offensive comments, printed or electronic material, jokes, innuendos and other sexually oriented statements.

Section 3. Examples Of Disruptive Conduct. For the purposes of these Bylaws, examples of "disruptive conduct" include, but are not limited to

- A Abusive behavior toward or comments directed toward hospital personnel, Allied Health Professionals, patients, or physicians
- B Verbal attacks or other types of public humiliation, which are personal, irrelevant or go beyond fair, professional conduct, and directed toward hospital personnel, Medical Staff, Allied Health Professionals, contracted staff, or patients
- C Abusive comments, drawings, or illustrations made in a patient's medical records or other hospital business records, or attacking particular Practitioners, Allied Health Professionals, nurses, other Hospital personnel
- D Lying, cheating, and knowingly making false accusations, altering or falsifying any patient's medical records or hospital documents

- E Verbal or physical maltreatment of another individual, including physical or sexual assault.
- F Written or spoken words (including improper joking or teasing) or physical conduct that denigrates or shows hostility or aversion towards an individual because of race, color, religion, creed, age, sex, national origin or ancestry, veteran's status, or status as a qualified individual with a disability, and that has the purpose or effect of creating an intimidating, hostile, or offensive working environment as defined by law, or has the purpose or effect of unreasonably interfering with an individual's work performance; or otherwise adversely affects an individual's employment opportunities.

Section 4. Response To Disruptive Conduct. Any employee of the hospital who engages in disruptive conduct shall be dealt with in accordance with the hospital's Human Resources policies.

Any member of the Medical Staff or other individual with clinical privileges who engages in disruptive conduct shall be dealt with in accordance with this Section of the Bylaws.

A Documentation.

- (1) Documentation of the alleged incident shall be factual and to the extent possible, include;
 - a. The date and time of the questionable behavior;
 - b. A factual description of the questionable behavior;
 - c. The name of any patient or patient's family members who were involved in the incident (including any patient or family member who witnessed the incident);
 - d. The circumstances which precipitated the incident,
 - e. The names of other witnesses to the incident;
 - f. Validation of the event by a Medical Staff member, supervisor, other employee, etc.
 - g. Consequences, if any, of the incident as it related to patient care, personnel, or hospital operations, and
 - h. Any action taken to intervene in, or remedy, the incident

B Review of Reports

- (1) Each report will be processed on an individual basis. Reports are not to be compiled and processed in "batches" of multiple reports. In the event the complaint is initiated by a hospital employee, the appropriate supervisor shall then forward a documented report to the Chief Executive Officer, or designee who shall immediately notify the Chief of Staff or designee. The complaint will also be provided to the individual practitioner in a timely manner for his/her notification and review. Members of the Medical Staff may report complaints to their Chief of Department and/or Chief of Staff. The Chief Executive Officer, or designee, the Chief of Staff and Department Chief, or designees, are the evaluation team and shall review the report and shall meet with the individual who prepared it and/or any witnesses to the incident to ascertain the details of the incident.

C Evaluation

- (1) If, after review of the report and appropriate interviews are conducted, it is determined that further evaluation is warranted, the Chief of Staff, CEO, and Department Chief (or designees) shall meet with the Practitioner in an expeditious time frame. During the meeting, the Practitioner shall be advised of the nature of the incident that was reported and shall be requested to provide a response and/or perspective concerning the incident. The Practitioner shall be notified if the evaluation requires further action.

D. Confidentiality/Non-Retaliation

- (1) The identity of the individual initiating the complaint of disruptive conduct shall not be disclosed at this time, unless the Chief Executive Officer and Chief of Staff (or their respective designees) agree in advance that it is appropriate to do so. In this case, or in the case where the Practitioner may suspect the identity of the individual preparing the report, the Practitioner will be instructed to not discuss the case with the person who has filed the complaint. The Practitioner shall be advised that any retaliation against the person reporting the incident will be reported to the MEC for review and possible disciplinary action.

E Initial Meeting Summary

- (1) The Practitioner shall be advised that a summary of the meeting shall be prepared and a copy provided to him or her. The Practitioner shall be advised if the evaluation committee feels the conduct was inappropriate and inconsistent with the standards of the hospital and the Bylaws. If any corrective action is deemed necessary by the evaluation committee, this will be fully detailed in this summary. The Practitioner will prepare a written response to the summary. The Chief of Staff, or designee, shall cause the summary and any response that is received to be kept in the confidential portion of the Practitioner's credentials file.

The Chief Executive Officer, or designee, shall cause the written report(s) of the incident, summary of the meeting, and any other records regarding the incident or the meeting to be kept as a confidential peer review record. Should any intervention be deemed necessary by the evaluation committee and/or agreed upon, the Practitioner may at this point be referred to the Physician Wellness Committee for monitoring to ensure the appropriate corrective action is completed. The Physician Wellness Committee may elect to defer the matter at any time to the Medical Executive Committee.

F. Completion of Evaluation

- (1) It is anticipated that the entire process from initial reporting to the completion of the review by the evaluation committee should be accomplished in no more than thirty (30) days.

G. MEC Referral To Board

- (1) The Medical Executive Committee may, at any point in the evaluation, refer the matter to the Board.—Any further action, including corrective action, hearing or appeal, shall then be conducted under the direction of the Board under the Corrective Action and Fair Hearing Procedures of the Bylaws. Again, should any corrective action be deemed necessary and/or agreed upon, the Practitioner may be referred to the Physician Wellness Committee for monitoring to ensure the appropriate intervention is completed

H. Continued Authority To Refer For Corrective Action

- (1) Nothing in this section shall in any way negate and/or alter the Summary Suspension provisions outlined in the WCH Medical Staff Bylaws, Article IX, Section 3, Summary Suspension.

I. Code Of Conduct Review

- (1) This Code of Conduct and Procedures must be reviewed at least biennially by the Bylaws Committee

J. Voting Rights

- (1) Under this Code of Conduct and Procedures, the Chief Executive Officer (and/or administrative designees) shall be considered ex-officio members of all committees and shall not have voting rights

ARTICLE XII PHYSICIAN WELLNESS COMMITTEE

Section 1. Establishment Of Committee. The purposes of establishing the Physician Wellness Committee (PWC) are to help safeguard the well-being of all patients treated in Georgetown Hospital System, educate physicians and hospital staff about physician impairment, and foster rehabilitation of impaired Practitioners in a non-punitive approach. The PWC shall consist of physicians from both hospitals assigned by the Chiefs of Staff of GMH and WCH, who have an interest in promoting physician wellness and who have agreed to serve as members of the committee for an extended period of time. The PWC shall consist of those physicians assigned by the Chiefs of Staff of WCH who have an interest in promoting physician wellness and who have agreed to serve as members of the committee for an extended period of time. The chairman of the committee will be selected by the physician committee members. The Chief Executive Officer (and/or administrative designees) shall be considered ex-officio members of the PWC and shall not have voting rights.

Section 2. Educational Programs The PWC shall meet as needed and will administer the education of Practitioners and hospital staff through educational materials, presentations, and any other resources the PWC believes will help to educate the medical staff and hospital staff on Practitioner impairment. The PWC will publish these materials and/or present these programs to the Medical Staff and hospital staff throughout the year

Section 3. Reporting Obligations

A Practitioner Reporting

- (1) It is the duty of every Practitioner to report to either the Chairman of the Physician Wellness Committee of WCH, or the Chief of Staff or the CEO any incident or behavior that suggests a colleague may be experiencing any condition (physical, mental, or behavioral) which could affect his/her ability to provide quality patient care or carry out his/her duties associated with membership on the hospital's medical staff.

B Hospital Staff Reporting

(1) Hospital staff also has the responsibility to report to either the Chief of Staff, the Chairman of the PWC, and/or the CEO any incident or behavior that suggests a physician may be suffering an impairment (physical, mental, or behavioral) which could affect his/her ability to provide quality patient care or interact appropriately with other Healthcare providers

Section 4. Definition Of Impairment

A The Medical Staff and the hospital will adopt the American Medical Associations definition for physician impairment, which defines physician impairment as "any physical,

mental or behavioral disorder that interferes with ability to engage safely in professional activities and will address all such conditions in its Physician Health Program.” (AMA Policy Number H-95.955) Behavioral disorders shall include Code of Conduct violations as deemed appropriate by the Chief of Staff, Medical Executive Committee, or Board of Trustees

Section 5. Investigation Of Allegations

A Once a formal allegation has been brought before the PWC through the Chief of Staff, the Chairman of the PWC, or the CEO, the PWC shall call a meeting to discuss the current allegations against the alleged impaired Practitioner. The Chief of the Medical Staff will write a letter to the person bringing the allegation before the PWC acknowledging receipt of the allegation. A letter will also be written to the alleged impaired physician notifying him of the allegation brought against him, the person bringing forth the allegation and advising him that an investigation will occur. All letters will be sent via Certified mail to ensure receipt.

If the results of the investigation by the PWC find that no concern is warranted, the results of the findings, along with a conclusion by the PWC will be included in the confidential PWC portion of the Practitioner's file.

Section 6. Monitoring

A. If the results of the investigation reveal a basis for concern, the results of the findings, along with a conclusion by the PWC, will be included in the confidential PWC portion of the Practitioner's file and the Practitioner's activities will be monitored by the PWC until the PWC has determined whether there is an impairment problem. The PWC shall monitor the clinical performance of the Practitioner during the investigation to ensure patient safety. A conclusion by the PWC after this review period will be placed in the confidential PWC portion of the Practitioner's file.

Section 7. Response To Impairment

A Meeting With Practitioner

- (1) If the PWC investigation reveals the existence or likelihood of impairment of the Practitioner, the Chief of Staff, Chairman of the PWC, and CEO shall meet with the Practitioner to discuss the current situation and the response by the PWC.

B Committee Action

- (1) The PWC may choose a response similar to those below depending on the nature and severity of the situation
- If the situation is determined to be mild, and patient care is not likely to be negatively impacted, the PWC may choose to give guidance to Practitioner from the committee with the help of outside sources, if needed

- The PWC may recommend to the MEC that the Practitioner be enrolled in a rehabilitation program if the Practitioner wishes to continue to have clinical privileges and be a member of the WCH Medical Staff.
- The PWC may recommend to the MEC that appropriate practice restrictions be placed on the Practitioner and/or monitoring of the Practitioner take place for a specified period of time to be determined by the PWC.
- A recommendation may be made to the MEC that the PWC and the Practitioner may agree that the practitioner will not exercise clinical privileges and membership on the medical staff until a rehabilitation program has been successfully completed.
- If at any time the PWC reasonably believes that the Practitioner cannot safely perform his/her clinical privileges, the matter will be referred to the Chief of Staff and to the Chief of the physician's Medical Staff Department for corrective action under the Bylaws

C Failure To Cooperate

(1) If at any time the Practitioner is unwilling to voluntarily accept any PWC guidance or requirements under this Section of the Bylaws to address the impairment, the matter will be referred by the PWC to the Medical Executive Committee for corrective action. Any subsequent adverse action recommended by the Medical Executive Committee shall entitle the Practitioner to the hearing and appeal rights as provided in the Fair Hearing Plan of the Medical Staff Bylaws.

Section 8. Identification Of Assistance Program

If a rehabilitation program is deemed necessary the PWC will assist the Practitioner in identifying an appropriate rehabilitation program for the Practitioner to complete. Upon sufficient proof of successful completion of the rehabilitation program, the practice restrictions placed on the Practitioner may be removed and the Practitioner may be reinstated, as appropriate, upon the recommendation of the PWC.

Section 9. Confidential Nature Of Activities

The PWC shall keep any allegation received from a medical staff member or hospital staff member confidential throughout this entire process, except as necessary to complete the investigation as outlined in Section 11 4-2 and implement the recommendations of the PWC. Each member of the PWC will be required to sign a confidentiality statement annually that ensures the PWC member will hold any information about a practitioner confidential throughout and after the investigation. The PWC will also require the person with an allegation against a Practitioner to sign a confidentiality statement and return it to the PWC to be kept with the meeting minutes.

Section 10 Self-Reports

Any member of the Medical Staff can at anytime self-refer themselves to the PWC. The PWC will help the Practitioner identify an appropriate rehabilitation program to complete and will be responsible for monitoring the Practitioner's performance during this time. Any member of the medical staff is highly encouraged to self-refer themselves to the PWC if they feel they have an impairment. The same confidentiality will be exhibited and required by the PWC during this process.

These Medical Staff Bylaws are acknowledged as the Medical Staff Bylaws of the Hospital as of November 18, 2010.

Chief of Staff
Waccamaw Community Hospital
Murrells Inlet, South Carolina

Date

These Medical Staff Bylaws are approved as the Medical Staff Bylaws of the Hospital.

Secretary of the Board
Waccamaw Community Hospital
Murrells Inlet, South Carolina

Date

EXHIBIT A DEFINITIONS

"Adverse Action" means a Professional Review Action that recommends or results in the reduction, restriction, suspension, revocation, denial or failure to renew the Clinical Privileges or Medical Staff membership of a Practitioner for a period of more than thirty (30) days.

"Appointment and Reappointment Procedures" means the specific requirements and procedures adopted by the Board for appointment and reappointment to the Medical Staff and granting Clinical Privileges to Medical Staff members

"Board" means the governing body of Waccamaw Community Hospital.

"CEO" means the chief executive officer appointed by the Board to act on its behalf in the overall management of the Hospital.

"Clinical Privileges" or "Privileges" means the permission granted to a Practitioner by the Board to render specific professional diagnostic, therapeutic, medical, dental, podiatric, or surgical services.

"Corrective Action and Fair Hearing Procedures" means the substantive and procedural rights and requirements for taking corrective action against Practitioners and reviewing Adverse Actions

"Data Bank" means the National Practitioner Data Bank established by the HCQIA.

"DEA" means the United States Department of Justice Drug Enforcement Administration that is responsible for issuing controlled substance registrations.

"Ex Officio" means service as a member of a body by virtue of an office or a position previously held and, unless otherwise expressly provided, means without voting rights.

"HCQIA" means the Health Care Quality Improvement Act of 1986 as may be amended from time to time.

"Hospital" means Waccamaw Community Hospital.

"Hospital-Based Services" means the services offered by the Hospital in the clinical specialties of anesthesia, emergency medicine, pathology or radiology

"Hospital Bylaws" means the duly adopted corporate bylaws of the Hospital as may be amended from time to time

"Licensing Board" means the South Carolina Board of Medical Examiners or any successor created to license physicians and osteopaths in South Carolina

“MEC” means the executive committee of the Medical Staff.

“Medical Staff” means all duly licensed physicians, osteopaths and podiatrists who are appointed to the Medical Staff and granted Clinical Privileges by the Board to attend patients at the Hospital.

“Practitioner” means, unless otherwise limited, any physician, osteopath, dentist or podiatrist applying for, or obtaining, Medical Staff membership or Clinical Privileges at the Hospital

“Prerogative” means the rights and responsibilities granted by virtue of Medical Staff category, or otherwise, to a Medical Staff member and exercisable subject to the conditions imposed in these Medical Staff Bylaws, the Rules and Regulations, other Medical Staff policies and procedures and Hospital policies.

“Professional Review Action” means an action or recommendation of a Professional Review Body that is taken or made in the conduct of a Professional Review Activity, which is based on the competence or professional conduct¹ of an individual Practitioner (which conduct affects or could affect adversely the health or welfare of a patient or patients), and which affects (or may affect) adversely the Medical Staff membership, Clinical Privileges of the Practitioner. Such term includes a formal decision of a Professional Review Body not to take an action or make a recommendation described in the previous sentence and also includes Professional Review Activities related to a Professional Review Action.

“Professional Review Activity” means an activity of the Hospital with respect to an individual Practitioner to accomplish any one or more of the following: (a) to determine whether the Practitioner may have Clinical Privileges or Medical Staff membership at the Hospital; (b) to determine the scope or condition of such Clinical Privileges or Medical Staff membership; or (c) to change or modify such Clinical Privileges or Medical Staff membership.

“Professional Review Body” means the Board, the CEO (or designee) or any committee of the Hospital which conducts Professional Review Activity, and includes any committee of the Medical Staff, individual, or entity with the authority to recommend an Adverse Action

¹ A Professional Review Action is not considered to be based on the competence or professional conduct of a Practitioner if the action is primarily based on

- 1 the Practitioner's association, or lack of association, with a professional society or association,
- 2 the Practitioner's fees or the Practitioner's advertising or engaging in other competitive acts intended to solicit or retain business,
- 3 the Practitioner's participation in prepaid group health plans, salaried employment, or any other manner of delivering health services whether on a fee-for-service or other basis,
- 4 a Practitioner's association with, supervision of, delegation of authority to, support for, training of, or participation in a private group practice with, as a member or members of a particular class of health care practitioner or professional, or
- 5 any other matter that does not relate to the competence or professional of a Practitioner

when assisting the Board in a Professional Review Activity including, without limitation, the Credentials Committee, the MEC, any Ad Hoc Committee and the Chief of Staff

"Rules and Regulations" means the rules and regulations adopted by the Medical Staff and approved by the Board to govern certain aspects of Medical Staff membership and the exercise of Clinical Privileges

"Special Notice" means written notification by hand delivery, receipt acknowledgement requested or sent by certified or registered mail, return receipt requested.

"Staff Year" means the fiscal year of the Hospital.

**MEDICAL STAFF BYLAWS
WACCAMAW COMMUNITY HOSPITAL
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THE STATE OF SOUTH CAROLINA
In the Court of Appeals

APPEAL FROM GEORGETOWN COUNTY
Court of Common Pleas

Diane S. Goodstein, Circuit Court Judge

Appellate Case No. 2015-000331
Case No. 12-CP-22-1004

RECEIVED
APR 15 2015
SC Court of Appeals

Nadene Holliday, Individually and as Personal Representative
of the Estate of David Holliday, ... Appellant,

vs.

Waccamaw Community Hospital and
Kent M. McGinley, M.D., ... Defendants,

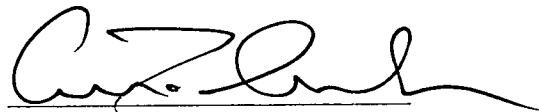
of whom

Waccamaw Community Hospital is the.....Respondent.

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.

/

A handwritten signature in black ink, appearing to read 'R. S. Rosen', with a long horizontal flourish extending to the right.

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THE STATE OF SOUTH CAROLINA
In the Court of Appeals

APPEAL FROM GEORGETOWN COUNTY
Court of Common Pleas

Diane S. Goodstein, Circuit Court Judge

Appellate Case No. 2015-000331
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of whom

Waccamaw Community Hospital is the..... Respondent.

PROOF OF SERVICE

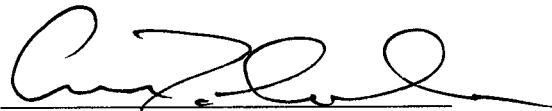
I do hereby certify that I have served all counsel of record in this action with a
copy of the documents herein below specified by mailing a copy of the same by United
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Documents: **Record on Appeal**

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A handwritten signature in black ink, appearing to read 'Richard S. Rosen', written over a horizontal line.

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