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THE STATE OF SOUTH CAROLINA
In The Court of Appeals

APPEAL FROM YORK COUNTY
Court of Common Pleas

J. Ernest Kinard, Jr., Circuit Court Judge

Case No. 2012-CP-46-00167
Appellant Case No. 2014-000913

Robert Randall M.D.,

Appellant,

v.

Amisub of South Carolina, Inc.
d/b/a/ Piedmont Medical Center,
Nathaniel Edwards, M.D., and
Richard Patterson, M.D.,

Respondents.

RECORD ON APPEAL
VOLUME ONE

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STATE OF SOUTH CAROLINA COUNTY OF YORK	)))	IN THE COURT OF COMMON PLEAS SIXTEENTH JUDICIAL CIRCUIT
Robert Randall, M.D., Plaintiff, v. Amisub of South Carolina, Inc. d/b/a Piedmont Medical Center, Nathaniel Edwards, M.D., and Richard Patterson, M.D., Defendants.	)	Civil Action No. 2012-CP-46-167 **ORDER GRANTING DEFENDANTS' MOTION FOR SUMMARY JUDGMENT**

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On August 5, 2013, Defendants filed a motion for summary judgment asserting that Plaintiff's claims for damages in this suit fail because Defendants are entitled to damages immunity under the Health Care Quality Improvement Act, 42 U.S.C. §§ 11101-11152. Defendants' motion also asserts that Plaintiff's causes of action fail as a matter of law for additional reasons.

On March 3, 2014, the Court convened a hearing on Defendants' motion. After carefully considering the parties' memoranda and the arguments of counsel made at the hearing, the Court *grants* Defendants' motion for summary judgment for the reasons set forth herein.

I. FACTS AND PROCEDURAL BACKGROUND

Defendant Amisub of South Carolina, Inc. d/b/a Piedmont Medical Center ("Piedmont") is a hospital located in Rock Hill, South Carolina. Defendant Nathaniel Edwards, MD is a cardiologist who formerly served as the Chief of Staff at Piedmont. Defendant Richard Patterson, MD is a retired general surgeon who formerly served as

the Chief Medical Officer at Piedmont. Plaintiff Robert Randall, MD is a general surgeon who formerly held privileges to practice at Piedmont.

As the result of a physician peer review action at Piedmont, Dr. Randall's abdominal surgery privileges were suspended in October 2010 and ultimately revoked in July 2011.[1] On January 13, 2012, Dr. Randall filed this suit asserting conspiracy and defamation causes of action against Defendants. Dr. Randall alleges that his peer review action at Piedmont was a conspiracy undertaken for various improper reasons, including as retaliation for Dr. Randall selling his medical practice to a competing hospital.

A. Peer Review Committee and Credentials Committee

Dr. Randall's peer review action began when his care became the subject of focused review by the physicians on Piedmont's Peer Review Committee in 2009 and 2010. This review was triggered by complications Dr. Randall was experiencing in abdominal surgery cases. The Peer Review Committee reviewed and analyzed Dr. Randall's surgical cases and also sent his cases outside Piedmont for external review by a general surgeon.

This review caused the Peer Review Committee to believe that Dr. Randall's surgical technique and judgment were deficient. Among other things, the Peer Review Committee was concerned that during his surgeries Dr. Randall was all too often perforating his patients' organs, and his rough and hurried handling of abdominal tissue was causing unnecessary complications. The Peer Review Committee was also

[1] Dr. Randall's remaining privileges at Piedmont expired when Dr. Randall chose not to seek reappointment to the medical staff.

concerned that Dr. Randall's technical surgical errors were made worse by his failure to timely appreciate and repair the injuries he caused.

On June 10, 2010, Dr. Edwards, who at the time was Chair of the Peer Review Committee in addition to being the Chief of Staff, brought Dr. Randall's cases to the physicians serving on Piedmont's Credentials Committee for consideration. The Credentials Committee concluded that the new cases manifested some of the same deficiencies that were observed with Dr. Randall's surgical care in 2006, including the rough handling of the bowel and the failure to recognize when patients needed to be returned to the operating room.[2] On July 13, 2010, after meeting with Dr. Randall to discuss the cases under review, the Credentials Committee recommended that Dr. Randall be reappointed for one year -- instead of two years -- and further recommended concurrent review of 100% of his abdominal and herniorrhaphy surgery cases for six months.

The Credentials Committee's recommendation was subsequently reviewed by the physicians on the Medical Executive Committee ("MEC") at Piedmont, and the MEC recommended reappointing Dr. Randall for one year, but increased the monitoring period. The MEC also determined that further investigation of Dr. Randall's patient care would be conducted.

[2] In 2006, internal and external reviews of Dr. Randall's cases found problems with Dr. Randall's surgical judgment and technique. As a result, Dr. Randall's peers imposed a year-long, retrospective review of 100% of Dr. Randall's open hernia and carotid surgery cases. This review occurred during 2007, and after Dr. Randall's cases received acceptable scores during this review period, the review terminated in 2008.

B. Ad Hoc Committee

The additional investigation of Dr. Randall's surgical care contemplated by the MEC was primarily conducted by an Ad Hoc Committee at Piedmont that consisted of the physician members of the Peer Review Committee, the Credentials Committee, and the MEC. In September 2010, the Ad Hoc Committee provided Dr. Randall with the external reviews of the cases at issue and asked him to provide a written response addressing each case.

After considering the external reviews, the pertinent portions of the medical records, Dr. Randall's written responses, and Dr. Randall's oral presentation regarding the cases, the Ad Hoc Committee concluded that Dr. Randall's care was substandard and recommended to the MEC that Dr. Randall's privileges to perform abdominal surgery be revoked.[3]

C. Dr. Randall's medical practice

Unbeknownst to the physician peer reviewers at Piedmont, they were not the only group scrutinizing Dr. Randall's care during this time. In 2009, Dr. Randall's practice, owned by Presbyterian Healthcare (Novant), conducted an internal investigation of his care.[4] As part of this investigation, Dr. Randall's surgeon partners and other professionals in the practice reported the following:

> Dr. Randall's "outcomes were less than optimal."
>
> "[P]atients have not been prepared properly for procedures under Dr. Randall's care."

[3] Notably, the Chairman of the Credentials Committee, who had previously recommended only monitoring, supported this new recommendation because he had become convinced that more needed to be done to protect patients.

[4] Defendants learned of this investigation through discovery in this case.

> Operating Room nurses reported that Dr. Randall's "cases are now bloody and there are numerous take-backs."
>
> Dr. Randall experienced "lots of personal complications – 'more than his share.'"
>
> When working with other surgeons on cases "Dr. Randall would 'take the case over,' handle tissues roughly and create unnecessary complications."

Dr. Randall's partners also reported that Dr. Randall's surgical care had become so compromised that they would no longer participate in follow-up care of Dr. Randall's patients, and one partner reported that he would leave if Dr. Randall remained a partner in the practice. Discovery revealed that after this investigation, Dr. Randall was terminated by the practice because the malpractice risk of continuing to employ him became too great.[5]

D. MEC

On October 11, 2010, the physicians on the MEC convened to consider the Ad Hoc Committee's recommendation that Dr. Randall's privileges to perform abdominal surgery be revoked. The MEC members reviewed the external reviews, the medical records, and the statements of Dr. Randall regarding the cases under review. The MEC also considered additional cases that had recently been reviewed by the Peer Review Committee and the external reviewer, and data that demonstrated Dr. Randall had experienced more unplanned returns to the operating room than other surgeons on the medical staff.

---

[5] Discovery also revealed that two of the cases under review in Dr. Randall's peer review action at Piedmont were the subject of medical malpractice suits. Dr. Randall's insurer paid a large sum to settle one, and the other was still pending at the time Dr. Randall's deposition was taken.

The MEC ultimately concluded that the surgical judgment and technique exhibited by Dr. Randall in the cases under review fell below the standards of the medical staff, and, therefore, Dr. Randall's abdominal surgical privileges should be revoked. In a letter dated October 15, 2010, the Chief Executive Officer of Piedmont provided Dr. Randall notice of the MEC's adverse recommendation and notice that he had the right under the medical staff bylaws to challenge this recommendation.

E. Suspension

Shortly after the MEC made its' recommendation, Dr. Edwards was made aware of a recent complaint made by the husband of a patient whose gallbladder had been removed by Dr. Randall. This patient lost eleven units of blood and had an extended stay in critical care. In response to this new case and the previous cases, Dr. Edwards summarily suspended Dr. Randall's abdominal surgery privileges. Dr. Edwards testified that he took this action because he believed that a suspension, which would take effect immediately, was necessary to protect patients from potential imminent harm.

In a letter dated October 15, 2010, Dr. Randall received notice of the suspension and the reasons it was imposed. This letter also informed Dr. Randall that he had the right under the medical staff bylaws to address the MEC before the MEC considered whether to continue, terminate, or modify the suspension. By letter dated October 18, 2010, Dr. Randall was sent copies of the external reviews of the more recent cases that had been considered by the MEC and the data regarding unplanned returns to the operating room.

On October 25, 2010, Dr. Randall met with the MEC regarding the suspension. During this meeting, Dr. Randall addressed all the cases previously under

consideration, the additional cases considered by the MEC on October 11, the data on unplanned returns to the operating room, and the case that triggered his suspension.[6] After Dr. Randall had presented to the MEC, he was excused from the meeting, and the MEC deliberated. Thereafter, the MEC unanimously voted to continue the suspension.

By letter dated October 28, 2010, Dr. Edwards informed Dr. Randall that the MEC had voted to uphold his suspension. This letter also informed Dr. Randall that he had the right to challenge the suspension.

F. Hearing

Dr. Randall requested a hearing to challenge the MEC's adverse recommendations regarding his medical staff privileges, as he had the right to do under the medical staff bylaws. Thereafter, Dr. Randall received a hearing notice that identified the Hearing Officer and the proposed Hearing Panel. The notice also provided Dr. Randall with a detailed description of the grounds for the adverse actions including a list of the ten cases at issue. None of the five physicians selected to serve on the Hearing Panel were economic competitors of Dr. Randall. Dr. Randall was afforded the right to object to the service of any of the individual physicians on the panel and to have counsel represent him at his hearing.

Dr. Randall did not object to any individual Hearing Panel members, but he did object that his panel did not contain a general surgeon. Piedmont's medical staff bylaws prohibit service on the Hearing Panel by the reviewed physician's economic competitors, partners, or physicians who had participated in the patient cases under

[6] Dr. Randall created concern among the physicians on the MEC at this meeting when he described this patient as having suffered "a little bit of bleeding."

review. When these criteria from the bylaws were applied, there were no general surgeons on Piedmont's medical staff eligible to serve on the Hearing Panel, and therefore, Dr. Randall's objection was overruled by the Hearing Officer.

On February 16 and 17, 2011, Dr. Randall's peer review hearing was conducted. At the hearing, both Dr. Randall and the MEC had the right to call witnesses and submit documents into evidence regarding the cases at issue. Both sides exercised that right. Eight witnesses were called, including each side calling a surgeon who offered expert opinions regarding the cases under review. In his deposition, Dr. Randall offered the following critique of his own expert witness:

> It was real apparent that he'd not very well reviewed the cases. He really didn't know them. He got up and they would ask him certain questions, and he wouldn't know or had to fumble through. He was not a very effective witness.

Numerous exhibits were entered into evidence including the relevant medical records, external reviews of Dr. Randall's cases, and minutes from the various hospital committees that considered the cases at issue.[7] The hearing generated a 482-page transcript. After the presentation of evidence, the Hearing Panel deliberated.

On April 16, 2011, the Hearing Officer issued the Hearing Panel's "Decision, Findings of Fact and Conclusions." The Hearing Panel unanimously decided that the MEC's recommendations to revoke and suspend Dr. Randall's abdominal surgery privileges should be upheld. The Hearing Panel's Decision included the following conclusions:

---

[7] The cases included the patient who suffered an 11-unit bleed after a gallbladder removal. At the hearing Dr. Randall described this patient's husband -- whose complaint caused this case to be reviewed -- as trying to "fix" the problem of his "southern porcelain princess."

> Substantial evidence supports the conclusion that Dr. Randall has demonstrated a persistent pattern of judgment error and lack of technical proficiency with respect to abdominal surgery.
>
> The evidence reasonably supports that these errors of judgment and skill led to the deaths of certain patients or caused others to suffer complications and prolonged hospitalizations. The outcomes for the patients at issue were adverse and severe in terms of morbidity and significant mortality.
>
> The evidence reasonably supports that Dr. Randall did not demonstrate that he appreciated the severity of the problems that existed in his surgical performance.

G. Appellate Review Committee and Board of Governors

On May 6, 2011, Dr. Randall appealed the Hearing Panel's Decision to Piedmont's Board of Governors. Piedmont's Board assigned an Appellate Review Committee to consider Dr. Randall's appeal. After considering written briefs, oral arguments, and the hearing record, the Appellate Review Committee upheld the Hearing Panel's Decision. The Appellate Review Committee reported their recommendation to the full Board. After considering the Hearing Panel's and Appellate Review Committee's findings, and after reviewing the hearing trasncript, the Board affirmed the termination of Dr. Randall's abdominal surgery privileges effective July 12, 2011.

II. LEGAL STANDARD

A. The Health Care Quality Improvement Act

Under the Health Care Quality Improvement Act ("HCQIA"), if a professional review action (more commonly known as a "peer review action") complies with certain standards, hospitals, physicians, and others are entitled to immunity from claims for monetary damages that arise from peer review activities. 42 U.S.C. § 11111(a)(1)(if a peer review action satisfies the HCQIA standards peer reviewers

"shall not be liable in damages under any law of the United States or of any State. . . ."); *see also Moore v. Williamsburg Reg. Hosp.*, 560 F.3d 166, 171 (4th Cir. 2009); *Wieters v. Roper Hosp. Inc.*, 2003 W.L. 550327 at *4 (4th Cir. 2003).

There are four HCQIA standards. Peer reviewers are entitled to immunity from damages if the peer review action at issue was taken:

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

42 U.S.C. § 11112(a).

Congress granted peer reviewers this immunity to encourage physicians to engage in peer review and take action to protect patients, including suspension and revocation of privileges, without fear of reprisal in the form of suits seeking monetary damages. *Oksanen v. Page Mem. Hosp.*, 945 F.2d 696, 704 (4th Cir. 1991)(noting that Congress intended HCQIA to protect peer reviewers from the threat of damages, and further that Congress expressly recognized "'[t]here is an overriding national need to provide incentive and protection for physicians engaging in effective professional peer review.'")(quoting 42 U.S.C. § 11101(5)). Rigorous peer review coupled with the reporting of sanctions to a national databank is a core component of federal policy to protect patients from incompetent or potentially dangerous physicians who could otherwise move from hospital to hospital without discovery and disclosure of their past problems. 42 U.S.C. § 11101(2).

B. **HCQIA summary judgment standard**

Providing further protection to peer reviewers, HCQIA provides a statutory presumption that the peer review action at issue satisfies the standards necessary to obtain damages immunity.

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

42 U.S.C. § 11112(a)(emphasis added).

The statutory presumption provided by HCQIA shifts the burden of proof and persuasion at the summary judgment stage onto the physician plaintiff. *Singh v. Blue Cross/Blue Shield of Mass., Inc.*, 308 F.3d 25, 33, n.5 (1st Cir. 2002)("Since HCQIA immunity may only be overcome by a preponderance of the evidence, the statutory presumption in favor of the health care entity shifts to the plaintiff 'not only the burden of producing evidence but the burden of persuasion as well.'")(internal citations omitted). Summary judgment for the peer reviewers should be granted unless a reasonable jury, viewing the facts in the best light for the plaintiff, could conclude that the plaintiff has shown by a preponderance of evidence that defendants' actions fail to satisfy the HCQIA standards. *Moore*, 560 F 3d. at 175; *Gabaldoni v. Washington Cty. Hosp.*, 250 F.3d 255, 260 (4th Cir. 2001).

HCQIA creates a summary judgment standard that differs greatly from the traditional Rule 56 summary judgment standard. *Guanciale v. McLeod Reg. Med. Ctr.*, Order at 8 (D.S.C. Mar. 8, 2004)("Under this unconventional standard, [physician] bears the burden of providing by a preponderance of the evidence that the defendant's

peer review process did not satisfy § 11112(a).”). A physician plaintiff cannot, therefore, avoid summary judgment by merely raising a genuine issue of material fact as to whether one of the HCQIA standards is satisfied. *See, e.g.*, *Moore*, 560 F.3d at 175-77; *Wieters*, 2003 W.L. 550327 at *6; *Hein-Muniz v. Aiken Reg. Med. Ctrs*, 2013 W.L. 3359277 at *3 (4th Cir. 2012).

HCQIA essentially requires the Court to act as a gatekeeper, weighing evidence at the summary judgment stage. If a physician's evidence of non-compliance with the HCQIA standards does not outweigh the peer reviewers' statutory presumption of compliance and evidence of compliance with the HCQIA standards, summary judgment for the peer reviewers is appropriate. *Moore*, 560 F.3d at 180.

III. ANALYSIS

A. HCQIA Standards

1. In the reasonable belief that the action was in the furtherance of quality healthcare

The first standard of HCQIA is satisfied if, looking at the totality of the circumstances, the peer review action was undertaken by Defendants “in the reasonable belief that the action was in the furtherance of quality healthcare.” 42 U.S.C. § 11112(a)(1). HCQIA calls for a “generous application of the concept of reasonableness” at the summary judgment stage similar to the “typical judicial review of administrative decisions and of such things as internal procedures for terminating membership in voluntary associations.” *Lee v. Trinity Lutheran Hosp.*, 2004 W.L. 212548 at *7 n. 5 (W.D. Mo. 2004), *affirmed* 408 F.3d 1064 (8th Cir. 2005); *see also Freilich v. Upper Chesapeake Health, Inc.*, 313 F.3d 205, 212 (4th Cir.

2002)(describing the HCQIA reasonableness standard as one that "embodies the discretion that health care professionals have traditionally exercised in determining whether or not their peers meet a requisite level of professional competence.").

This HCQIA standard does not require that the peer review decision be correct or that the decision actually improve the quality of health care. *Imperial v. Suburban Hosp. Ass'n, Inc.*, 37 F.3d 1026, 1030 (4th Cir. 1994). As long as the record contains evidence that would support a reasonable belief that the action in question would restrict incompetent behavior, would protect patients, or otherwise further quality healthcare, standard one is satisfied. *Gabaldoni*, 250 F.3d at 261.

Defendants offered abundant evidence that Dr. Randall's peer review action was undertaken to ensure quality care and patient safety. Defendants provided meeting minutes and testimony from physician members of the Peer Review Committee, the Credentials Committee, the Ad Hoc Committee, and the MEC regarding the lengthy and thorough review of Dr. Randall's surgical care that caused these physicians to believe that Dr. Randall's surgical judgment and technique was substandard. Additionally, Defendants submitted the testimony of the surgeon called to testify by the MEC at Dr. Randall's hearing who found Dr. Randall's abdominal surgical care deficient.

After Dr. Randall challenged the MEC's recommendation, the Hearing Panel, the Appellate Review Committee, and the Board considered Dr. Randall's surgical care and upheld the MEC's recommendation. The Court finds that the record of this peer review action contains overwhelming evidence that this peer review action was undertaken in the reasonable belief that it was in furtherance of quality health care.

Dr. Randall's counsel deposed many of the peer review participants, and their testimony provides additional confirmation that the peer review action was undertaken in the reasonable furtherance of quality healthcare. Dr. Edwards, the Chief of Staff, testified as follows:

> Q: Why did you vote to revoke – to recommend the revocation of privileges?
>
> A: Because I was concerned that there had been a -- there had been a body of cases in which there were problems with pre-operative assessment, intraoperative technique, and post-operative care, as well as – I think, that meeting, we also had the return-to-OR data suggesting a high volume of return to OR. And, during the whole process, we had – I don't recall other cases coming in that were of concern from any other general surgeon. We continued to have a large volume of cases coming in with Dr. Randall, and they continued to come in throughout the process more – more. And they were raised by physicians, hospital employees, as well as patient families. So it wasn't all coming from one source.

Dr. Patterson, the Chief Medical Officer, offered the following testimony:

> Q: . . . Why did the MEC take the action that they took, the revocation –
>
> A: Right –
>
> Q: -- the recommendation of revocation?
>
> A: The general sense of – of my listening to their concerns was that the gravity, the number of complications, the similarity, suggesting technique deficiencies and lack of insight into the difficulties.

A physician on the MEC testified as follows:

> Q: . . . You mentioned there was some sentiment. "Gosh why can't we just pass this [Dr. Randall's problems with surgical care] on to others?"
>
> A: Yes.
>
> Q: Why didn't you pass it on to others?

A: You are asking me personally?

Q: Yeah.

A: Because I felt a responsibility to do something for the patients and the community.

Another physician on the MEC offered the following:

Q: Why did the MEC vote to uphold the suspension of his privileges?

A: I think the question has been and that's for the Peer Review Committee – after reviewing several cases, it was felt that his surgical procedures in regards to abdominal surgeries, including herniorrhaphy, was suboptimal, had a lot of complications, and from patient's safety point of view, there was unanimously agreed and recommended that his privileges should be suspended effective immediately.

In response to this evidence, Dr. Randall's complaint offers allegations that his peer review action was a conspiracy. In his deposition, Dr. Randall alleged that Drs. Edwards and Patterson acted against him for improper purposes. Dr. Randall's allegations, however, are not relevant to the appropriate analysis under HCQIA.

The test under HCQIA is whether an *objectively reasonable basis* existed for the peer review action in question. *Freilich*, 313 F.3d at 212; *Imperial*, 37 F.3d at 1030. The sufficiency of the basis for the peer reviewers' action -- not alleged personal bias, malice, or bad faith on the part of the peer reviewers -- is relevant under HCQIA. *Id.; see also Sugarbaker v. SSM Health Care*, 190 F.3d 905, 914 (8th Cir. 1999)("[T]he subjective bias or bad faith of the peer reviewers is irrelevant."); *Austin v. McNamara*, 979 F.2d 728, 734 (9th Cir. 1992)(alleged personal animosity of peer reviewers is "irrelevant to the reasonableness standards of § 11112(a). . ." because "[t]he test is an objective one, so bad faith is immaterial."). Therefore, even if Dr. Randall had

evidence that his peer review action was based upon personal animus, bad faith, or malice, this would have no effect upon the HCQIA analysis.

Though it is not relevant to the appropriate HCQIA analysis, it should also be noted that Defendants offered abundant evidence -- in the form of deposition testimony taken in this case from Dr. Edwards, Dr. Patterson, and others -- that Dr. Randall's peer review was *not* a conspiracy motivated by improper purposes.

The record of Dr. Randall's peer review action and the testimony from the peer reviewers constitutes overwhelming evidence that the peer review action of Dr. Randall was objectively reasonable under the circumstances. Dr. Randall's claims of conspiracy are irrelevant and immaterial, and they fall far short of the preponderance-of-the-evidence showing necessary to overcome the presumption HCQIA provides to Defendants. For these reasons, and because Dr. Randall did not contest Defendants' assertion that HCQIA standard one has been satisfied in his memorandum, the Court finds that Defendants have satisfied standard one of HCQIA.

2. After a reasonable effort to obtain the facts of the matter

Standard two of HCQIA requires that the peer reviewers engage in a reasonable effort to obtain the facts relevant to the peer review action. 42 U.S.C. § 11112(a)(2). A peer review action that consists of multiple levels of investigation and review generally satisfies this element of HCQIA. *Moore,* 560 F.3d at 175-76 (three-tier peer review process after suspension held to satisfy standard two). The hospital's Board, the ultimate decision-maker in a peer review action, is entitled to rely upon investigation conducted by the previous levels of the peer review process. *Gabaldoni*, 250 F.3d at 261-62.

Dr. Randall's peer review action was a multi-level process that included a thorough investigation of the facts. Dr. Randall's surgical care was reviewed over two years during numerous meetings of the Peer Review Committee, the Credentials Committee, the Ad Hoc Review Committee, and the MEC. These multiple levels of review involved numerous physicians considering the relevant medical records, external reviews, and Dr. Randall's written and oral comments.

Defendants' peer review process included a two-day hearing that allowed Dr. Randall and the MEC to present witnesses, offer documentary evidence, and cross-examine each other's witnesses. The Appellate Review Committee then accepted briefs and oral argument of counsel before the matter was ultimately considered and decided by the Board.

For the reasons set forth above, and because Dr. Randall did not contest compliance with HCQIA standard two in his memorandum, the Court finds that Defendants' evidence regarding the entirety of this peer review investigation established the existence of a reasonable investigation. Defendants have, therefore, satisfied the second HCQIA standard.

3. After adequate notice and hearing procedures

In order to obtain immunity under HCQIA, peer reviewers must provide a physician adequate notices and hearing procedures during the peer review process. 42 U.S.C. 11112(a)(3). HCQIA provides a list of notices and hearing procedures that should be afforded to a physician in a peer review action. 42 U.S.C. § 11112(b). If the peer reviewers provide the notices and hearing procedures set forth in section 11112(b), the peer review action satisfies a "safe harbor," and the presumption of compliance

with HCQIA standard three becomes a *finding* of compliance. *Wieters v. Roper Hosp. Inc.*, 58 Fed. App'x 40, 46 (4th Cir. 2003)("If a hospital follows the procedures laid out in § 11112(b), it is deemed to have satisfied § 11112(a)(3)."); *Smith v. Ricks*, 31 F. 3d 1478, 1487 (9th Cir. 1994)("[Section] 11112(b) lists certain procedures, which, if satisfied, guarantee a shield from liability."); *Guanciale*, Order at 11 ("With compliance, there is no second-guessing or judicial review of the hospital's disciplinary decision.").

Because section 11112 provides a "safe harbor" for peer review actions that provide the delineated procedures, a claim of unfair process that does not involve a specific provision in section 11112(b) is immaterial to the standard three analysis. *Moore*, 560 F.3d at 176 (rejecting physician's argument of flawed process because "it is not based on the statutory requirement").

Defendants' evidence established that Dr. Randall received timely and appropriate notices and procedures during his hearing that complied with the requirements in subsection 11112(b). Moreover, Dr. Randall conceded that he received the appropriate notices and procedures during his deposition.

Dr. Randall does however, allege four violations of HCQIA standard three which will be addressed *seriatim*.

i. Suspension

Dr. Randall claims he should have been provided a hearing *before* his suspension was imposed. There is no provision in HCQIA standard three that provides for notice and a hearing *before* a suspension is imposed. 42 U.S.C. 11112(b). As a pre-suspension hearing is not a procedure set forth in section 11112(b)'s safe

harbor, the Court finds that the absence of a pre-suspension hearing in Dr. Randall's peer review action cannot establish non-compliance with standard three.

Moreover, the following statutory provision regarding suspensions also appears in HCQIA:

> [N]othing in this section shall be construed as—
> . . .
> (2) precluding an immediate suspension or restriction of clinical privileges, subject to *subsequent notice and hearing* or other adequate procedures, where the failure to take such an action may result in an imminent danger to the health of any individual.

42 U.S.C. 11112(c)(2)(emphasis added). Dr. Randall's abdominal surgery privileges were suspended when the Chief of Staff learned that a patient of Dr. Randall's whose gallbladder had been removed experienced an inordinate amount of internal bleeding. This case, coming on the heels of the other cases that had been reviewed, caused the Chief of Staff, and thereafter the entire MEC, to believe that a suspension was necessary to protect patients from potential imminent harm. After the suspension was imposed, Dr. Randall received the "subsequent notice and hearing" provided for by section 11112(c)(2).

Dr. Randall's suspension and post-suspension hearing occurred in exactly the manner and order prescribed by HCQIA. The suspension to protect patients was imposed first, and then the hearing came second. For this additional reason, the absence of a pre-suspension hearing in Dr. Randall's peer review action is of no moment, and the Court rejects this claim of non-compliance with HCQIA standard three.

Dr. Randall contends that the Federal District Court's order in *Guanciale v. McLeod Regional Medical Center* (attached to Dr. Randall's memorandum) supports his claim that a pre-suspension hearing was required in his peer review action. Dr. Randall is mistaken. The District Court found that the suspension of Guanciale's privileges did not comply with HCQIA standard three because Guanciale's peer review action provided him with *no opportunity whatsoever* to contest his suspension. *Guanciale*, Order at 12-21. The District Court recognized that a personal appearance before the MEC, or perhaps even as little as the opportunity to submit a written statement to the MEC, would have complied with HCQIA standard three. *Id.* at 16. The District Court also recognized that a hearing provided to Guanciale after the imposition of the suspension would have complied with HCQIA standard three. *Id.* at 21.

In sharp contrast to Guanciale's peer review action, Dr. Randall's peer review action included a full-blown hearing followed by an appellate review. Before that, Dr. Randall was permitted to submit a written statement to, and make a personal appearance before, the MEC. The lack of any opportunity afforded to Guanciale to contest the adverse action taken against his privileges is clearly distinguishable from the multi-level process afforded to Dr. Randall.

Finally, Dr. Randall contends that Dr. Edwards acted too precipitously when he imposed the suspension. While there may be evidence that Dr. Edwards acted too precipitously with respect to the summary suspension, the Court finds that this argument does not implicate any of the elements of the safe harbor in section 11112(b). The Court also rejects this argument because shortly after Dr. Edwards suspended Dr.

Randall's abdominal surgery privileges, the MEC voted to affirm the suspension and, thereafter, the Hearing Panel affirmed that the suspension was a reasonable measure taken to protect patients from potential imminent harm.

ii. MEC meeting

Dr. Randall claims that his peer review action violates HCQIA standard three because he was not permitted to have counsel represent him at a MEC meeting,[8] and Dr. Patterson allegedly made misstatements at the MEC meeting regarding the procedural options under the medical staff bylaws and Dr. Randall's patient care. There are no provisions in HCQIA standard three requiring physicians to be represented by counsel at MEC meetings or that otherwise govern MEC meetings in any way. 42 U.S.C. § 11112(b). Because Dr. Randall's allegations of flawed process and inappropriate conduct[9] at MEC meetings do not implicate any of the procedures in section 11112(b)'s safe harbor, the Court finds that these allegations cannot establish a lack of compliance with HCQIA standard three.

iii. Hearing date

Dr. Randall claims that his peer review action violates HCQIA standard three because his hearing did not occur within 90 days after the MEC's decision to continue his suspension. HCQIA standard three does not contain a provision that requires peer review hearings to occur within 90 days after MEC decisions. 42 U.S.C. § 11112(b).

[8] When Dr. Randall attempted to bring counsel to a MEC meeting, counsel was informed that the medical staff bylaws did not provide for legal counsel at this meeting – for either the reviewed physician or the MEC – and counsel departed.

[9] It should also be noted that Defendants submitted deposition testimony from a physician on the MEC that refuted Dr. Randall's claim that Dr. Patterson misstated procedural options and facts at the MEC meeting.

Therefore, the Court finds that the complaint Dr. Randall makes regarding the timing of his hearing cannot establish non-compliance with HCQIA standard three.[10]

iv. General surgeons on the hearing panel

Finally, Dr. Randall claims his peer review action violates HCQIA standard three because his hearing panel did not contain general surgeons with experience in laparoscopic abdominal surgery. HCQIA standard three does not contain a provision that requires hearing panels to have physician members who practice in the same specialty area as the physician under review. 42 U.S.C. § 11112(b). Because this claim, like Dr. Randall's other claims, does not implicate a safe harbor procedure, it too fails.

While Dr. Randall's panel did not contain a general surgeon, it did contain an oral surgeon and an orthopedic surgeon who, along with the other panel members, had the benefit of hearing testimony from general surgeons called as witnesses by the MEC and Dr. Randall.

HCQIA also contains the following provision regarding hearing panels:

> (A) subject to subparagraph (B), the hearing shall be held (as determined by the health care entity)—
>
> . . .
>
> (iii) before a panel of individuals who are appointed by the entity and are not in direct economic competition with the physician involved;

[10] The MEC requested and was granted two continuances of the hearing by the Hearing Officer. Dr. Randall's counsel consented to the first continuance. Dr. Randall's counsel objected to the second continuance, but the Hearing Officer found "good cause shown" under the medical staff bylaws for the second continuance because the MEC's expert unexpectedly and belatedly informed the MEC that he would not be available to testify at the hearing.

42 U.S.C. 11112(b)(3)(A)(emphasis added). Ironically then, if Piedmont would have appointed a general surgeon from a competing surgical practice to serve on Dr. Randall's hearing panel, this peer review action would have violated HCQIA standard three.

Defendants submitted overwhelming evidence showing that Dr. Randall's peer review action provided all the notices and procedures set forth in section 11112(b). Because Dr. Randall does not dispute this showing, and instead makes claims about alleged flaws in the peer review process that do not implicate the procedures in the safe harbor and that are otherwise invalid, the Court finds that Dr. Randall's peer review action complies with HCQIA standard three.

4. In the reasonable belief that the action was warranted by the facts known after the investigation

HCQIA standard four is violated if "the facts relied upon by the Board were so obviously mistaken or inadequate as to make reliance upon them unreasonable." *Hein-Muniz,* 2013 WL 3359277 at *3 (quoting *Meyers v. Columbia/HCA Healthcare Corp.*, 341 F.3d 461, 471 (6th Cir. 2003)). "[T]he role of the federal courts 'on review of [peer review] actions is not to substitute our judgment for that of the hospital's governing board or to reweigh the evidence regarding the . . . termination of medical staff privileges'." *Bryan v. James E. Holmes Reg. Med. Ctr.*, 33 F.3d 1318, 1337 (11th Cir. 1994)(internal citations omitted).

Dr. Randall's peers, after an exhaustive peer review process, concluded that Dr. Randall's poor surgical judgment and technique was causing bad outcomes. When the Board members that comprised the Appellate Review Committee and the full Board

considered whether Dr. Randall should continue to have abdominal surgery privileges at Piedmont, they had before them, among other things, the Hearing Panel's report and the transcript from the hearing. These materials were replete with negative facts, findings, and opinions regarding Dr. Randall's care. The Court finds that the decision to terminate Dr. Randall's abdominal surgery privileges was not "obviously mistaken" under these circumstances. The Court, therefore, finds Defendants satisfy standard four of HCQIA.[11]

5. Conclusion as to HCQIA damages immunity

Defendants have offered a large quantity of probative evidence establishing that Dr. Randall's peer review action satisfied the four HCQIA standards. Defendants also have the benefit of HCQIA's statutory presumption. Dr. Randall, on the other hand, has not offered evidence upon which a reasonable jury, viewing the facts in the best light for him, could find by a preponderance of the evidence that Defendants failed to meet the HCQIA standards. Therefore, the Court finds that Defendants are immune from damages under HCQIA.[12]

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[11] Dr. Randall's memorandum notes that there is a "question of fact" as to whether Defendants can meet "the third and fourth provisions of the [HCQIA] statute." As set forth above, whether a "question of fact" exists regarding compliance with a HCQIA standard is not the appropriate inquiry.

[12] Dr. Randall's complaint contains conspiracy and defamation causes of action. The sole remedy Dr. Randall seeks pursuant to these causes of action is damages. As HCQIA damages immunity has eliminated Dr. Randall's ability to recover damages from Defendants, these causes of action are no longer viable and the Court grants summary judgment on them.

B. Individual causes of action

Defendants assert that Dr. Randall's causes of action fail as a matter of law for additional reasons that arise under South Carolina state law. The Court agrees for the reasons set forth below.

1. Conspiracy

A civil conspiracy requires: (1) a combination of two or more persons; (2) for the purpose of injuring the plaintiff; and (3) causing plaintiff special damages. *Kuznik v. Bees Ferry Assocs.*, 342 S.C. 579, 610, 538 S.E.2d 15, 31 (Ct. App. 2000). A civil conspiracy, however, cannot arise "in the context of a principal-agent relationship because by virtue of the relationship such acts do not involve separate entities." *McMillan v. Oconee Mem. Hosp., Inc.*, 367 S.C. 559, 564, 626 S.E.2d 884, 886-87 (2006).

When a hospital's medical staff, administrators, and other agents conduct a peer review action they are considered a single person and therefore cannot conspire. *Moore*, 560 F.3d at 178; *Oksanen*, 945 F.2d at 699 ("[T]he Board of Trustees and the medical staff of Page Memorial comprised a single entity during the peer review process. Because an entity cannot conspire with itself, the Board and the staff lacked the capacity to conspire."); *Cohn v. Bond*, 953 F.2d 154, 159 (4th Cir. 1991)(holding medical staff are hospital's agents when undertaking credentialing for hospital and therefore defendants could not conspire for antitrust purposes).

Dr. Randall alleges that Dr. Patterson, the Chief Medical Officer at Piedmont, and Dr. Edwards, the Chief of Staff at Piedmont, are the conspirators in a peer review conspiracy. Because these physicians were both agents of Piedmont for the purpose of

conducting Dr. Randall's peer review acting within the scope of their duties under the medical staff bylaws, there is no "combination" of Defendants legally capable of conspiring, and, therefore, the Court finds that summary judgment on this claim is appropriate for this additional reason.[13]

Finally, and most fundamentally, the Court finds that Dr. Randall's conspiracy claim also fails because it is undisputed that the alleged conspirators in this case – Drs. Edwards and Patterson – did not make the ultimate decisions regarding Dr. Randall's privileges. While Dr. Edwards suspended Dr. Randall's abdominal surgery privileges, days later his action was reviewed and approved by the entire MEC as required under the medical staff bylaws. Dr. Randall concedes the MEC acted in good faith. Thereafter, the MEC's recommendations regarding Dr. Randall's privileges were reviewed by the Hearing Panel, the Appellate Review Committee, and the full Board. These bodies, that did not include Drs. Edwards or Patterson, affirmed the MEC's recommendations and thereby terminated Dr. Randall's abdominal surgery privileges. Dr. Randall concedes that these bodies acted in good faith. Therefore, even if Dr. Randall had evidence that Drs. Edwards and Patterson acted out of bias or bad faith,[14]

---

[13] Dr. Randall argues that *Anthony v. Ward*, 336 Fed. App'x 311 (4th Cir. 2009), holds that the intra-corporate immunity doctrine does not apply to the "agent-agent" conspiracy allegedly present in this case. Dr. Randall is mistaken. In *Anthony*, the Fourth Circuit Court of Appeals held that the District Court erred when it failed to recognize that the intra-corporate immunity doctrine could apply in agent-agent conspiracies and correspondingly erred when it failed to give the jury a scope of employment charge. *Anthony*, 336 Fed. App'x at 316 (noting "no conspiracy can exist if the conduct challenged is a single act by a single corporation acting exclusively through its own directors, officers, and employees, each acting within the scope of his employment")(internal citations omitted).

[14] The Court also notes that Dr. Randall has not come forward with any evidence, or any reasonable inference from evidence, that supports the allegation that Defendants engaged in conspiratorial conduct for the purpose of injuring him. *Moore,* 560 F.3d at

because these peer review bodies that were undisputedly free of bias and bad faith made the ultimate decisions regarding Dr. Randall's privileges, Dr. Randall's allegations of conspiracy against Drs. Edwards and Patterson are immaterial.

2. Defamation

A defamation claim requires a plaintiff to establish: (1) a false and defamatory statement was made; (2) unprivileged publication of the statement to a third party; (3) the publisher was at fault; and (4) either the statement is actionable irrespective of harm or the publication of the statement caused special harm. *Williams v. Lancaster County Sch. Dist.*, 369 S.C. 293, 631 S.E.2d 286, 292 (Ct. App. 2006). Truth is an absolute defense to a defamation claim. *Parker v. Evening Post Pub. Co.*, 317 S.C. 236, 245, 452 S.E.2d 640, 645-46 (Ct. App. 1994).

Dr. Randall's defamation claim is based upon Piedmont's submission of a report to the National Practitioner Databank ("NPDB") concerning the suspension of Dr. Randall's privileges. Dr. Randall testified at his deposition that the report Piedmont made to the NPDB is factually accurate. Because Dr. Randall concedes the statement upon which his defamation claim rests is true, this claim fails as a matter of law.[15]

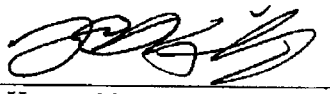
178 (conspiracy claim failed as physician had no evidence "that formal peer review process was 'conspiratorial' in any real sense of the word"). Moreover, if such evidence existed, surely Dr. Randall's counsel would have informed the Hearing Panel, the Appellate Review Committee, and the Board of this conspiracy.

[15] Even if the NPDB report were false and defamatory, because Piedmont is required by federal law to report Dr. Randall's adverse peer review action to the NPDB, 42 U.S.C. § 11133, the Court also finds that Piedmont's report to the NPDB is privileged and cannot constitute defamation. *Swinton Creek Nursery v. Edisto Farm Credit, ACA*, 334 S.C. 469, 514 S.E.2d 126 (1999).

IV. CONCLUSION

For the reasons set forth above, the Court grants summary judgment for Defendants on HCQIA damages immunity and grants summary judgment for Defendants on all of Dr. Randall's causes of action in the complaint.

AND IT IS SO ORDERED.



The Honorable J. Ernest Kinard, Jr.

Camden, South Carolina

3/28, 2014

STATE OF SOUTH CAROLINA)
)
COUNTY OF YORK)

IN THE COURT OF COMMON PLEAS

CIVIL ACTION COVERSHEET

2012-CP-46-167

Robert Randall, M.D., Plaintiff(s)

vs.

Amisub of South Carolina, Inc. d/b/a/ Piedmont Medical Center, Nathaniel Edwards, M.D., and Richard Patterson, M.D., Defendant(s)

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NOTE: The cover sheet and information contained herein neither replaces nor supplements the filing and service of pleadings or other papers as required by law. This form is required for the use of the Clerk of Court for the purpose of docketing. It must be filled out completely, signed, and dated. A copy of this cover sheet must be served on the defendant(s) along with the Summons and Complaint.

DOCKETING INFORMATION (*Check all that apply*)

***If Action is Judgment/Settlement do not complete*

☒ JURY TRIAL demanded in complaint. ☐ NON-JURY TRIAL demanded in complaint.
☐ This case is subject to ARBITRATION pursuant to the Court Annexed Alternative Dispute Resolution Rules.
☐ This case is subject to MEDIATION pursuant to the Court Annexed Alternative Dispute Resolution Rules.
☐ This case is exempt from ADR. (Proof of ADR/Exemption Attached)

NATURE OF ACTION (*Check One Box Below*)

Contracts
- ☐ Constructions (100)
- ☐ Debt Collection (110)
- ☐ Employment (120)
- ☐ General (130)
- ☐ Breach of Contract (140)
- ☐ Other (199)

Torts - Professional Malpractice
- ☐ Dental Malpractice (200)
- ☐ Legal Malpractice (210)
- ☐ Medical Malpractice (220)

Previous Notice of Intent Case # 20____-CP-____-_____
- ☐ Notice/ File Med Mal (230)
- ☐ Other (299)

Torts – Personal Injury
- ☒ Assault/Slander/Libel (300)
- ☐ Conversion (310)
- ☐ Motor Vehicle Accident (320)
- ☐ Premises Liability (330)
- ☐ Products Liability (340)
- ☐ Personal Injury (350)
- ☐ Wrongful Death (360)
- ☐ Other (399)

Real Property
- ☐ Claim & Delivery (400)
- ☐ Condemnation (410)
- ☐ Foreclosure (420)
- ☐ Mechanic's Lien (430)
- ☐ Partition (440)
- ☐ Possession (450)
- ☐ Building Code Violation (460)
- ☐ Other (499)

Inmate Petitions
- ☐ PCR (500)
- ☐ Mandamus (520)
- ☐ Habeas Corpus (530)
- ☐ Other (599)

Judgments/Settlements
- ☐ Death Settlement (700)
- ☐ Foreign Judgment (710)
- ☐ Magistrate's Judgment (720)
- ☐ Minor Settlement (730)
- ☐ Transcript Judgment (740)
- ☐ Lis Pendens (750)
- ☐ Transfer of Structured Settlement Payment Rights Application (760)
- ☐ Other (799)

Administrative Law/Relief
- ☐ Reinstate Driver's License (800)
- ☐ Judicial Review (810)
- ☐ Relief (820)
- ☐ Permanent Injunction (830)
- ☐ Forfeiture-Petition (840)
- ☐ Forfeiture—Consent Order (850)
- ☐ Other (899)

Appeals
- ☐ Arbitration (900)
- ☐ Magistrate-Civil (910)
- ☐ Magistrate-Criminal (920)
- ☐ Municipal (930)
- ☐ Probate Court (940)
- ☐ SCDOT (950)
- ☐ Worker's Comp (960)
- ☐ Zoning Board (970)
- ☐ Public Service Commission (990)
- ☐ Employment Security Comm (991)
- ☐ Other (999)

Special/Complex /Other
- ☐ Environmental (600)
- ☐ Automobile Arb. (610)
- ☐ Medical (620)
- ☐ Other (699)
- ☐ Pharmaceuticals (630)
- ☐ Unfair Trade Practices (640)
- ☐ Out-of State Depositions (650)
- ☐ Motion to Quash Subpoena in an Out-of-County Action (660)
- ☐ Sexual Predator (510)

Submitting Party Signature: _____ Date: January 12, 2012

Note: Frivolous civil proceedings may be subject to sanctions pursuant to SCRCP, Rule 11, and the South Carolina Frivolous

Civil Proceedings Sanctions Act, S.C. Code Ann. §15-36-10 et. seq.

FOR MANDATED ADR COUNTIES ONLY

Allendale, Anderson, Beaufort, Clarendon, Colleton, Florence, Greenville, Hampton, Horry, Jasper, Lee, Lexington, Pickens (Family Court Only), Richland, Sumter, Union, Williamsburg, and York

SUPREME COURT RULES REQUIRE THE SUBMISSION OF ALL CIVIL CASES TO AN ALTERNATIVE DISPUTE RESOLUTION PROCESS, UNLESS OTHERWISE EXEMPT.

You are required to take the following action(s):

1. The parties shall select a neutral and file a "Proof of ADR" form on or by the 210th day of the filing of this action. If the parties have not selected a neutral within 210 days, the Clerk of Court shall then appoint a primary and secondary mediator from the current roster on a rotating basis from among those mediators agreeing to accept cases in the county in which the action has been filed.

2. The initial ADR conference must be held within 300 days after the filing of the action.

3. Pre-suit medical malpractice mediations required by S.C. Code §15-79-125 shall be held not later than 120 days after all defendants are served with the "Notice of Intent to File Suit" or as the court directs. (Medical malpractice mediation is mandatory statewide.)

4. Cases are exempt from ADR only upon the following grounds:

    a. Special proceeding, or actions seeking extraordinary relief such as mandamus, habeas corpus, or prohibition;

    b. Requests for temporary relief;

    c. Appeals

    d. Post Conviction relief matters;

    e. Contempt of Court proceedings;

    f. Forfeiture proceedings brought by governmental entities;

    g. Mortgage foreclosures; and

    h. Cases that have been previously subjected to an ADR conference, unless otherwise required by Rule 3 or by statute.

5. In cases not subject to ADR, the Chief Judge for Administrative Purposes, upon the motion of the court or of any party, may order a case to mediation.

6. Motion of a party to be exempt from payment of neutral fees due to indigency should be filed with the Court within ten (10) days after the ADR conference has been concluded.

Please Note: **You must comply with the Supreme Court Rules regarding ADR. Failure to do so may affect your case or may result in sanctions.**

STATE OF SOUTH CAROLINA	)	IN THE COURT OF COMMON PLEAS
COUNTY OF YORK	)	
Robert Randall, M.D.,	)	SUMMONS
Plaintiff,	)	FILE NO. 2012 CP 46 - 167
v.	)	
Amisub of South Carolina, Inc. d/b/a/ Piedmont Medical Center, Nathaniel Edwards, M.D., and Richard Patterson, M.D.,	)	
Defendants.	)	

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CLERK OF COURT
SC

TO THE DEFENDANTS ABOVE-NAMED:

YOU ARE HEREBY SUMMONED and required to answer the complaint herein, a copy of which is herewith served upon you, and to serve a copy of your answer to this complaint upon the subscriber, at the address shown below, within thirty (30) days after service hereof, exclusive of the day of such service, and if you fail to answer the complaint, judgment by default will be rendered against you for the relief demanded in the complaint.

Columbia, South Carolina

Dated: January 12, 2012

Plaintiff/Attorney for Plaintiff

Address: Lewis, Babcock & Griffin L.L.P.
James M. Griffin
Post Office Box 11208
Columbia, SC 29211

STATE OF SOUTH CAROLINA	)	IN THE COURT OF COMMON PLEAS
	)	FOR THE
COUNTY OF YORK	)	THIRTEENTH JUDICIAL CIRCUIT
	)	
Robert Randall, M.D.,	)	
	)	CIVIL ACTION NO. 2012CP46-167
Plaintiff,	)	
	)	
v.	)	**COMPLAINT**
	)	
Amisub of South Carolina, Inc. d/b/a/ Piedmont Medical Center, Nathaniel Edwards, M.D., and Richard Patterson, M.D.,	)	(Jury Trial Demanded)
	)	
Defendants.	)	
	)	

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DAVID HAMILTON
CLERK OF COURT
SC

Plaintiff Robert Randall, M.D. respectfully brings this action against Defendants named herein and would show this Court the following:

PARTIES – PLAINTIFF

1. Plaintiff Robert Randall, M.D. is a citizen and resident of York County, South Carolina.

PARTIES – DEFENDANT

2. Defendant Amisub of South Carolina, Inc. d/b/a Piedmont Medical Center ("Piedmont Medical Center" or "the Hospital") is a corporation organized and existing under the laws of the State of South Carolina and located in York County, South Carolina. Defendant is a wholly owned subsidiary of Tenet Healthcare of Dallas Texas.

3. Defendant Nathaniel Edwards, M.D. is a citizen and resident of York County, South Carolina and, at all relevant times herein, was the Chief of Staff at Piedmont Medical Center.

4. Defendant Richard Patterson, M.D., is a citizen and resident of York County, South

Carolina, and, at all relevant times herein, was the Chief Medical Officer of and employed by Piedmont Medical Center.

JURISDICTION AND VENUE

5. This Court has jurisdiction over these matters based upon S.C. Const. Art. V, Sec. 11.

6. Venue is proper in this Court as the Defendants are citizens and residents of York County and the actions and omissions giving rise to this case took place in York County, South Carolina.

FACTS

7. Plaintiff is a board certified general surgeon licensed to practice medicine in the State of South Carolina.

8. Prior to the actions complained of herein, Plaintiff was also licensed to practice medicine in the State of North Carolina.

9. Plaintiff has been a surgeon since 1982, and has had surgical privileges at Piedmont Medical Center since that time.

10. Plaintiff has received extensive training in the performance of open abdomen and laparoscopic surgeries and he has performed thousands of these procedures at Piedmont Medical Center since that time.

11. Plaintiff was also a part owner of a surgical medical practice in Rock Hill, S.C. named Rock Hill Surgical Associates, P.A.

12. In March 2008, Plaintiff sold Rock Hill Surgical Associates, P.A. to Novant Medical Group, which operates a for-profit hospital in Charlotte, N.C. named Presbyterian Healthcare.

13. Presbyterian Health is a competitor with Piedmont Medical Center.

14. Both Presbyterian Health and Piedmont Medical Center have been vying for a coveted Certificate of Need to build a hospital in Fort Mill, South Carolina.

15. Upon information and belief, Piedmont Medical Center and its parent company Tenet Healthcare viewed Plaintiff's sale of Rock Hill Surgical Associates as an act of betrayal, which provided Presbyterian Health a physical presence and patient population based in the Ft. Mill area, which Presbyterian Health could exploit in support of their efforts to obtain a Certificate of Need for the Ft. Mill hospital.

16. Furthermore, following the sale of Rock Hill Surgical Associates Plaintiff became insured under Presbyterian Health's self-insurance policy.

17. Tenet Healthcare also provides self-insurance to Piedmont Medical Center and its employed physicians, nurses and staff.

18. At the time of the sale of Rock Hill Surgical Associates to Novant Medical, Plaintiff had been sued along with certain Emergency Room nurses and doctors employed by Piedmont Medical Center for alleged medical negligence.

19. After the sale of Plaintiff's practice to Novant and during the discovery phase of the medical negligence lawsuit Plaintiff testified truthfully under oath during a deposition regarding the care provided to the patient. However, the truth was harmful to the Emergency Room nurses and physicians employed Piedmont Medical and insured by its parent corporation Tenet Healthcare.

20. In part because of Plaintiff's testimony, Piedmont Medical Center paid a substantial sum to settle the claims against the nurses. Plaintiff ultimately went to trial in that case and was

exonerated by the jury verdict in his favor.

21. As retaliation against Plaintiff for his decision to sale the practice to Novant and his refusal to cover up for the negligent conduct of employees of Presbyterian Medical Center, the Defendant Presbyterian by and through its employee and Chief Medical Officer Defendant Patterson, acting in concert with others, including Defendant Edwards, started a campaign to ruin Plaintiff's career by falsely accusing him of incompetence.

22. In December 2008, within months after the sale of Rock Hill Surgical Associates to Novant, Defendant Patterson, the CMO Piedmont Medical Center selected the records ofa patient who was operated on by Plaintiff and had an unexpected outcome to be sent to a consulting firm AllMed Healthcare Management for a determination as to whether Plaintiff'ssurgical privileges to practice medicine at the Hospital should be limited because of substandard care.

23. A few months previous, the Hospital's Peer Review Committee reviewed Plaintiff's open hernia repairs and carotid surgical procedures for 2006-2007. The Peer Review Committee found no errors associated with Plaintiff's procedures and the review was terminated.

24. In early May 2009 AllMed issued a report regarding the December 2008 complaint initiated by Defendant Patterson and concluded the Plaintiff's treatment of this patient was appropriate.

25. Undeterred, Defendant Patterson as CMO of Defendant Piedmont Medical thereafter selected seven (7) additional charts of patients that were operated on by Plaintiff during 2008-2009 and developed post-operative complications to be sent for review to determine if Plaintiff's surgical privileges should be limited.

26. This second time though, Defendant Patterson and Piedmont Medical Center sent the patient records to a different consulting firm, Advanced Medical Review.

27. The second consulting firm issued reports for these additional patient charts and found areas to criticize Plaintiff's treatment of these patients in some instances.

28. Thereafter, Defendant Patterson requested Defendant Edwards to present these reports to the Hospital's Peer Review Committee (PRC) in April 2010.

29. Because Plaintiff Randall's credentials at Piedmont Hospital were up for renewal, the PRC sent the AMR reports to the Credentials Committee for their consideration in July 2010.

30. The Credentials Committee met with Plaintiff in July 2010 to discuss the cases that had been reviewed. The Credentials Committee thereafter renewed Plaintiff's surgical privileges without restrictions.

31. In or around August 2010, another lawsuit against Plaintiff and Defendant alleging that negligence by Plaintiff and Defendant Piedmont in the case where a patient pulled her feeding tube out. The complaint sought damages in excess of $1 million.

32. In September 2010, the Medical Executive Committee ("MEC") chaired by Defendant Edwards considered the recommendation of the Credentials Committee.

33. Without explanation, the MEC did not accept the Credentials Committee's recommendation and appointed an ad hoc committee to review the matter and make a recommendation to the MEC.

34. The ad hoc committee sent seven cases with the outside reviews to Plaintiff and asked that he provide a written response to the outside reviewers. On September 16, 2010, Plaintiff

provided his response.

35. Plaintiff was invited by letter dated September 28, 2010 to meet with the ad hoc committee before the ad hoc committee made its recommendations to the Medical Executive Committee (MEC). In the letter, the ad hoc committee advised Plaintiff that it was considering a recommendation to the MEC that Plaintiff's surgical privileges be revoked.

36. On October 4, 2010, Plaintiff appeared with legal counsel at Piedmont Medical to meet with the ad hoc committee. However, Defendant Patterson physically barred Plaintiff's legal counsel from entering the meeting.

37. After the meeting, the ad hoc committee made its recommendation to the MEC that the Hospital revoke Plaintiff's privileges for abdominal surgery, by either open or laparoscopic technique.

38. The MEC accepted the ad hoc committee's recommendation on October 11, 2010. The MEC also claimed that there were two more cases that should be included.

39. The MEC also prepared an accounting of unplanned returns to the operating room by Plaintiff and all other general surgeons. In 2008, Plaintiff's number of returns to the operating room were about the same as all other five surgeons considered. In 2009, Plaintiff's returns were higher than the other surgeons considered, but Defendants failed to consider the context. Plaintiff's patients did not involve routine procedures done on otherwise healthy patients (such as an appendectomy), but instead involved severely ill or otherwise compromised patients before the surgeries were even performed, which lead to certain post-operative complications. In addition, in many of the cases, Plaintiff was not notified by Defendants or Defendants' employees of

complications and other physicians and nurses (who are employees of Defendants) handling the post-operative care failed to recognize that complications has arisen.

40. The MEC notified Plaintiff of the decision to revoke Plaintiff's privileges on October 15, 2010.

41. Under the Piedmont Medical Center's By-Laws Plaintiff had a right to appeal the decision to suspend his surgical privileges to an appellate panel made up in part of physicians practicing in the same field of medicine at the appellant, in this instance general surgery.

42. However, rather than providing the Plaintiff his due process rights to appeal, the Chairman of the MEC, Defendant Edwards unilaterally and without seeking approval from the other members of the MED summarily suspended Plaintiff's privileges, by letter dated October 15, 2010.

43. Under the South Carolina law, whenever a physician's privileges are suspended at a hospital, regardless of the amount of time, the hospital is required to report the suspension to the South Carolina Medical Board.

44. As a result, Defendant Piedmont reported Plaintiff's suspension to the South Carolina Medical Board as required.

45. On October 25, 2010, Plaintiff met with MEC to contest the summary suspension. Again, Defendants Patterson and Edwards denied Plaintiff the right to bring his attorney with him to this meeting.

46. By letter dated October 28, 2010, the MEC sustained Plaintiff's summary suspension.

47. Plaintiff thereafter requested a hearing to contest both the summary suspension and the

revocation of clinical privileges.

48. Under the Piedmont Medical Center's By-Laws, Plaintiff had a right to a hearing to contest the suspension within 90 days from the date of making the request.

49. On November 4, 2010, Plaintiff was notified that the hearing would be held on January 12, 2011. The hearing was then moved up to January 5-6, 2010.

50. On January 3, 2011, just two days before the hearing, Defendant Piedmont requested a postponement of the hearing on the grounds that their expert had a scheduling conflict.

51. A couple of days later, Defendants indicated that their expert would no longer testify.

52. Subsequently, Defendants named a new expert, Paul Skudder, M.D.

53. The hearing was eventually rescheduled for February 16-17, 2011 before a panel of five physicians ("the Hearing Committee"). The panel was comprised of a pathologist, an oncologist, a anesthetist, an oral surgeon, and an orthopedic surgeon, but no general surgeons.

54. Plaintiff objected and requested that a general surgeon be included as a member of the Hearing Committee, as required. Defendants refused on the grounds that all general surgeons were either Plaintiff's partners or in economic competition with Plaintiff.

55. Plaintiff did not object to the inclusion of a general surgeon in economic competition with him, but the MEC found that the absence of a surgeon would not materially affect its ability to consider and decide the matter.

56. Defendants' supposed expert, Dr. Paul Skudder, only performs vascular surgery and critical care. He does not perform abdominal surgeries and has never even been trained in laparoscopic techniques.

57. Plaintiff's expert was a general surgeon, Dr. Ben Tribble. At the proceeding before the Hearing Committee, Dr. Tribble testified, as to each patient, that Plaintiff had exercised the proper medical judgment. The Hearing Committee ignored this testimony, as is apparent from their written decision in March 2010, in which the Hearing Committee did not refer to any of Dr. Tribble's testimony or opinions.

58. The written decision of the Hearing Committee upheld the MEC's recommendation for revocation and summary suspension of Plaintiff's clinical privileges to perform abdominal surgery, whether open or by laparoscopic technique.

59. The written decision of the Hearing Committee is arbitrary, unreasonable and/or capricious, as well as internally inconsistent. For example, as to Patient JP (MR 156580), the Hearing Committee's decision states that "Dr. Skudder's testimony does not support a finding of deviation from accepted standards of care in the selection of operative procedure." The Decision also found the there was insufficient evidence to support Dr. Skudder's testimony that Dr. Randall injured the patient's colon during a laparoscopic procedure. Yet, the Hearing Committee concluded that "the MEC's findings concerning Dr. Randall's exercise of judgment have a substantial factual basis and were not arbitrary, unreasonable or capricious."

60. Defendants' revocation of Plaintiff's surgical privileges was in retaliation for the lawsuits in which Plaintiff testified as to the negligence of Defendants' employees and for the sale of Plaintiff's practice to one of Defendants' competitors.

FOR A FIRST CAUSE OF ACTION
Civil Conspiracy

61. The preceding allegations are incorporated herein by reference.

62. Defendants Edwards and Patterson along with Defendant Piedmont Medical, through its agents and employees, formed, in combination with others, both known and unknown, a civil conspiracy to harm Plaintiff and to avoid responsibility for negligent patient care by Defendant Piedmont Medical's employees and others.

63. The goals of the conspiracy were to avoid responsibility for negligent care; to suborn a wall of silence by those who witnessed such acts and to discourage those from testifying truthfully in the future about such acts and to retaliate against Plaintiff for entering into lawful agreements with Defendants Piedmont Medical's competitor.

64. Plaintiff has suffered special damages as a direct and proximate result of this conspiracy and is entitled to judgment against Defendant, to wit:

(A) Costs, attorneys' fees, and expert witness fees in having to defendant against the allegations of misconduct;

(B) Humiliation, emotional distress and anguish arising out of the peer review process;

(C) Damage to Plaintiff's reputation and standing within the Piedmont Medical staff;

(D) Loss of income relating to Plaintiff's loss of privileges at Piedmont Medical;

65. Plaintiff is therefore entitled to an award of special damages in an amount to be proven at trial against the Defendants jointly and severally and an award of punitive damages against each separate Defendant.

FOR A SECOND CAUSE OF ACTION
Defamation

66. The preceding allegations are incorporated herein by reference.

67. Defendants acted maliciously, in bad faith, and in order to injure and defame Plaintiff directly and their acts have resulted in the public dissemination of reports of Plaintiff's summary suspension and the revocation of Plaintiff's surgical privileges.

68. Defendants knew the suspension, and the report thereof, would be made a part of Plaintiff's permanent professional record, and that the suspension would be published on a network, accessible to any interested patient, colleague, employer, healthcare provider, insurer, or credentialing committee. The direct effect of the report was to characterize Plaintiff as incompetent.

69. The purpose and known effect of the suspension was to imply that Plaintiff had committed conduct requiring that he be reported, to deny him employment opportunities, and to permanently damage his reputation.

70. As a direct and proximate result of the Defendants' acts, Plaintiff has suffered mental anguish and distress, has been deprived of employment opportunities, career advancement, referrals, and fees.

71. The Defendants' acts have also caused Plaintiff to suffer economic loss, humiliation, and damage to his reputation and standing in the York County community and the medical community at large. Plaintiff is informed and believes that these effects will continue for many years in the future, and likely throughout his career and lifetime.

72. Plaintiff further alleges that his suspension, and the report thereof, were not based on his "competence or professional conduct".

73. The suspension process did not comport with the definition of "professional review action" contained in the Health Care Quality Improvement Act and the Piedmont Medical By-Laws.

74. Plaintiff further alleges that the message had the following characteristics:

(A) It had a defamatory meaning;

(B) It was published with actual or implied malice;

(C) It was false;

(D) It was published by the Defendant;

(E) It concerned Plaintiff;

(F) It resulted in legally presumed and special damages.

75. Plaintiff further alleges that as a direct and proximate result of Defendant's defamatory statements, he has been damaged and is entitled to judgment against Defendant for an award of actual damages in an amount to be proven at trial, and for an award of punitive damages.

WHEREFORE, Plaintiff prays for the following:

56) Judgment on all causes of action herein, and actual, special, and punitive damages;

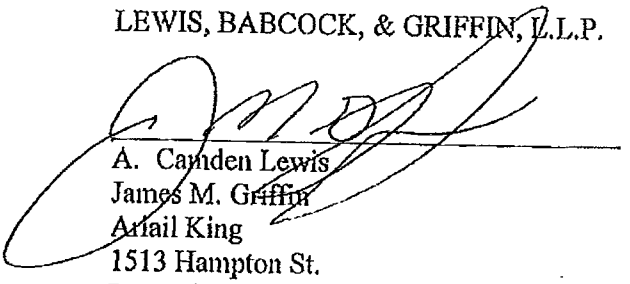
57) Reinstatement of Plaintiff's surgical privileges

58) For the costs of this action, including reasonable attorneys' fees, if permitted by law; and

59) For such other and further relief as this Court deems just and proper.

PLAINTIFF HEREBY DEMANDS A TRIAL BY JURY

LEWIS, BABCOCK, & GRIFFIN, L.L.P.



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Attorneys for Plaintiffs

Columbia, South Carolina
January 12, 2012

STATE OF SOUTH CAROLINA COUNTY OF YORK	)	IN THE COURT OF COMMON PLEAS SIXTEENTH JUDICIAL CIRCUIT
Robert Randall, M.D., Plaintiff, v. Amisub of South Carolina, Inc. d/b/a Piedmont Medical Center, Nathaniel Edwards, M.D., and Richard Patterson, M.D., Defendants.	)	Civil Action No. 2012-CP-46-167 **ANSWER OF AMISUB OF SOUTH CAROLINA, INC. D/B/A PIEDMONT MEDICAL CENTER**

COMES NOW, Defendant Amisub of South Carolina, Inc. d/b/a Piedmont Medical Center ("Piedmont"), answering Plaintiff's Complaint as follows:

FIRST DEFENSE TO COMPLAINT

1. Piedmont is without knowledge or information sufficient to admit or deny the allegations in paragraph 1, and therefore denies same.

2. With respect to the allegations in paragraph 2, Piedmont admits that it is a corporation organized and existing under the laws of the State of South Carolina, located in York County, South Carolina. Piedmont denies the remaining allegations in paragraph 2.

3. Piedmont admits the allegations in paragraphs 3, 4, and 5.

4. With respect to the allegations in paragraph 6, Piedmont admits that venue is proper in this Court, and Defendants are residents of York County. Piedmont denies the remaining allegations in paragraph 6.

5. Piedmont is without knowledge or information sufficient to admit or deny the allegations in paragraphs 7 and 8, and therefore denies same.

6. Piedmont admits the allegations in paragraph 9.

7. With respect to the allegations in paragraph 10, Piedmont admits that Dr. Randall has performed numerous open abdomen and laparoscopic surgeries while on staff at Piedmont. Piedmont is without knowledge or information sufficient to admit or deny the remaining allegations in paragraph 10.

8. Piedmont admits the allegations in paragraph 11.

9. With respect to the allegations in paragraph 12, Piedmont admits that Dr. Randall and/or his practice became associated with Presbyterian Healthcare, but Piedmont is without knowledge or information sufficient to admit or deny the other allegations regarding this association, and therefore denies same. Piedmont denies the remaining allegations in paragraph 12.

10. Piedmont denies the allegations in paragraph 13.

11. With respect to the allegations in paragraph 14, Piedmont admits that Piedmont seeks a Certificate of Need to build a new hospital in Fort Mill, South Carolina. Piedmont denies the remaining allegations in paragraph 14.

12. Piedmont denies the allegations in paragraph 15.

13. Piedmont is without knowledge or information sufficient to admit or deny the allegations in paragraph 16, and therefore denies same.

14. With respect to the allegations in paragraph 17, Piedmont admits that Tenet Healthcare Corporation, Inc. and its affiliated hospitals are primarily "self-insured" as that term is generally understood. Piedmont denies the remaining allegations in paragraph 17.

15. Piedmont is without knowledge or information sufficient to admit or deny the allegations in paragraphs 18, 19, and 20, and therefore denies same.

16. Piedmont denies the allegations in paragraph 21.

17. With respect to the allegations in paragraph 22, Piedmont admits that as part of Dr. Randall's peer review, medical records were sent to external reviewers, including AllMed Healthcare Management, for review and analysis. Piedmont denies the remaining allegations in paragraph 22.

18. With respect to the allegations of paragraph 23, Piedmont admits that the Peer Review Committee engaged in a focused review of Dr. Randall's open hernia repairs and carotid surgical procedures because of concerns about Dr. Randall's patient care that arose from review of Dr. Randall's cases during his reappointment process, and Piedmont further admits that this focused review was ultimately discontinued based upon the findings of the external reviews. Piedmont denies the remaining allegations in paragraph 23.

19. With respect to the allegations in paragraph 24, Piedmont admits that in May 2009 AllMed issued a report containing an external review of one of Dr. Randall's cases, and Piedmont craves reference to this report for a complete statement of its findings and contents, and denies all allegations inconsistent therewith. Piedmont denies the remaining allegations in paragraph 24.

20. With respect to the allegations in paragraphs 25 and 26, Piedmont admits that as part of Dr. Randall's peer review, medical records were sent to external reviewers, including Advanced Medical Review, for review and analysis. Piedmont denies the remaining allegations in paragraphs 25 and 26.

21. With respect to the allegations in paragraph 27, Piedmont admits that Advanced Medical Review produced reports containing external reviews of Dr. Randall's cases, and Piedmont craves reference to these reports for complete statements of their findings and

contents, and denies all allegations inconsistent therewith. Piedmont denies the remaining allegations in paragraph 27.

22. Piedmont denies the allegations in paragraph 28.

23. With respect to the allegations in paragraph 29, Piedmont admits that the Peer Review Committee referred Dr. Randall's cases under review to the Credentials Committee for consideration pertaining to Dr. Randall's reappointment. Piedmont denies the remaining allegations in paragraph 29.

24. With respect to the allegations in paragraph 30, Piedmont admits that Dr. Randall appeared before the Credentials Committee to discuss the care he provided in the cases under review, and Piedmont further admits that the Credentials Committee recommended that Dr. Randall be reappointed to the Medical Staff for one year with certain conditions. Piedmont denies the remaining allegations in paragraph 30.

25. Piedmont is without knowledge or information sufficient to admit or deny the allegations in paragraph 31, and therefore denies same.

26. Piedmont admits the allegations in paragraph 32.

27. With respect to the allegations in paragraph 33, Piedmont admits that the Medical Executive Committee ("MEC") appointed an ad hoc committee comprised of members of the MEC, Peer Review Committee, and Credentials Committee to review this matter further and make a recommendation to the MEC. Piedmont denies the remaining allegations in paragraph 33.

28. Piedmont admits the allegations in paragraphs 34 and 35.

29. With respect to the allegations in paragraph 36, Piedmont admits that Dr. Randall attempted to have his legal counsel participate in the meeting with the Ad Hoc

Committee in violation of the Medical Staff Bylaws. Piedmont denies the remaining allegations in paragraph 36.

30. Piedmont admits the allegations in paragraph 37.

31. With respect to the allegations in paragraph 38, Piedmont admits that the MEC considered, *inter alia*, two additional cases which had been externally reviewed and that the MEC agreed with the ad hoc committee's recommendation. Piedmont denies the remaining allegations in paragraph 38.

32. With respect to the allegations in paragraph 39, Piedmont admits that the MEC reviewed and considered comparative data regarding returns to the operating room within thirty days of the first operation, and Piedmont craves reference to that data for a complete statement of its contents and denies all allegations inconsistent therewith. Piedmont denies the remaining allegations in paragraph 39.

33. With respect to the allegations in paragraph 40, Piedmont admits that Dr. Randall was provided notice, via letter dated October 15, 2010, that the MEC recommended that certain of his surgical privileges be revoked. Piedmont denies the remaining allegations in paragraph 40.

34. Piedmont denies the allegations in paragraph 41.

35. With respect to the allegations in paragraph 42, Piedmont admits that Dr. Randall's privileges to perform abdominal surgery including herniorrhaphy, whether by open or laparoscopic technique were suspended by the Chief of Staff and notice of this suspension was provided via letter dated October 15, 2010. Piedmont denies the remaining allegations in paragraph 42.

36. With respect to the allegations in paragraphs 43 and 44, Piedmont admits that Dr. Randall's suspension was reported to the South Carolina Board of Medical Examiners. Piedmont denies the remaining allegations in paragraphs 43 and 44.

37. With respect to the allegations in paragraph 45, Piedmont admits that on October 25, 2010, Dr. Randall met with the MEC regarding his suspension, and Dr. Randall attempted to have legal counsel participate in the meeting in violation of the Medical Staff Bylaws. Piedmont denies the remaining allegations in paragraph 45.

38. With respect to the allegations in paragraph 46, Piedmont admits that the MEC voted to sustain Dr. Randall's suspension and provided him notice of this decision via letter dated October 28, 2010. Piedmont denies the remaining allegations in paragraph 46.

39. Piedmont admits the allegations in paragraph 47.

40. Piedmont denies the allegations in paragraph 48.

41. With respect to the allegations in paragraph 49, Piedmont admits that Dr. Randall received notice, via a letter dated November 4, 2010, that his peer review hearing was scheduled for January 12, and subsequently the hearing was rescheduled to January 5-6. Piedmont denies the remaining allegations in paragraph 49.

42. With respect to the allegations in paragraph 50, Piedmont admits that the MEC submitted a written request for postponement of the hearing on January 3, 2011, and Piedmont craves reference to that written request for a complete statement of its contents and denies all allegations inconsistent therewith. Piedmont denies the remaining allegations in paragraph 50.

43. With respect to the allegations in paragraph 51, Piedmont admits that the MEC submitted a second written request for postponement of the hearing on January 5, 2011, that informed Dr. Randall that the MEC's expert witness was no longer available to testify, and

Piedmont craves reference to that written request for a complete statement of its contents and denies all allegations inconsistent therewith. Piedmont denies the remaining allegations in paragraph 51.

44. Piedmont admits the allegations in paragraph 52.

45. With respect to the allegations in paragraph 53, Piedmont admits that Dr. Randall's hearing was rescheduled for February 16-17, 2011, and Piedmont further admits that the Hearing Committee was comprised of an orthopedic surgeon, an oral surgeon, a pathologist, two oncologists, and an anesthesiologist and there was not a general surgeon on the Hearing Committee. Piedmont denies the remaining allegations in paragraph 53.

46. With respect to the allegations in paragraph 54, Piedmont admits that Dr. Randall objected and requested that a general surgeon be included as a member of the Hearing Committee. Piedmont denies the remaining allegations of paragraph 54.

47. Piedmont denies the allegations in paragraphs 55 and 56.

48. With respect to the allegations in paragraph 57, Piedmont admits that Dr. Tribble is a general surgeon who testified before the Hearing Committee, and Piedmont craves reference to the hearing transcript regarding the contents of his testimony and denies the allegations inconsistent therewith. Piedmont denies the remaining allegations in paragraph 57.

49. With respect to the allegations in paragraph 58, Piedmont admits that the Hearing Committee upheld the MEC's recommendation and craves reference to the Hearing Committee's report for a complete statement of its contents and denies all allegations inconsistent therewith. Piedmont denies the remaining allegations in paragraph 58.

50. With respect to the allegations in paragraph 59, Piedmont craves reference to the Hearing Committee's report for a complete statement of its contents and denies all allegations inconsistent therewith. Piedmont denies the remaining allegations in paragraph 59.

51. Piedmont denies the allegations in paragraph 60.

52. Piedmont denies every allegation in the Complaint not specifically admitted by Piedmont.

FIRST DEFENSE TO FIRST CAUSE OF ACTION

53. With respect to the allegations in paragraph 61, Piedmont incorporates by reference herein all of the responses to the allegations in paragraphs 1 through 60.

54. Piedmont denies the allegations in paragraphs 62, 63, 64, and 65.

FIRST DEFENSE TO SECOND CAUSE OF ACTION

55. With respect to the allegations in paragraph 66, Piedmont incorporates by reference herein all of the responses to the allegations in paragraphs 1 through 65.

56. Piedmont denies the allegations in paragraphs 67, 68, 69, 70, 71, 72, 73, 74, and 75.

57. To the extent that the "Wherefore" clause contains factual allegations to which a response is required, the allegations are denied, and Piedmont specifically denies that Plaintiff is entitled to any of the relief requested in the Complaint.

FIRST AFFIRMATIVE DEFENSE TO COMPLAINT AND CAUSES THEREIN

58. Plaintiff's Complaint fails, in whole or in part, to state a claim for which relief may be granted and should therefore be dismissed.

SECOND AFFIRMATIVE DEFENSE TO COMPLAINT AND CAUSES THEREIN

59. Plaintiff's claims are barred, in whole or in part, by the immunity provisions of the Health Care Quality Improvement Act, 42 U.S.C. § 11101 *et seq.*, and pursuant to § 11113 of this Act, Piedmont is entitled to an award of attorneys' fees.

THIRD AFFIRMATIVE DEFENSE TO COMPLAINT AND CAUSES THEREIN

60. Plaintiff's claims are barred, in whole or in part, by the immunity provisions of S.C. Code Ann. § 40-71-10.

FOURTH AFFIRMATIVE DEFENSE TO COMPLAINT AND CAUSES THEREIN

61. Plaintiff's claims, in whole or in part, are barred by state and federal law providing immunity for reports to the South Carolina Board of Medical Examiners and/or National Practitioner Databank.

FIFTH AFFIRMATIVE DEFENSE TO COMPLAINT AND CAUSES THEREIN

62. Plaintiff's claims, in whole or in part, are barred by Piedmont's medical staff bylaws, credentialing policy, and/or Plaintiff's medical staff application.

SIXTH AFFIRMATIVE DEFENSE TO COMPLAINT AND CAUSES THEREIN

63. At all relevant times, Defendants acted in good faith and without malice, precluding Plaintiff's claims for relief.

SEVENTH AFFIRMATIVE DEFENSE TO COMPLAINT AND CAUSES THEREIN

64. Piedmont would show that any allegedly defamatory statements made by Defendants are absolutely and/or conditionally privileged pursuant to federal and state law.

EIGHTH AFFIRMATIVE DEFENSE TO COMPLAINT AND CAUSES THEREIN

65. Plaintiff's claims, in whole or in part, are barred by the economic loss rule.

NINTH AFFIRMATIVE DEFENSE TO COMPLAINT AND CAUSES THEREIN

66. Plaintiff's claims, in whole or in part, are barred by the doctrine of consent.

TENTH AFFIRMATIVE DEFENSE TO COMPLAINT AND CAUSES THEREIN

67. Plaintiff's claims, in whole or in part, are barred by the doctrines of laches, estoppel, unclean hands, and/or waiver.

ELEVENTH AFFIRMATIVE DEFENSE TO COMPLAINT AND CAUSES THEREIN

68. To the extent that Plaintiff failed to mitigate his damages, if any, he is barred from relief.

TWELFTH AFFIRMATIVE DEFENSE TO COMPLAINT AND CAUSES THEREIN

69. Piedmont would show that Plaintiff's alleged damages, if any, were proximately caused by the intervening and superceding acts or omissions of Plaintiff.

THIRTEENTH AFFIRMATIVE DEFENSE TO COMPLAINT AND CAUSES THEREIN

70. Plaintiff's claims and requests for relief, in whole or in part, are barred by the South Carolina common law doctrine of non-review enunciated in *Wood v. Hilton Head Hosp., Inc.*, 292 S.C. 403, 356 S.E.2d 841, 842 (1987) and *Gowan v. St Francis Cnty. Hosp.*, 275 S.C. 203, 268 S.E.2d 580 (1980), cert. denied, 449 U.S. 1062 (1980).

FOURTEENTH AFFIRMATIVE DEFENSE
TO COMPLAINT AND CAUSES THEREIN

71. Plaintiff's claim for punitive damages is barred by the due process clauses of the United States Constitution and the South Carolina Constitution.

FIFTEENTH AFFIRMATIVE DEFENSE
TO COMPLAINT AND CAUSES THEREIN

72. Plaintiff's civil conspiracy claim is barred by the intra-corporate immunity doctrine.

SIXTEENTH AFFIRMATIVE DEFENSE
TO COMPLAINT AND CAUSES THEREIN

73. Plaintiff's civil conspiracy claim fails because the acts for which relief is sought and the alleged damages are the same acts and damages alleged in other causes of action.

SEVENTEENTH AFFIRMATIVE DEFENSE
TO COMPLAINT AND CAUSES THEREIN

74. Plaintiff's defamation claim fails because the statements made and allegedly made regarding Plaintiff are true.

EIGHTEENTH AFFIRMATIVE DEFENSE
TO COMPLAINT AND CAUSES THEREIN

75. Piedmont pleads all applicable statutes of limitations in defense and as a bar to the Plaintiff's claims.

NINETEENTH AFFIRMATIVE DEFENSE
TO COMPLAINT AND CAUSES THEREIN

76. Piedmont hereby gives notice that it intends to rely upon any other defense that may become available or appear during the discovery proceedings in this case and hereby reserves its right to amend its Answer to assert any such defense.

WHEREFORE, having fully set forth the Answer to Plaintiff's Complaint, Piedmont prays that this Court dismiss Plaintiff's claims with prejudice, and award Piedmont its costs and attorneys' fees incurred in this action and such other relief as this Court determines appropriate.

NELSON MULLINS RILEY & SCARBOROUGH, LLP

By: _____

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Post Office Box 11070 (29211-1070)
Columbia, SC 29201

Attorneys for Amisub of South Carolina, Inc. d/b/a
Piedmont Medical Center

Columbia, SC
3/22, 2012

CERTIFICATE OF SERVICE

I, the undersigned Administrative Assistant of the law offices of Nelson Mullins Riley & Scarborough LLP, attorneys for Defendants, do hereby certify that I have served all counsel in this action with a copy of the pleading(s) hereinbelow specified by mailing a copy of the same by United States Mail, postage prepaid, to the following address(es):

Pleadings:

ANSWER OF AMISUB OF SOUTH CAROLINA, INC. D/B/A PIEDMONT MEDICAL CENTER

Counsel Served:

James M. Griffin, Esq.
Lewis, Babcock & Griffin L.L.P.
1513 Hampton Street (29201)
P.O. Box 11208
Columbia, SC 29211

Jane Heinzelman

Jane Heinzelman
Administrative Assistant

March 23, 2012

STATE OF SOUTH CAROLINA COUNTY OF YORK	)	IN THE COURT OF COMMON PLEAS SIXTEENTH JUDICIAL CIRCUIT
Robert Randall, M.D., Plaintiff, v. Amisub of South Carolina, Inc. d/b/a Piedmont Medical Center, Nathaniel Edwards, M.D., and Richard Patterson, M.D., Defendants.	)	Civil Action No. 2012-CP-46-167 **ANSWER OF NATHANIEL EDWARDS, M.D.**

COMES NOW, Defendant Nathaniel Edwards, M.D. answering Plaintiff's Complaint as follows:

FIRST DEFENSE TO COMPLAINT

1. Dr. Edwards is without knowledge or information sufficient to admit or deny the allegations in paragraph 1, and therefore denies same.

2. With respect to the allegations in paragraph 2, Dr. Edwards admits that Piedmont Medical Center is a corporation organized and existing under the laws of the State of South Carolina, located in Your County, South Carolina. Dr. Edwards denies the remaining allegations in paragraph 2.

3. Dr. Edwards admits the allegations in paragraphs 3, 4, and 5.

4. With respect to the allegations in paragraph 6, Dr. Edwards admits that venue is proper in this Court, and Defendants are residents of York County. Dr. Edwards denies the remaining allegations in paragraph 6.

5. Dr. Edwards is without knowledge or information sufficient to admit or deny the allegations in paragraphs 7 and 8, and therefore denies same.

6. Dr. Edwards admits the allegations in paragraph 9.

7. With respect to the allegations in paragraph 10, Dr. Edwards admits that Dr. Randall has performed numerous open abdomen and laparoscopic surgeries while on staff at Piedmont. Dr. Edwards is without knowledge or information sufficient to admit or deny the remaining allegations in paragraph 10.

8. Dr. Edwards admits the allegations in paragraph 11.

9. Dr. Edwards is without knowledge or information sufficient to admit or deny the allegations in paragraph 12, and therefore denies same.

10. Dr. Edwards denies the allegations in paragraph 13.

11. With respect to the allegations in paragraph 14, Dr. Edwards admits that Piedmont seeks a Certificate of Need to build a new hospital in Fort Mill, South Carolina. Dr. Edwards denies the remaining allegations in paragraph 14.

12. Dr. Edwards denies the allegations in paragraph 15.

13. Dr. Edwards is without knowledge or information sufficient to admit or deny the allegations in paragraph 16, and therefore denies same.

14. Dr. Edwards is without knowledge or information sufficient to admit or deny the allegations in paragraphs 17, 18, 19, and 20, and therefore denies same.

15. Dr. Edwards denies the allegations in paragraph 21.

16. With respect to the allegations in paragraph 22, Dr. Edwards admits that as part of Dr. Randall's peer review, medical records were sent to external reviewers, including

AllMed Healthcare Management, for review and analysis. Dr. Edwards denies the remaining allegations in paragraph 22.

17. With respect to the allegations of paragraph 23, Dr. Edwards admits that the Peer Review Committee engaged in a focused review of Dr. Randall's open hernia repairs and carotid surgical procedures because of concerns about Dr. Randall's patient care that arose from review of Dr. Randall's cases during his reappointment process, and Dr. Edwards further admits that this focused review was ultimately discontinued based upon the findings of the external reviews. Dr. Edwards denies the remaining allegations in paragraph 23.

18. With respect to the allegations in paragraph 24, Dr. Edwards admits that in May 2009 AllMed issued a report containing an external review of one of Dr. Randall's cases, and Dr. Edwards craves reference to this report for a complete statement of its findings and contents, and denies all allegations inconsistent therewith. Dr. Edwards denies the remaining allegations in paragraph 24.

19. With respect to the allegations in paragraphs 25 and 26, Dr. Edwards admits that as part of Dr. Randall's peer review, medical records were sent to external reviewers, including Advanced Medical Review, for review and analysis. Dr. Edwards denies the remaining allegations in paragraphs 25 and 26.

20. With respect to the allegations in paragraph 27, Dr. Edwards admits that Advanced Medical Review produced reports containing external reviews of Dr. Randall's cases, and Dr. Edwards craves reference to these reports for complete statements of their findings and contents, and denies all allegations inconsistent therewith. Dr. Edwards denies the remaining allegations in paragraph 27.

21. Dr. Edwards denies the allegations in paragraph 28.

22. With respect to the allegations in paragraph 29, Dr. Edwards admits that the Peer Review Committee referred Dr. Randall's cases under review to the Credentials Committee for consideration pertaining to Dr. Randall's reappointment. Dr. Edwards denies the remaining allegations in paragraph 29.

23. With respect to the allegations in paragraph 30, Dr. Edwards admits that Dr. Randall appeared before the Credentials Committee to discuss the care he provided in the cases under review, and Dr. Edwards further admits that the Credentials Committee recommended that Dr. Randall be reappointed to the Medical Staff for one year with certain conditions. Dr. Edwards denies the remaining allegations in paragraph 30.

24. Dr. Edwards is without knowledge or information sufficient to admit or deny the allegations in paragraph 31, and therefore denies same.

25. Dr. Edwards admits the allegations in paragraph 32.

26. With respect to the allegations in paragraph 33, Dr. Edwards admits that the Medical Executive Committee ("MEC") appointed an ad hoc committee comprised of members of the MEC, Peer Review Committee, and Credentials Committee to review this matter further and make a recommendation to the MEC. Dr. Edwards denies the remaining allegations in paragraph 33.

27. Dr. Edwards admits the allegations in paragraphs 34 and 35.

28. With respect to the allegations in paragraph 36, Dr. Edwards admits that Dr. Randall attempted to have his legal counsel participate in the meeting with the Ad Hoc Committee in violation of the Medical Staff Bylaws. Dr. Edwards denies the remaining allegations in paragraph 36.

29. Dr. Edwards admits the allegations in paragraph 37.

30. With respect to the allegations in paragraph 38, Dr. Edwards admits that the MEC considered, *inter alia*, two additional cases which had been externally reviewed and that the MEC agreed with the ad hoc committee's recommendation. Dr. Edwards denies the remaining allegations in paragraph 38.

31. With respect to the allegations in paragraph 39, Dr. Edwards admits that the MEC reviewed and considered comparative data regarding returns to the operating room within thirty days of the first operation, and Dr. Edwards craves reference to that data for a complete statement of its contents and denies all allegations inconsistent therewith. Dr. Edwards denies the remaining allegations in paragraph 39.

32. With respect to the allegations in paragraph 40, Dr. Edwards admits that Dr. Randall was provided notice, via letter dated October 15, 2010, that the MEC recommended that certain of his surgical privileges be revoked. Dr. Edwards denies the remaining allegations in paragraph 40.

33. Dr. Edwards denies the allegations in paragraph 41.

34. With respect to the allegations in paragraph 42, Dr. Edwards admits that Dr. Randall's privileges to perform abdominal surgery including herniorrhaphy, whether by open or laparoscopic technique were suspended by the Chief of Staff and notice of this suspension was provided via letter dated October 15, 2010. Dr. Edwards denies the remaining allegations in paragraph 42.

35. With respect to the allegations in paragraphs 43 and 44, Dr. Edwards admits that Dr. Randall's suspension was reported to the South Carolina Board of Medical Examiners. Dr. Edwards denies the remaining allegations in paragraphs 43 and 44.

36. With respect to the allegations in paragraph 45, Dr. Edwards admits that on October 25, 2010, Dr. Randall met with the MEC regarding his suspension. Dr. Edwards is without knowledge or information sufficient to admit or deny the remaining allegations in paragraph 45, and therefore denies same.

37. With respect to the allegations in paragraph 46, Dr. Edwards admits that the MEC voted to sustain Dr. Randall's suspension and provided him notice of this decision via letter dated October 28, 2010. Dr. Edwards denies the remaining allegations in paragraph 46.

38. Dr. Edwards admits the allegations in paragraph 47.

39. Dr. Edwards denies the allegations in paragraph 48.

40. With respect to the allegations in paragraph 49, Dr. Edwards admits that Dr. Randall received notice, via a letter dated November 4, 2010, that his peer review hearing was scheduled for January 12, and subsequently the hearing was rescheduled to January 5-6. Dr. Edwards denies the remaining allegations in paragraph 49.

41. With respect to the allegations in paragraph 50, Dr. Edwards admits that the MEC submitted a written request for postponement of the hearing on January 3, 2011, and Dr. Edwards craves reference to that written request for a complete statement of its contents and denies all allegations inconsistent therewith. Dr. Edwards denies the remaining allegations in paragraph 50.

42. With respect to the allegations in paragraph 51, Dr. Edwards admits that the MEC submitted a second written request for postponement of the hearing on January 5, 2011, that informed Dr. Randall that the MEC's expert witness was no longer available to testify, and Dr. Edwards craves reference to that written request for a complete statement of its

contents and denies all allegations inconsistent therewith. Dr. Edwards denies the remaining allegations in paragraph 51.

43. Dr. Edwards admits the allegations in paragraph 52.

44. With respect to the allegations in paragraph 53, Dr. Edwards admits that Dr. Randall's hearing was rescheduled for February 16-17, 2011, and Dr. Edwards further admits that the Hearing Committee was comprised of an orthopedic surgeon, an oral surgeon, a pathologist, two oncologists, and an anesthesiologist and there was not a general surgeon on the Hearing Committee. Dr. Edwards denies the remaining allegations in paragraph 53.

45. With respect to the allegations in paragraph 54, Dr. Edwards admits that Dr. Randall objected and requested that a general surgeon be included as a member of the Hearing Committee. Dr. Edwards denies the remaining allegations of paragraph 54.

46. Dr. Edwards denies the allegations in paragraphs 55 and 56.

47. With respect to the allegations in paragraph 57, Dr. Edwards admits that Dr. Tribble is a general surgeon who testified before the Hearing Committee, and Dr. Edwards craves reference to the hearing transcript regarding the contents of his testimony and denies the allegations inconsistent therewith. Dr. Edwards denies the remaining allegations in paragraph 57.

48. With respect to the allegations in paragraph 58, Dr. Edwards admits that the Hearing Committee upheld the MEC's recommendation and craves reference to the Hearing Committee's report for a complete statement of its contents and denies all allegations inconsistent therewith. Dr. Edwards denies the remaining allegations in paragraph 58.

49. With respect to the allegations in paragraph 59, Dr. Edwards craves reference to the Hearing Committee's report for a complete statement of its contents and denies all

allegations inconsistent therewith. Dr. Edwards denies the remaining allegations in paragraph 59.

50. Dr. Edwards denies the allegations in paragraph 60.

51. Dr. Edwards denies every allegation in the Complaint not specifically admitted by Dr. Edwards.

FIRST DEFENSE TO FIRST CAUSE OF ACTION

52. With respect to the allegations in paragraph 61, Dr. Edwards incorporates by reference herein all of the responses to the allegations in paragraphs 1 through 60.

53. Dr. Edwards denies the allegations in paragraphs 62, 63, 64, and 65.

FIRST DEFENSE TO SECOND CAUSE OF ACTION

54. With respect to the allegations in paragraph 66, Dr. Edwards incorporates by reference herein all of the responses to the allegations in paragraphs 1 through 65.

55. Dr. Edwards denies the allegations in paragraphs 67, 68, 69, 70, 71, 72, 73, 74, and 75.

56. To the extent that the "Wherefore" clause contains factual allegations to which a response is required, the allegations are denied, and Dr. Edwards specifically denies that Plaintiff is entitled to any of the relief requested in the Complaint.

FIRST AFFIRMATIVE DEFENSE TO COMPLAINT AND CAUSES THEREIN

57. Plaintiff's Complaint fails, in whole or in part, to state a claim for which relief may be granted and should therefore be dismissed.

SECOND AFFIRMATIVE DEFENSE TO COMPLAINT AND CAUSES THEREIN

58. Plaintiff's claims are barred, in whole or in part, by the immunity provisions of the Health Care Quality Improvement Act, 42 U.S.C. § 11101 *et seq.*, and pursuant to § 11113 of this Act, Dr. Edwards is entitled to an award of attorneys' fees.

THIRD AFFIRMATIVE DEFENSE TO COMPLAINT AND CAUSES THEREIN

59. Plaintiff's claims are barred, in whole or in part, by the immunity provisions of S.C. Code Ann. § 40-71-10.

FOURTH AFFIRMATIVE DEFENSE TO COMPLAINT AND CAUSES THEREIN

60. Plaintiff's claims, in whole or in part, are barred by state and federal law providing immunity for reports to the South Carolina Board of Medical Examiners and/or National Practitioner Databank.

FIFTH AFFIRMATIVE DEFENSE TO COMPLAINT AND CAUSES THEREIN

61. Plaintiff's claims, in whole or in part, are barred by Piedmont's medical staff bylaws, credentialing policy, and/or Plaintiff's medical staff application.

SIXTH AFFIRMATIVE DEFENSE TO COMPLAINT AND CAUSES THEREIN

62. At all relevant times, Defendants acted in good faith and without malice, precluding Plaintiff's claims for relief.

SEVENTH AFFIRMATIVE DEFENSE TO COMPLAINT AND CAUSES THEREIN

63. Dr. Edwards would show that any allegedly defamatory statements made by Defendants are absolutely and/or conditionally privileged pursuant to federal and state law.

EIGHTH AFFIRMATIVE DEFENSE TO COMPLAINT AND CAUSES THEREIN

64. Plaintiff's claims, in whole or in part, are barred by the economic loss rule.

NINTH AFFIRMATIVE DEFENSE TO COMPLAINT AND CAUSES THEREIN

65. Plaintiff's claims, in whole or in part, are barred by the doctrine of consent.

TENTH AFFIRMATIVE DEFENSE TO COMPLAINT AND CAUSES THEREIN

66. Plaintiff's claims, in whole or in part, are barred by the doctrines of laches, estoppel, unclean hands, and/or waiver.

ELEVENTH AFFIRMATIVE DEFENSE TO COMPLAINT AND CAUSES THEREIN

67. To the extent that Plaintiff failed to mitigate his damages, if any, he is barred from relief.

TWELFTH AFFIRMATIVE DEFENSE TO COMPLAINT AND CAUSES THEREIN

68. Dr. Edwards would show that Plaintiff's alleged damages, if any, were proximately caused by the intervening and superceding acts or omissions of Plaintiff.

THIRTEENTH AFFIRMATIVE DEFENSE TO COMPLAINT AND CAUSES THEREIN

69. Plaintiff's claims and requests for relief, in whole or in part, are barred by the South Carolina common law doctrine of non-review enunciated in *Wood v. Hilton Head Hosp., Inc.*, 292 S.C. 403, 356 S.E.2d 841, 842 (1987) and *Gowan v. St Francis Cmty. Hosp.*, 275 S.C. 203, 268 S.E.2d 580 (1980), cert. denied, 449 U.S. 1062 (1980).

FOURTEENTH AFFIRMATIVE DEFENSE
TO COMPLAINT AND CAUSES THEREIN

70. Plaintiff's claim for punitive damages is barred by the due process clauses of the United States Constitution and the South Carolina Constitution.

FIFTEENTH AFFIRMATIVE DEFENSE
TO COMPLAINT AND CAUSES THEREIN

71. Plaintiff's civil conspiracy claim is barred by the intra-corporate immunity doctrine.

SIXTEENTH AFFIRMATIVE DEFENSE
TO COMPLAINT AND CAUSES THEREIN

72. Plaintiff's civil conspiracy claim fails because the acts for which relief is sought and the alleged damages are the same acts and damages alleged in other causes of action.

SEVENTEENTH AFFIRMATIVE DEFENSE
TO COMPLAINT AND CAUSES THEREIN

73. Plaintiff's defamation claim fails because the statements made and allegedly made regarding Plaintiff are true.

EIGHTEENTH AFFIRMATIVE DEFENSE
TO COMPLAINT AND CAUSES THEREIN

74. Dr. Edwards pleads all applicable statutes of limitations in defense and as a bar to the Plaintiff's claims.

NINETEENTH AFFIRMATIVE DEFENSE
TO COMPLAINT AND CAUSES THEREIN

75. Dr. Edwards hereby gives notice that it intends to rely upon any other defense that may become available or appear during the discovery proceedings in this case and hereby reserves its right to amend its Answer to assert any such defense.

WHEREFORE, having fully set forth the Answer to Plaintiff's Complaint, Dr. Edwards prays that this Court dismiss Plaintiff's claims with prejudice, and award Dr. Edwards its costs and attorneys' fees incurred in this action and such other relief as this Court determines appropriate.

NELSON MULLINS RILEY & SCARBOROUGH, LLP

By: _____

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Attorneys for Dr. Edwards

Columbia, South Carolina

3/22, 2012

CERTIFICATE OF SERVICE

I, the undersigned Administrative Assistant of the law offices of Nelson Mullins Riley & Scarborough LLP, attorneys for Defendants, do hereby certify that I have served all counsel in this action with a copy of the pleading(s) hereinbelow specified by mailing a copy of the same by United States Mail, postage prepaid, to the following address(es):

Pleadings:

ANSWER OF NATHANIEL EDWARDS, M.D.

Counsel Served:

James M. Griffin, Esq.
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Columbia, SC 29211

Jane Heinzelman
Administrative Assistant

March 23, 2012

STATE OF SOUTH CAROLINA COUNTY OF YORK	)	IN THE COURT OF COMMON PLEAS SIXTEENTH JUDICIAL CIRCUIT
Robert Randall, M.D., Plaintiff, v. Amisub of South Carolina, Inc. d/b/a Piedmont Medical Center, Nathaniel Edwards, M.D., and Richard Patterson, M.D., Defendants.	)	Civil Action No. 2012-CP-46-167 **ANSWER OF RICHARD PATTERSON, M.D.**

COMES NOW, Defendant Richard Patterson, M.D. answering Plaintiff's Complaint as follows:

FIRST DEFENSE TO COMPLAINT

1. Dr. Patterson is without knowledge or information sufficient to admit or deny the allegations in paragraph 1, and therefore denies same.

2. With respect to the allegations in paragraph 2, Dr. Patterson admits that Piedmont Medical Center is a corporation organized and existing under the laws of the State of South Carolina, located in York County, South Carolina. Dr. Patterson denies the remaining allegations in paragraph 2.

3. Dr. Patterson admits the allegations in paragraphs 3, 4, and 5.

4. With respect to the allegations in paragraph 6, Dr. Patterson admits that venue is proper in this Court, and Defendants are residents of York County. Dr. Patterson denies the remaining allegations in paragraph 6.

5. Dr. Patterson is without knowledge or information sufficient to admit or deny the allegations in paragraphs 7 and 8, and therefore denies same.

6. Dr. Patterson admits the allegations in paragraph 9.

7. With respect to the allegations in paragraph 10, Dr. Patterson admits that Dr. Randall has performed numerous open abdomen and laparoscopic surgeries while on staff at Piedmont. Dr. Patterson is without knowledge or information sufficient to admit or deny the remaining allegations in paragraph 10.

8. Dr. Patterson is without knowledge or information sufficient to admit or deny the allegations in paragraph 11, and therefore denies same.

9. With respect to the allegations in paragraph 12, Dr. Patterson admits that Dr. Randall and/or his practice became associated with an entity affiliated with Presbyterian Healthcare, but Dr. Patterson is without knowledge or information sufficient to admit or deny the other allegations regarding this association, and therefore denies same. Dr. Patterson denies the remaining allegations in paragraph 12.

10. Dr. Patterson denies the allegations in paragraph 13.

11. With respect to the allegations in paragraph 14, Dr. Patterson admits that Piedmont seeks a Certificate of Need to build a new hospital in Fort Mill, South Carolina. Dr. Patterson denies the remaining allegations in paragraph 14.

12. Dr. Patterson denies the allegations in paragraph 15.

13. Dr. Patterson is without knowledge or information sufficient to admit or deny the allegations in paragraph 16, and therefore denies same.

14. With respect to the allegations in paragraph 17, Dr. Patterson admits that Tenet Healthcare Corporation, Inc. and its affiliated hospitals are primarily "self-insured" as that term is generally understood. Dr. Patterson denies the remaining allegations in paragraph 17.

15. Dr. Patterson is without knowledge or information sufficient to admit or deny the allegations in paragraphs 18, 19, and 20, and therefore denies same.

16. Dr. Patterson denies the allegations in paragraph 21.

17. With respect to the allegations in paragraph 22, Dr. Patterson admits that as part of Dr. Randall's peer review, medical records were sent to external reviewers, including AllMed Healthcare Management, for review and analysis. Dr. Patterson denies the remaining allegations in paragraph 22.

18. With respect to the allegations of paragraph 23, Dr. Patterson admits that the Peer Review Committee engaged in a focused review of Dr. Randall's open hernia repairs and carotid surgical procedures because of concerns about Dr. Randall's patient care that arose from review of Dr. Randall's cases during his reappointment process, and Dr. Patterson further admits that this focused review was ultimately discontinued based upon the findings of the external reviews. Dr. Patterson denies the remaining allegations in paragraph 23.

19. With respect to the allegations in paragraph 24, Dr. Patterson admits that in May 2009 AllMed issued a report containing an external review of one of Dr. Randall's cases, and Dr. Patterson craves reference to this report for a complete statement of its findings and contents, and denies all allegations inconsistent therewith. Dr. Patterson denies the remaining allegations in paragraph 24.

20. With respect to the allegations in paragraphs 25 and 26, Dr. Patterson admits that as part of Dr. Randall's peer review, medical records were sent to external reviewers,

including Advanced Medical Review, for review and analysis. Dr. Patterson denies the remaining allegations in paragraphs 25 and 26.

21. With respect to the allegations in paragraph 27, Dr. Patterson admits that Advanced Medical Review produced reports containing external reviews of Dr. Randall's cases, and Dr. Patterson craves reference to these reports for complete statements of their findings and contents, and denies all allegations inconsistent therewith. Dr. Patterson denies the remaining allegations in paragraph 27.

22. Dr. Patterson denies the allegations in paragraph 28.

23. With respect to the allegations in paragraph 29, Dr. Patterson admits that the Peer Review Committee referred Dr. Randall's cases under review to the Credentials Committee for consideration pertaining to Dr. Randall's reappointment. Dr. Patterson denies the remaining allegations in paragraph 29.

24. With respect to the allegations in paragraph 30, Dr. Patterson admits that Dr. Randall appeared before the Credentials Committee to discuss the care he provided in the cases under review, and Dr. Patterson further admits that the Credentials Committee recommended that Dr. Randall be reappointed to the Medical Staff for one year with certain conditions. Dr. Patterson denies the remaining allegations in paragraph 30.

25. Dr. Patterson is without knowledge or information sufficient to admit or deny the allegations in paragraph 31, and therefore denies same.

26. Dr. Patterson admits the allegations in paragraph 32.

27. With respect to the allegations in paragraph 33, Dr. Patterson admits that the Medical Executive Committee ("MEC") appointed an ad hoc committee comprised of members of the MEC, Peer Review Committee, and Credentials Committee to review this matter further

and make a recommendation to the MEC. Dr. Patterson denies the remaining allegations in Paragraph 33.

28. Dr. Patterson admits the allegations in paragraphs 34 and 35.

29. With respect to the allegations in paragraph 36, Dr. Patterson admits that Dr. Randall attempted to have his legal counsel participate in the meeting with the Ad Hoc Committee in violation of the Medical Staff Bylaws. Dr. Patterson denies the remaining allegations in paragraph 36.

30. Dr. Patterson admits the allegations in paragraph 37.

31. With respect to the allegations in paragraph 38, Dr. Patterson admits that the MEC considered, *inter alia*, two additional cases which had been externally reviewed and that the MEC agreed with the ad hoc committee's recommendation. Dr. Patterson denies the remaining allegations in paragraph 38.

32. With respect to the allegations in paragraph 39, Dr. Patterson admits that the MEC reviewed and considered comparative data regarding returns to the operating room within thirty days of the first operation, and Dr. Patterson craves reference to that data for a complete statement of its contents and denies all allegations inconsistent therewith. Dr. Patterson denies the remaining allegations in paragraph 39.

33. With respect to the allegations in paragraph 40, Dr. Patterson admits that Dr. Randall was provided notice, via letter dated October 15, 2010, that the MEC recommended that certain of his surgical privileges be revoked. Dr. Patterson denies the remaining allegations in paragraph 40.

34. Dr. Patterson denies the allegations in paragraph 41.

35. With respect to the allegations in paragraph 42, Dr. Patterson admits that Dr. Randall's privileges to perform abdominal surgery including herniorrhaphy, whether by open or laparoscopic technique were suspended by the Chief of Staff and notice of this suspension was provided via letter dated October 15, 2010. Dr. Patterson denies the remaining allegations in paragraph 42.

36. With respect to the allegations in paragraphs 43 and 44, Dr. Patterson admits that Dr. Randall's suspension was reported to the South Carolina Board of Medical Examiners. Dr. Patterson denies the remaining allegations in paragraphs 43 and 44.

37. With respect to the allegations in paragraph 45, Dr. Patterson admits that on October 25, 2010, Dr. Randall met with the MEC regarding his suspension, and Dr. Randall attempted to have legal counsel participate in the meeting in violation of the Medical Staff Bylaws. Dr. Patterson denies the remaining allegations in paragraph 45.

38. With respect to the allegations in paragraph 46, Dr. Patterson admits that the MEC voted to sustain Dr. Randall's suspension and provided him notice of this decision via letter dated October 28, 2010. Dr. Patterson denies the remaining allegations in paragraph 46.

39. Dr. Patterson admits the allegations in paragraph 47.

40. Dr. Patterson denies the allegations in paragraph 48.

41. With respect to the allegations in paragraph 49, Dr. Patterson admits that Dr. Randall received notice, via a letter dated November 4, 2010, that his peer review hearing was scheduled for January 12, and subsequently the hearing was rescheduled to January 5-6. Dr. Patterson denies the remaining allegations in paragraph 49.

42. With respect to the allegations in paragraph 50, Dr. Patterson admits that the MEC submitted a written request for postponement of the hearing on January 3, 2011, and Dr.

Patterson craves reference to that written request for a complete statement of its contents and denies all allegations inconsistent therewith. Dr. Patterson denies the remaining allegations in paragraph 50.

43. With respect to the allegations in paragraph 51, Dr. Patterson admits that the MEC submitted a second written request for postponement of the hearing on January 5, 2011, that informed Dr. Randall that the MEC's expert witness was no longer available to testify, and Dr. Patterson craves reference to that written request for a complete statement of its contents and denies all allegations inconsistent therewith. Dr. Patterson denies the remaining allegations in paragraph 51.

44. Dr. Patterson admits the allegations in paragraph 52.

45. With respect to the allegations in paragraph 53, Dr. Patterson admits that Dr. Randall's hearing was rescheduled for February 16-17, 2011, and Dr. Patterson further admits that the Hearing Committee was comprised of an orthopedic surgeon, an oral surgeon, a pathologist, two oncologists, and an anesthesiologist and there was not a general surgeon on the Hearing Committee. Dr. Patterson denies the remaining allegations in paragraph 53.

46. With respect to the allegations in paragraph 54, Dr. Patterson admits that Dr. Randall objected and requested that a general surgeon be included as a member of the Hearing Committee. Dr. Patterson denies the remaining allegations of paragraph 54.

47. Dr. Patterson denies the allegations in paragraphs 55 and 56.

48. With respect to the allegations in paragraph 57, Dr. Patterson admits that Dr. Tribble is a general surgeon who testified before the Hearing Committee, and Dr. Patterson craves reference to the hearing transcript regarding the contents of his testimony and denies the

allegations inconsistent therewith. Dr. Patterson denies the remaining allegations in paragraph 57.

49. With respect to the allegations in paragraph 58, Dr. Patterson admits that the Hearing Committee upheld the MEC's recommendation and craves reference to the Hearing Committee's report for a complete statement of its contents and denies all allegations inconsistent therewith. Dr. Patterson denies the remaining allegations in paragraph 58.

50. With respect to the allegations in paragraph 59, Dr. Patterson craves reference to the Hearing Committee's report for a complete statement of its contents and denies all allegations inconsistent therewith. Dr. Patterson denies the remaining allegations in paragraph 59.

51. Dr. Patterson denies the allegations in paragraph 60.

52. Dr. Patterson denies every allegation in the Complaint not specifically admitted by Dr. Patterson.

FIRST DEFENSE TO FIRST CAUSE OF ACTION

53. With respect to the allegations in paragraph 61, Dr. Patterson incorporates by reference herein all of the responses to the allegations in paragraphs 1 through 60.

54. Dr. Patterson denies the allegations in paragraphs 62, 63, 64, and 65.

FIRST DEFENSE TO SECOND CAUSE OF ACTION

55. With respect to the allegations in paragraph 66, Dr. Patterson incorporates by reference herein all of the responses to the allegations in paragraphs 1 through 65.

56. Dr. Patterson denies the allegations in paragraphs 67, 68, 69, 70, 71, 72, 73, 74, and 75.

57. To the extent that the "Wherefore" clause contains factual allegations to which a response is required, the allegations are denied, and Dr. Patterson specifically denies that Plaintiff is entitled to any of the relief requested in the Complaint.

FIRST AFFIRMATIVE DEFENSE
TO COMPLAINT AND CAUSES THEREIN

58. Plaintiff's Complaint fails, in whole or in part, to state a claim for which relief may be granted and should therefore be dismissed.

SECOND AFFIRMATIVE DEFENSE
TO COMPLAINT AND CAUSES THEREIN

59. Plaintiff's claims are barred, in whole or in part, by the immunity provisions of the Health Care Quality Improvement Act, 42 U.S.C. § 11101 *et seq.*, and pursuant to § 11113 of this Act, Dr. Patterson is entitled to an award of attorneys' fees.

THIRD AFFIRMATIVE DEFENSE
TO COMPLAINT AND CAUSES THEREIN

60. Plaintiff's claims are barred, in whole or in part, by the immunity provisions of S.C. Code Ann. § 40-71-10.

FOURTH AFFIRMATIVE DEFENSE
TO COMPLAINT AND CAUSES THEREIN

61. Plaintiff's claims, in whole or in part, are barred by state and federal law providing immunity for reports to the South Carolina Board of Medical Examiners and/or National Practitioner Databank.

FIFTH AFFIRMATIVE DEFENSE
TO COMPLAINT AND CAUSES THEREIN

62. Plaintiff's claims, in whole or in part, are barred by Piedmont's medical staff bylaws, credentialing policy, and/or Plaintiff's medical staff application.

SIXTH AFFIRMATIVE DEFENSE TO COMPLAINT AND CAUSES THEREIN

63. At all relevant times, Defendants acted in good faith and without malice, precluding Plaintiff's claims for relief.

SEVENTH AFFIRMATIVE DEFENSE TO COMPLAINT AND CAUSES THEREIN

64. Dr. Patterson would show that any allegedly defamatory statements made by Defendants are absolutely and/or conditionally privileged pursuant to federal and state law.

EIGHTH AFFIRMATIVE DEFENSE TO COMPLAINT AND CAUSES THEREIN

65. Plaintiff's claims, in whole or in part, are barred by the economic loss rule.

NINTH AFFIRMATIVE DEFENSE TO COMPLAINT AND CAUSES THEREIN

66. Plaintiff's claims, in whole or in part, are barred by the doctrine of consent.

TENTH AFFIRMATIVE DEFENSE TO COMPLAINT AND CAUSES THEREIN

67. Plaintiff's claims, in whole or in part, are barred by the doctrines of laches, estoppel, unclean hands, and/or waiver.

ELEVENTH AFFIRMATIVE DEFENSE TO COMPLAINT AND CAUSES THEREIN

68. To the extent that Plaintiff failed to mitigate his damages, if any, he is barred from relief.

TWELFTH AFFIRMATIVE DEFENSE TO COMPLAINT AND CAUSES THEREIN

69. Dr. Patterson would show that Plaintiff's alleged damages, if any, were proximately caused by the intervening and superceding acts or omissions of Plaintiff.

THIRTEENTH AFFIRMATIVE DEFENSE
TO COMPLAINT AND CAUSES THEREIN

70. Plaintiff's claims and requests for relief, in whole or in part, are barred by the South Carolina common law doctrine of non-review enunciated in *Wood v. Hilton Head Hosp., Inc.*, 292 S.C. 403, 356 S.E.2d 841, 842 (1987) and *Gowan v. St Francis Cmty. Hosp.*, 275 S.C. 203, 268 S.E.2d 580 (1980), cert. denied, 449 U.S. 1062 (1980).

FOURTEENTH AFFIRMATIVE DEFENSE
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71. Plaintiff's claim for punitive damages is barred by the due process clauses of the United States Constitution and the South Carolina Constitution.

FIFTEENTH AFFIRMATIVE DEFENSE
TO COMPLAINT AND CAUSES THEREIN

72. Plaintiff's civil conspiracy claim is barred by the intra-corporate immunity doctrine.

SIXTEENTH AFFIRMATIVE DEFENSE
TO COMPLAINT AND CAUSES THEREIN

73. Plaintiff's civil conspiracy claim fails because the acts for which relief is sought and the alleged damages are the same acts and damages alleged in other causes of action.

SEVENTEENTH AFFIRMATIVE DEFENSE
TO COMPLAINT AND CAUSES THEREIN

74. Plaintiff's defamation claim fails because the statements made and allegedly made regarding Plaintiff are true.

EIGHTEENTH AFFIRMATIVE DEFENSE
TO COMPLAINT AND CAUSES THEREIN

75. Dr. Patterson pleads all applicable statutes of limitations in defense and as a bar to the Plaintiff's claims.

NINETEENTH AFFIRMATIVE DEFENSE TO COMPLAINT AND CAUSES THEREIN

76. Dr. Patterson hereby gives notice that it intends to rely upon any other defense that may become available or appear during the discovery proceedings in this case and hereby reserves its right to amend its Answer to assert any such defense.

WHEREFORE, having fully set forth the Answer to Plaintiff's Complaint, Dr. Patterson prays that this Court dismiss Plaintiff's claims with prejudice, and award Dr. Patterson its costs and attorneys' fees incurred in this action and such other relief as this Court determines appropriate.

NELSON MULLINS RILEY & SCARBOROUGH, LLP

By: _____

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1320 Main Street / 17th Floor
Post Office Box 11070 (29211-1070)
Columbia, SC 29201

Attorneys for Dr. Patterson

Columbia, SC
3/22, 2012

CERTIFICATE OF SERVICE

I, the undersigned Administrative Assistant of the law offices of Nelson Mullins Riley & Scarborough LLP, attorneys for Defendants, do hereby certify that I have served all counsel in this action with a copy of the pleading(s) hereinbelow specified by mailing a copy of the same by United States Mail, postage prepaid, to the following address(es):

Pleadings:

ANSWER OF RICHARD PATTERSON, M.D.

Counsel Served:

James M. Griffin, Esq.
Lewis, Babcock & Griffin L.L.P.
1513 Hampton Street (29201)
P.O. Box 11208
Columbia, SC 29211

Jane Heinzelman
Jane Heinzelman
Administrative Assistant

March 23, 2012

State of South Carolina.,	)	In the Court of
	)	Common Pleas
	)	
County of York.	)	Case No.: 2012-CP-46-00167
Robert Randall, M.D.,	)	
	)	
Plaintiff.,	)	
	)	
-vs-	)	Transcript of Record
	)	
Amisub of South Carolina., d/b/a Piedmont Medical Center, Nathaniel Edwards, M.D., and Richard Patterson, M.D.	)	
	)	
Defendants.	)	

March 3, 2014
York, South Carolina

B E F O R E:

The Honorable Ernest Kinard, Judge.

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

Mr. James M. Griffith
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For the Defendants

I-N-D-E-X

E-X-A-M-I-N-A-T-I-O-N

WITNESS	BY:	PAGE NO.

No Witnesses were called.

I-N-D-E-X - CON'T

E-X-H-I-B-I-T-S

NO.	DESCRIPTION	ID.	EVD.

No Exhibits were received into the record.

(COURT IN SESSION AT 09:40 A.M..)

THE COURT: All right. Okay, have at it.

MR. DAYHUFF: Good morning, Judge Kinard. My name is Travis Dayhuff I am representing the defendants. I'm here with Susan Nelson my associate from Nelson Mullins. We've got Monte Todd who represents one of the individual defendants.

The Defendants in this case are Amisub of South Carolina, Inc., that's Piedmont Medical Center in Rock Hill, a full service acute care hospital.

Then we have two individually named defendants. Doctor Patterson and Doctor Edwards. Doctor Edwards is the former Chief of Staff at Piedmont and Doctor Patterson was the former Chief Medical Officer.

With this motion the Defendants - all the defendants - seek summary judgment on all the claims in this case and all the request for damages in this case. This motion while it is a Rule 56 Motion for Summary Judgment, is based primarily upon the application of a federal statute to the facts in this case, and that federal statute is called the Health Care Quality Improvement Act, a statute passed in 1986.

Since this is primarily about applying that statute to the facts I'm gonna start with the facts. This --

THE COURT: Are you prepared - take as long as you

want - but I mean I have read everything twice so I am conversed on it. But go ahead.

MR. DAYHUFF: Excellent. Well I can hit anything you would like me to hit. I'll start with some of the facts and if you have questions about any of the elements of what you're read I'd be glad to address those.

If you read everything then you know this came out of a peer review action at our hospital. Peer review actions happen in all the hospitals in the state and across the nation and peer review actions are essentially physicians reviewing each other's cases and deciding whether the reviewed physician needs to keep all his privileges, some of his privileges, do something to improve his care. That's where this arises from.

And at Piedmont Medical Center about two years ago Doctor Randall's cases - Doctor Randall's patients were all too often suffering things like perforated organs. They were suffering excessive bleeding. They were suffering infections. They were even suffering from sepsis. These problems then caused these patients to have to go back for more surgery, to go back for surgery for problems they didn't have when they came to see Doctor Randall in the first place.

Some of these patients had long stays in the ICU and some of these patients unfortunately died. Those cases -

that care required the peer reviewer's to investigate and they did investigate. They began the peer review process. The peer review process and I'll summarize it for you - -

THE COURT: Their whole problem basically is not peer review but they had some peer review and then whamo there was a ad hac action and that's what he's gonna tell me.

MR. DAYHOFF: Right. They have problems with parts of the peer review, you're absolutely right.

THE COURT: And then after somebody lost some blood ---

MR. DAYHOFF: Right.

THE COURT: --- they say Doctor over reacted. But go ahead.

MR. DAYHUFF: Absolutely. There are - I would say there are eight cases that form the heart of the peer review and those were reviewed by a peer review committee, a credentials committee, an ad hoc committee which consisted of members of the peer review credentials, the MEC, everybody who dealt with this case. And then the MEC which is the head committee, the leadership committee of the staff they reviewed eight cases. Those cases had complications that I mentioned to you before.

They decided after reviewing those cases that there needed to be a restriction placed on privileges. They found that after reviewing those cases that the care was

substandard. There were problems with technique, there was problems with judgment, and maybe perhaps importantly - most importantly - Doctor Randall didn't seem to appreciate that he had these issues which caused great concern.

Now, the case you mentioned, the case that created the suspension is one that they focused on and spent a lot of time on. After those other eight cases came in, a final case came in. A lady had a gall bladder problem so Doctor Randall removed the gall bladder laproscopically, had a lot of problems wiht the laproscopic surgery. Removed the gall bladder, she went into intensive care and bled and bled for days and days. Had a blood loss amounting to eleven units of blood which is about the blood you have in the human body.

That patient came to the notice of the Chief of the medical staff Doctor Edwards, one of our defendants, through a family complaint. The husband complained about the care that his wife had received.

Doctor Edwards as the Chief of Staff has the authority to impose a summary suspension which they don't particularly appreciate or like. He looked at the case considered the case and felt like that case plus all the others they had reviewed made him believe that he had to act now to take the privileges away and not allow the peer review process to go forward with him having privileges so

he did that. A day or two days after he took Doctor Randall's abdominal surgery privileges - and he didn't take all his privileges just abdominal surgery - the entire MEC reviewed the case. All those folks who had been reviewing the case before. And they have the power to revoke that suspension, affirm it, or modify it. So everyone got a chance to analyze that case on the MEC and they said we're gonna keep that suspension in place during the pendency of this matter while we have this hearing to ensure that patient's aren't subjected to an unnecessary risk of imminent harm. So that's the suspension.

Now I want to mention this to you. At the same time the peer reviewers of Piedmont were reviewing these cases in 2009, 2010, we learned through discovery, Doctor Randall's practice, a practice owned by Novant which is Presbyterian Hospital, his practice was reviewing his cases. His practice had become very concerned about the bad outcomes they were hearing about. So they started doing interviews and we got the notes of those interviews through discovery.

They interviewed all his partners, the people that work with him and know him the best. Those partners - and the memo is attached to the memo for Summary Judgment and you've probably seen it - list problems with some of the same cases that we have in our case. List problems with

rough handling of tissue, perforations. His partners - Importantly his partners won't cover for him any more. They tell the practice leaders at Novant we won't cover for him any more. One doctor, Doctor Novell, says if Randall doesn't leave the practice he'll leave the practice. So that's how serious it had become in his practice.

Now we didn't know anything about that. At Piedmont our peer reviewers didn't know anything about it. We were dealing with some of the same cases. But I mention that to you because the notion that the peer reviewers were off the markers in respect to the medicine seems to me to be ---- by the fact that his practice is investigating the same things.

So I mention one other thing to you. A lot of the cases that are subject to the peer review become the subject of medical malpractice cases.

Now that was the assigned Presbyterian. So our peer reviewers have to decide what to do and I mentioned they recommend - the MEC first recommends revocation of his abdominal surgery privileges. Not all his privileges. So he has the other elements of his privileges left.

The case comes in with a lady who languished in the ICU. They suspend the abdominal surgery privileges and that then triggers the process part of the peer - the internal hearing that you read about. And the Health Care

and Quality Improvement Act is all about whether that internal hearing meets certain rules, certain standards. And that's what I want to talk to you about a little bit now the hearing.

There was a two day evidentiary hearing. A panel of five or more physicians sit in judgment of this entire case. They focused on the eight cases, there are probably ten total, eight are the focus. There is a hearing officer, Daws Cook is appointed the hearing officer to make things - to make sure things progress appropriately. Doctor Randall had representation of counsel. Jaye McKay was his attorney at the peer review hearing. Both the MEC and Doctor Randall were allowed to call the witnesses they wanted, cross examine witnesses, offer evidence, documentary evidence and both offered an expert General Surgeon who testified. And I want to mention the eight cases that were reviewed by the hearing committee briefly.

The first case dealt with diverticulitis. There was surgery that resulted in a non viable colostomy. That non-viable colostomy resulted in escemia and necrosis of the bowel. That was case one.

Case two: There was a lapcolia bowel perforation, sepsis, death. Case Three: Partial bowel obstruction. The bowel was cut out. There was eschemia loss of blood flow. A break down of the reconnection the bowel, sepsis

and short bowel syndrome. Case two. That was actually case three.

Case Four: Lapcoly. Colon puncture.

Case Five: Hernia surgery. Placed a feeding tube, not placed correctly. The patient had infection then sepsis.

Case Six: A hernia repair where there was a perforation of the bowel.

Case Seven: An appendectomy that resulted in the death of a thirty-four year old.

And the last case I mention to you, a lapcoly bleeding hematoma, sepsis and then eleven units of blood.

Those are the cases they looked at. The hearing panel found unanimously that Doctor Randall wasn't providing quality care to those patients. They found unanimously that the MEC's recommendation of suspension and revocation of abdominal surgery privileges was appropriate.

After the hearing panel - this goes through an appellate process - Doctor Randall appealed. A subcommittee of the Board sat and heard oral argument from his attorney and from the MEC's attorney, accepted briefs, and then after that a Board hearing. All of the board members, all of the physicians, supported the MEC's initial recommendation.

Now, --

THE COURT: He complained that you didn't have a general surgeon?

MR. DAYHOFF: He did. He did. And I can address --

THE COURT: I'm only mentioning that. I can say I read it.

MR. DAYHOFF: You have proven it.

THE COURT: I have to throw things out there.

MR. DAYHOFF: Yes. You have absolutely proven it, cause that's a detail that they certainly - they said put - we want a panel of five general surgeons to review our care.

Well the problem with that from the perspective of the hospital was the bylaws - the medical staff bylaws say you can't have a partner or a competitor so that pretty much ruled out everybody at Piedmont. Now that's not uncommon for hospitals not to allow competitors and partners on a hearing council. So the remedy for that is you call an expert surgeon and they did, Doctor Tribber. We called and expert surgeon Doctor Scudder I believe is his name.

So that panel had the benefit of hearing from expert surgeons. I also mention this. On that panel sat a pathologist who while is not a general surgeon certainly sees the result of the surgery. Had an orthopedic surgeon on the panel. An anesthesiologist. So there was some surgical expertise on that panel.

Now Doctor Randall alleges that that peer review process that I've summarized for you - and I can go back to any elements of it you have questions about - that peer review process that stretched over two years, twenty physicians looking at his cases, six board members looking at his cases, that it was a conspiracy; that it was a fraud and it was not done in good faith.

Now Doctor Randall is not the first physician to sue over loss of privileges. And in fact it was a national problem, doctor's suing over privileges. That's why we have the Health Care Quality Improvement Act in 1986.

What was happening before 1986, peer review was the ultimate no good deed goes unpunished type job. Hospitals, chief's of staff who try to get their physicians to do peer review, the physicians would say so you want me to go review my friend's cases and then after I review them and if I restrict his or her privileges they're gonna sue me. There wasn't much peer review being done in hospitals. So what was happening instead would be a bad doctor --

THE COURT: Well that's not really so because - Well one, in private practice we represented hospitals. I would say I probably heard more malpractice suits than anybody. One, cause I been doing it twenty-six years. Two, been Chief Judge. Three, I took 'em cause other judges didn't' like being imposed on by handling them but the motions that

I have heard I say sixty percent of the motions that I have heard involving hospitals and doctors involve peer review process. People wanting access to it. Peer review people not wanting to give anybody anything and Monte's been there standing there saying they can't see it it's peer review its protected.

MR. TODD: Right.

THE COURT: You know, he killed three people but we aren't gonna let anybody see it. So I mean I heard those and heard those and heard those so I mean peer review did go on. Wasn't necessarily after the '86 Act improvement. But go ahead.

MR. DAYHOFF: And I'm sure that there was peer review before '86 and I would hope there was peer review before '86. I think - I think - I've represented hospitals for a while and they'll tell me stories about what was going on in the days past. And they tell me that sometimes hospitals and sometimes doctors they wouldn't do the peer review, instead just push that physician on down the road. You know Doctor Smith, you've had some bad results we can do some peer review or me might have to report it well maybe you can just go on down the road find another place to work. So the physicians who were not exercising the appropriate care, weren't getting retrained and they were just pushed on down the road to the next hospital to the

next set of patients with no reporting. So that was the problem that Congress tried to address with peer review.

So what do they do? They do two things. They pass this statute and this statute says peer reviewers get damages immunity if you need forced damages and forced damages are pretty straight forward. Did we undertake this peer review in the reasonable furtherance of quality health care? Did the peer reviewers do a reasonable job of investigating the facts? Prong three of standard three, did the peer review process provide the reviewed physician certain protections? It's not due process per se since it's a private hospital but their process points. Was there a hearing? Was there counsel? That type thing. Was there adequate notice?

And then four, after you do all that processes the ultimate decision, one that's reasonable. Now reasonable and reasonableness permeates all those standards. And it's not a particularly rigorous concept of reasonableness that's applied and that's because there needs to be peer view incentives. That's the idea that Congress had when they passed that statute.

Now the standards are also written that way to avoid re-litigating peer review matters in court. We've had a hearing, we've had a two day hearing where all these medical professionals sat and opined on the care. So the

idea is sk them something unusual - and I'll tell you there's something unusual here - you don't re-litigate a peer review matter in court. You litigate malpractice cases in court not peer review actions in court. If those standards are met - those four standards I mentioned - there's no damages which essentially ends these cases. Now Congress didn't stop there though. They also granted a statutory presumption to the peer reviewers in the hospital and that those standards have been met, which creates the very unusual summary judgment standard that you have applied, Your Honor, and that is this.

You ask the question could a reasonable jury viewing the facts in the most favorable light to plaintiff, could a reasonable jury conclude that Doctor Randall has shown by a preponderance of the evidence that his peer review action fell outside those four prongs. That is a strong verdict that is granted in the favor of the peer reviewers. And it's unusual. It requires you to weigh evidence in the summary judgment stage.

With all due respect to Mr. Griffith its not a scintilla of evidence. It's not a genuine issue of material fact any more. The Court looks at the evidence the peer reviewers bring and the presumption that those standards have been met and look to see if Doctor Randall has overcome any of those five, preponderance of the

evidence.

Now the result of those standards in that presumption particularly in Federal Court where these things are tried most of the time. They are not tried when the motions hearings happen. Physicians don't survive summary judgment very often. And in fact there is not a recorded case in the Fourth Circuit where the Fourth Circuit Court of Appeals has allowed one of these to go forward.

Now this is a matter at least in my understanding of a first impression for South Carolina. There is not an Appellate Court case, Supreme Court, Court of Appeals analyzing the Heath Care Quality Improvement Act so this would be the first one. So applying the HICWA standards to this case I mention Standard One was the peer review action undertaking in the reasonableness furtherance of quality health care. That's an objective standard, bad faith doesn't matter there is no bad faith in this case I would argue but it doesn't matter. The question is whether it was reasonable considering the facts and circumstances of the cases that were reviewed.

Doctor Randall's - I'm gonna move quickly through this one because Doctor Randall doesn't contest --

THE COURT: Well Randall's deposition he basically admitted there was no bad faith on the part --

MR. DAYHOFF: He did except for Doctor Edwards ---

THE COURT: And Patterson.

MR. DAYHOFF: --- and Patterson. You're right. But I think that's key. Bad faith doesn't matter anyway in Health Care Quality Improvement Act even if Doctor Edwards or Doctor Patterson were bad actors - and I would suggest to you there is no evidence that there are - it doesn't matter because these guys didn't make the ultimate decision. Doctor Edwards suspended him. But then that whole MEC, this group, Doctor Randall says acted in good faith. I give him credit for that. They affirmed it. The hearing panel, this group that Doctor Randall says acted in good faith heard the whole case. Doctor Patterson and Edwards are out of it. Then comes the Board.

But to short cut Standard One, Doctor Randall concedes that Standard One was met; that the peer reviewers had a reasonable belief that they need to take some action. Doctor Randall concedes Number Two that's the investigation. They don't allege that our investigation is shotty that we didn't thoroughly look at the cases or take our time. They do challenge us on Standard Three so I'll spend a little time on Standard Three.

Standard Three is whether we provided Doctor Randall adequate notice in hearing procedures. They don't contest the notice but they contest the hearing procedures. I'll tell you what they said. They say we violated three, four

- three or four reasons. One, we didn't provide a hearing before he was suspended and I'll address that first.

That's not the way the Health Care Quality Improvement Act works I think is the first or the medical staff bylaws. There are occasions when you may impose the restriction of privileges before the hearing. And one of those occasions is when the peer reviewers believe imminent harm will result if you don't. That's exactly what Doctor Edwards believed and that's exactly what the MEC affirmed. So there is no right under HCQIA Standard Three for a resuspension hearing. And let me mention this also. HICWA Standard Three is a little different, it creates a safe harbor. If you do the things in HCQIA standard Three that presumption of compliance that we talked about becomes a finding of compliance. That presumption of compliance that we talked about becomes a finding of compliance.

They say that they should have had a hearing before ninety days. The medical staff bylaws say you should have a hearing within ninety days unless there's good cause to extend it. Doctor Randall's attorney consented to a continuance until January 5th based on the convenience of the parties and he testified that he wanted to prepare all these cases. The hearing happened February 17th. Doctor Randall' counsel did not consent to the continuance the 17th. The MEC's counsel at the time petitioned Daws Cook

and the hearing panel and said we have good cause, our expert can't come, he won't come. The hearing panel overruled their objection and they went ahead with the hearing.

The key is, there's nothing in HCQIA Standard Three that says you get a hearing within ninety days. So it's not a problem under our bylaws its not a problem under HCQIA Standard Three.

The last element - Got one more element. He wasn't allowed to have an attorney present at MEC. Doctor Randall appeared before the credentials committee, he appeared before the Ad Hoc Committee I believe and the MEC. Those are hearings, those are hearings, those are meetings where they're deciding what to do. Doctor Randall attempted to bring an attorney with him, he was told look the bylaws don't provide for an attorney here, you're allowed to have an attorney at the hearing, and so Jay McKay left.

There is nothing in HCQIA Standard Three that says you get an attorney at a meeting. It says you get an attorney at the hearing and that's what they got.

The last thing I mention is the one you've already alluded to. The idea that he didn't have a general surgeon sitting on this panel. HCQIA Standard Three doesn't provide for surgeons that practitioners of the same speciality sitting on the panel. In fact HCQIA Standard

Three says if you have economic competitors - general surgeons from the area - sitting on that hearing panel you would loose your HCQIA immunity on Standard Three.

So to summarize, we satisfy that safe harbor. They have no evidence otherwise. Standard Four they do contest. I'm not exactly sure how they contest it so I'll leave that to Jim to offer some comments on that. But the Standard Four is pretty - it gives a lot of discretion to the peer reviewers. The case law said essentially to not comply with Standard Four, the court would have to find that the peer review action with a decision to remove abdominal surgery privileges was obviously mistaken that's the standard that applies.

I suggest to you that the evidence that we've provided in the memos, meeting minutes, and the hearing panel's report, it's not obviously mistaken to do what they did so it was the right decision.

Now so what - If we satisfy HCQIA then I suggest we do what happens? I would suggest to you that the causes of action are over. Conspiracy cause of action and defamation where they ask for damages. If you don't have the ability to get damages I think those causes of action are done. I will say this though. We have alternative basis for summary judgment to causes of action straight Rule 56 analysis that Your Honor is familiar with. Conspiracy: We

say a couple of things about conspiracy. Our primary defense is there aren't multiple parties who conspired here. When physicians do peer review, they're acting as agents of the hospital.

Doctor Edwards, Doctor Patterson, the Hospital, can't be conspirators when they are acting within the scope of their duties performing peer review. Now Mr. Griffin I'm sure will say something about the personal stake exception and that is an exception to the intercorporate immunity that I'm talking about. There is no evidence to support a personal stake exception. The evidence they would have to bring forward is evidence that Doctor Edwards or Doctor Patterson had some financial benefit to gain by bouncing Doctor Randall out of the practice of abdominal surgery. There is no evidence of that.

Defamation: Our defense of defamation is what we said about him is true. They allege that we had to report to something called National Practitioner's Data Bank which is part of the Health Care Quality Improvement Act. We sent in a report that said, on this date we suspended you, with some other language. I went through that whole report with Doctor Randall. He conceded every element of that was true. The truth is a defense of defamation.

So I think those substantive causes of action go away by the damages immunity of HCQIA. But if they don't, I

think their alternative grounds, traditional grounds, we're all familiar with whereby these causes of action would succeed. Now - -

THE COURT: Defamation obviously disappears from me anyway. They had to report it. He admitted everything was factual they reported and they say something about defamation by inference or whatever and they just reported what happened to get that. Defamation is gone. No need for him to spend a lot of time on it when you argue it, but you can.

MR. DAYHOFF: Okay.

THE COURT: Now I - On the agency cannot conspire they can. Depends on the facts. I'm not ruling on that. I'm not gonna ---

MR. DAYHOFF: I understand.

THE COURT: --- accept that cartblanc.

MR. DAYHOFF: I agree. I agree. I think you're right. If an agent is acting outside of the scope ---

THE COURT: That's right.

MR. DAYHOFF: --- and doing something bad you're right. And all I'm suggesting is there is no evidence of that. I'd like to hear from Jim, if he's got anything.

THE COURT: All right.

MR. DAYHOFF: But you're right, if he does that's not a ground that works. But the Health Care Quality

Improvement Act I would say eliminates that anyway.

Now, Your Honor, I've gone through I hope in summary fashion the arguments I have on both the HCQIA and on the substantive causes of action. I'll be glad to answer any questions you have or certainly I can wait and respond maybe to what ---

THE COURT: Let's see what Mr. Griffith has to say.

MR. GRIFFITH: Good morning, Judge Kinard.

THE COURT: All right.

MR. GRIFFITH: The - We are here on a Rule 56 Motion for Summary Judgment. I won't repeat the standard but it is - We do get the presumption of evidence that is viewed in the light most favorable to the non moving party. And under the HCQIA immunity we do bear the burden of showing the Court there is a factual question viewing the evidence in the light most favorable to us as to whether that immunity applies.

I don't think there is really any factual issues on one significant point that - that establishes the HCQIA immunity does not apply and it is in order for HCQIA immunity to apply the professional review action must have been taken after adequate notice and hearing procedures are afforded.

Now what our pressful complaint is, is the fact that on October the 15th, 2010 Doctor Edwards after meeting with

Doctor Patterson took it upon himself to summarily suspend Doctor Randall's portion of his surgical privileges. He takes that action when the MEC, just two days or three days later voted that Doctor Randall although they recommended that those privileges be suspended that he have the right to continue practicing surgery in the hospital while he appealed the decision to the - to a hearing panel which they anticipated would be comprised of at least one general surgeon which they had here before been asking for one. And that - And so the MEC on October the 10th, 2010 after reviewing all of these cases except for one - this JR - stated that privileges will not be restricted during the thirty days he can request a hearing. That's October 10th. October 15th just a few days later Doctor Edwards issues this summary suspension letter saying your suspended based upon - And the letter is somewhat generic but based upon my determination that your continued practice here is imminent danger to patients. That was done without notice, that was done without a hearing, and we believe, Your Honor, that there is a factual question whether that was done in reasonable belief based upon the facts known.

And Doctor Edwards in his deposition testified he didn't pull a chart, he didn't talk to the intensivist or the hospitalist or any other physician who was seeing that patient, patient JR. Doctor Edwards admitted though that

he knew that that patient JR was discharged in July of 2010 months earlier with no adverse complications. Yet he takes it upon himself on October the 15th to without notice and opportunity for a hearing provided that Doctor Randall - to summarily suspend Doctor Randall.

It wasn't a limited duration. The letter says that you are suspended. You have a right to request a hearing - a review by the MEC but it was - if Doctor Randall had not requested a review then the suspension would have continued indefinitely. And the reason I point that out is HCQIA immunity in the HCAIA statute does have an exception for imminent danger situations where no hearing is required and it's dealt with on Page 12 of my brief and you have to hit all the points and there are a couple of things.

There is no need for a hearing when there has been no adverse professional review action taken. Well clearly a summary suspension is adverse review action there is no dispute. It says in the case of a suspension or restriction of clinical privileges for a period of not longer than fourteen days during which an investigation is being conducted to determine the needs for a professional review action. Well here it said we wasn't limited duration and secondly, Doctor Edwards and Doctor Patterson testified that they were not investigating trying to make any further determination at all. They were sat back and

if Doctor Randall requested a hearing they were gonna have a hearing. If he didn't they wouldn't. And it was not a hearing as defined in the statute because Mr. McKay tried to show up. He did show up they wouldn't let him participate. And so the hearing is somewhat defined under HCQIA and that was not a hearing.

And then the next exception it is that it says that HCQIA does not preclude an immediate suspension or restriction of clinical privileges subject to subsequent notice of hearing which is what we had here, where the failure to take such action may result in an imminent danger to the health of any individual.

Now this is our factual question because what we have a time line of - of review of these cases and a process where Doctor Randall just participated in and the parties who are reviewing his conduct say he should not be immediately suspended; that he should be allowed to practice medicine until the review process takes its course.

Yet Doctor Edwards and Doctor Patterson - Well Doctor Patterson goes and gets a case from four months earlier in July and brings it to Doctor Edwards. Neither one of them apparently look at it very well because what happens after the fact they send that case on off to external review and the external reviewers says I cannot criticize Doctor

Randall's care of this patient, because the outcome was successful.

Now he's says, you know, I can't say it was within the standard or outside the standard. You can't argue with a success and that's essentially what the external reviewer is saying. And so viewing the evidence in light most favorable to Doctor Randall on this point there is a jury question as to whether there is imminent danger of patient's safety from Doctor Randall who no one has alleged was - had a mental issue, had a substance abuse issue, had an alcohol issue, none whatsoever. This was a gentleman who had been practicing surgery in the hospital for twenty-five years without any significant questions or challenges to his competency. Then in 2007, 2008, they reviewed all of his cases and most all of the cases we're talking about here and that who's credentials were up, Judge Kinard, in the summer of 2010 and the credentials committee reappointed him for another year after Doctor Edwards appeared before the credentials committed and argued these same cases. And the credentials committee recommended that Doctor Randall be reappointed for another year. That recommendation went to the MEC, the MEC adopted it and on July 13th 2013, the credentials committee says in their report that Doctor Randall was quote safe to continue performing surgery. And then the patient JR as we've

discussed that was in July of 2010. All this time in 2010 Doctor Randall was reappointed into the surgical staff. And then September 13th, 2010 that's when Doctor Edwards created his Ad Hoc Committee to investigate Doctor Randall.

And again, so the elements of Federal immunity precluding a citizen of South Carolina suing under its state laws, do not apply here. Or at minimum a jury should be charged on the question of, you know, is there evidence that failure to take action would result in imminent danger. I think the records clearly indicates that that is not the case.

And so then - And then you follow through. There was some sort of informal meeting at Doctor Randall's request but it wasn't a hearing as I pointed out under the procedures because Doctor Randall was not allowed to cross examine the witnesses and he was not allowed to call witnesses. He couldn't have an attorney and the - But the hearing was ultimately had in February, months, months, months later. And there are factual disputes at the hearing but again there the burden is on Doctor Randall before the hearing but Doctor Ben Tribble who is a very well respected general surgeon in the Columbia community, he practices at Palmetto Richland, he came and testified. And he testified that Doctor Randall conformed to the standard of care. They had a witness who said he didn't.

They mention Doctor Revel. Doctor Revel didn't testify at this hearing. They have unearthed a document that Doctor Revel had in the file at the old practice when in - and it's another factual dispute Doctor Revel never performed surgery with Doctor Randall and Doctor Revel was a newby to the practice, that the practices merged and Doctor Randall and Doctor Revel did not have a long surgical practice together. The other doctors in the surgical practice were very supportive of Doctor Randall. And so if you - And I would also point out some things that we learned that we didn't know at the time of the hearing back in February 2015[sic] and that is we got the notes from this meeting that informal meeting when Jay McKay could not participate and that the deliberations and the things that were told to this committee that reviewed the summary suspension by Doctor Edwards we didn't know then we know now. We know now a couple of things.

One is Doctor Patterson misrepresented to the committee, the status of patient JR's case. First Doctor Patterson misrepresented to the committee that patient JR case had been reviewed by an external reviewer. And that it showed that Doctor Randall injured this patient which is completely contradicted to. Well first the external review had not been completed and then when it was completed it doesn't show that whatsoever. And then Doctor Edwards -

Doctor Patterson in this meeting says what their options are. And he does not tell the committee that their option - one option is to vacate the summary suspension, it is to modify it or continue it. He doesn't give them all three options, he only gives them two of the three options.

We didn't know that and Doctor Randall and Mr. McKay did not know that because there was no discovery that was committed back then. And so HCQIA immunity does not apply at mimimum, it's a factual question. And then, Your Honor, the causes of action that we pled are civil conspiracy and defamation. I heard you loud and clear on defamation and I'm not gonna spend any time on it, other than to request the court to review the Wuchenich W-u-c-h-e-n-i-c-h v. Shannondoa Memorial Hospital Case, it's cited in our brief, in there I know it was a factually accurate report. The insinuation is that he was so incompetent to practice medicine that he is an imminent danger to patient safety in that underlying factual representation when its filed that he was summarily suspended, we think it's false and we think that the evidence will show that it's false.

As to civil conspiracy, Your Honor, in addition to the case that's cited in the brief, I'm sure Your Honor is familiar with Levi Chesterfield General Hospital case and we do rely upon that 289 S.C. 6, and that deals specifically with a conspiracy amongst physicians in a

hospital - physicians on the medical staff. It was at a motion to dismiss stage and this intricate corporate conspiracy, a document was addressed in the case and I think this is a Court of Appeals decision and it says the hospital – argues that the complaint fails to state a cause of action because Maddery the hospital administrator is legally incapable of conspiring with his employer. And then the Court of Appeals then goes on to say however the complaint alleges that Maddery and the hospital conspired with other members of the medical staff since the agents of the corporation are legally capable as individuals of conspiracy amongst themselves or with third parties the complaint is sufficient to withstand demur they cited Gobble v. American Railway Express case agents of corporations may conspire amongst themselves.

And so then the question is you have evidence viewed in the light most favorable to Doctor Randall that you have two things going on.

You have Doctor Edwards who has been elevated to Chief of Staff, who has a history with Doctor Randall and personal animus against Doctor Randall as Doctor Randall will testify. Doctor Edwards admitted that there was a basis that there was some patient of Doctor Edwards wife's friend and that there was an issue over that. You have a Doctor Patterson who is the hospital employee who is the

medical officer and he's not licensed to practice medicine in South Carolina. He is retired from the practice of medicine and he is an employee. And you have a situation where the - where Doctor Randall was instrumental in merging the surgical practice with a competing company in Novant up in Charlotte. You have Piedmont through Tenet competing with Doctor Randall's surgical practice cause they're out trying to build their own in-house surgical practice which they did. And then you have this confluence of events where Doctor Edwards and Doctor Patterson unilaterally go against the recommendation of a credentials committee, the medical executive committee and the Ad Hoc Committee and that they do so in a way that they mislead the MEC when they consider the - They do so in a way they mislead the MEC when they consider the summary suspension. The summary suspension was based upon an old case that turns out that no one can say that Doctor Randall violated the standard of care. No one did and that you know civil conspiracies are - are by their nature clandestine. You will never get someone to come in and admit yeah we've conspired to injure Doctor Randall but you clearly have an agreement here, you clearly have acts in furtherance of agreement and you clearly have injury that was - that was suffered by Doctor Randall and so we believe the case should go forward to a jury. Thank you.

THE COURT: All right.

MR. DAYHOFF: Your Honor, may I pass up a time line? Mr. Griffin has a time line and I've - I'd like to say improved upon. I don't think Mr. Griffin will agree with that. I've added some things to the time line. My stuff is in yellow.

(DOCUMENTS RECEIVED UP BY THE COURT.)

MR. DAYHOFF: Let me - I want to start with a few things. Part of what Mr. Griffin is doing is digging down into a lot of the facts at the peer review hearing. And I have no problem with those facts but one of the things the HCQIA allows us to do is not to re-litigate the peer review hearing. The other thing I think he mentions is kind of part of the story with respect to Doctor Randall and his practice. I've highlighted a few of these things on the time line. Mr. Griffin mentioned that Doctor Randall had twenty-five years of great practice at Piedmont. He had a long good history at Piedmont. I will not deny that. But Doctor Randall's had other issues and I note them in the first yellow highlighted section. 2006 he had twenty-one cases reviewed by the peer review committee. High rate of complications, DVT complications, documentation, errors in judgment and technique. Some of the same problems he has now. Lack of surgical experience handling difficult dissections. That happened in 2006.

In 2007, the peer review committee looked at that. They imposed a hundred percent review for a year. He came through that hundred percent review pretty well. He got things back together which is good. I think the peer reviewers at Piedmont were happy to see that but it didn't last. We had the problems in 2009 again.

Mr. Griffin mentions these elements of the conspiracy that Doctor Randall joined a practice with Novant. That this was somehow about the CON fight for the Fort Mill Hospital up here in Fort Mill. Well if you take a look on the time line the Fort Mill Hospital thing began in 2005. This is the same time that the peer reviewers of Piedmont reviewed him in 2007 and put him back on the medical staff.

The idea that this is about Doctor Randall joining Novant there are a lot of people who joined Novant. There are a lot of people who joined Carolinas. Hospitals are buying up practices. Piedmont has a practice. All those other people at Novant, all those other people at CMC they didn't have their privileges restricted. The conspiracy that he's spitting out doesn't' make sense. I would suggest to you that its an unreasonable inference from the evidence. Yeah the Fort Mill happened. Hospitals bought up practices but there is no connection, there is no evidence that any of these are connected.

Let me mention the JR case a little bit. The idea

that no one found fault with the JR case, this is the lady that came into the hospital who had a laproscopic colystoectimy and relanguished in ICU for days with a big hematoma of blood in her bowel. She survived, that's great. The external reviewer in this matter - Jim did mention a few of the things the external reviewer said. He also said it's difficult to know if Doctor Randall has a quality issue for a reckless pursuit of a laproscopic approach for he and his patient may not be as fortunate the next time or if he should be praised as being a skillful laproscopic surgeon. Again watching an eleven unit bleed knowing this patient had a gangrenous gall bladder with higher risk for infections, intra abdominal complications appears very cavalier, while intervening may have prevented some of this patient's ICU morbidity. What this guy says at the end he's not sure its one case. So what he says is this case needs to be included with other case reviews to access if there is an over all lap of good surgical judgment and reasoning of skills. He had a snap shot of Doctor Randall's practice.

Doctor Edwards, Doctor Patterson, the MEC, the hearing panel, they had more than a snap shot. They had the other cases, they had the eight to ten other cases so what those guys did is exactly what this external reviewer is saying, you got to consider the history and not just one case and

they did that. The MEC was very close at that first meeting - The undisputed testimony said they were very close to suspending him the first meeting and they said you know we're not gonna do it, we're gonna hope nothing else happens and we're gonna give him the due process first and the suspend later. But then the JR case came out and they felt like they had imminent danger and they felt like they owed it to the patients to stop the practice in the interim, let them have a hearing and in fact the hearing panel came back and said you know what MEC you're wrong. Doctor Edwards you were wrong about suspension. Fine. They got a panel of five physicians to decide that.

Now the idea that there is something wrong with suspension first and due process later is just wrong. The Health Care Quality Improvement Act - and we've cited the portion in our reply brief - said specifically you can have suspension first as long as you have due process later. Now there would be a problem if we didn't give them the due process later. And Jim said in the case that he had in front of Judge Wooten the one Seattle case that comes to that very conclusion. The problem in Juan Seattle was they suspended and they didn't give him any process at all. They didn't do part two. But the idea that there is something wrong with suspension first and due process later is not right.

Now so the question is, it's not whether there is a genuine issue of material fact about the suspension. The question is whether he has brought forth evidence by which this court can say the decision to suspend wasn't about patients, was it reasonable? They have to be right under the Health Care Quality Improvement Act. You don't have to re-litigate this. The question is was the decision to take action on the privileges beyond the realm of reason. That's the standard. And I suggest to you we don't have the evidence that supports that. In fact we have a ton of evidence that says it was very reasonable. It was the right thing to do.

Now Jim mentioned that the federal law doesn't apply about whether you get to a jury or not. I suggest to you that well we've got the Health Care Quality Improvement Act. It certainly applies. And I don't know if Your Honor has had any cases but the only time it seems to come up in South Carolina state courts is railroad cases. It was in a railroad statute in play. And the case law is pretty clear that says if you got a writer defense provided by federal statute, the state court not only applies to that statute but applies to the federal law regarding whether summary judgment should be granted.

So I'll mention that to the court but I think that takes that out of traditional South Carolina Rule 56

scintilla test.

Now if you're ruling on defamation and conspiracy with out HCQIA you're - Jim's right it's South Carolina Rule 56 genuine issue of material fact. The defamation case I will just mention that LaChenic case. The reason the suspension was a problem and it was defamation was the physician was suspended, he had a hearing the suspension was lifted but they didn't change the report, for months. That's why it was defamation in the LaChenic case. Conspiracy the question is and we've talked about this whether our peer reviewers were outside the scope. That's the only question. And I have not - still have not heard anything that says these folks were acting outside the scope for personal interest. There is no evidence of that. Doctor Randall can say that, but him saying that in an allegation is not evidence.

I mention one other thing about the JR case. It was in part the case that they raised so much concern. But then the other thing that raised concern was Doctor Randall's reaction to that case. When he went before the MEC to talk about the case where the lady was in the ICU languishing, when he described it, he described a little bit of bleeding. That's in the hearing panel report. That worried people. That worried his physician colleagues because they were concerned he didn't appreciate the

problem. At the hearing that happened later when that case came up Doctor Randall testified about it. And the reason it came up was the husband of the patient sent in a complaint after the care was rendered. Doctor Randall realized that - I was told that in a hearing - he described the husband as trying to fix the complaints of his southern porcelain princess. When the hearing panel heard that they were disturbed by that. They felt that reflected a lack of appreciation for the severity of what was going on with that patient, with that patient's family. So it wasn't just the JR case and what happened in that case. It was the inability to react in a way that the colleagues thought was proportionate to the risk and the issues of that case.

Now, they did reappoint Doctor Randall and when this was going on and that time line lays this out. Reappointment and peer review are kind of different tracks. The question was should he be reappointed or just kicked to the end of his privileges and they weren't gonna do that. They were gonna finish the investigation. And if you look at the minutes when the credentials committee said he's safe to practice they also said, if, we review a hundred percent of his cases, if, we concurrently monitor his cases at the same time he's doing it, if, he does better with patients and family members. There are a lot of things that were left off that description.

I mention this about these ideas of conspiracy about no bond, about joining the other practice. Jay McKay is a good attorney; he does medical malpractice cases. He represented Doctor Randall at this hearing. Jay McKay didn't mention any of this stuff at the hearing. If this stuff existed, if they believed that Doctor Patterson or Doctor Edwards or anybody else was doing this in bad faith, they would have brought that up at the hearing. They would have said you know what this isn't about medicine, this is about bad conduct. None of that came up in the hearing. I suggest to you because it doesn't exist.

So I'll conclude and I know Monte wants to I think wants to make a comment or two. I'll conclude with this. I think these peer reviewers put in a couple of years at work on this matter. They don't like doing peer review anyway. No one likes doing peer review reviewing each other's cases is difficult. I really do think that requiring these folks to go to trial while trial doesn't bother a lawyer, we'd do fine with a trial. We would make money at trial. I think the problem though is it would disincentivize peer review particularly at a hospital that has just gone through two years of it, to have to then go before a court and go through again.

So - And this is a matter of first impression and I think it would roll up to the appellate process. I just

think it really would be a difficult message to have to give to peer reviewers and the next time we have a peer review case at Piedmont or other hospital in this area I think they'd look to t his case and say, geez, do we really want to do peer review.

We had to be sued. We had to go to trial, so I think there is a lot more at stake than just this case with respect to peer review in South Carolina. So with that I'll turn it over to Mr. Todd.

MR. TODD: May it please the Court.

Your Honor, I represent Doctor Nathaniel Edwards he is a cardiologist and just very briefly I just wanted to point out one thing is that the plaintiff in his complaint alleged in paragraph 13 and 14 that this action was taken in retaliation for Doctor Randall selling his practice to Novant which is Presbyterian Hospital. I don't know how much familiar you are with this area but in the area that the hospital --

THE COURT: I'm quite familiar with it. We got families all over the state.

MR. TODD: Well I think - -

THE COURT: The doctors fight the hospitals. Doctors want to do everything the hospital does. Used to send x-rays they do them in the office now. The blood work they do now in the office. I'm aware of all of that.

MR. TODD: What I was gonna say the hospitals in the area are involved with the Piedmont Medical Center which is the defendant and then Novant Presbyterian and then Carolinas Medical Center. And in this case Doctor Edwards was actually the cardiologist with Sonyar which he was employed by Carolinas Medical Center. But anyway I just bring that out to give you a little background.

But the plaintiff claims that the action by Piedmont was taken in retaliation for Doctor Randall selling his practice to Novant Presbyterian. But at the time - I think the sell was sometime in 2007, 2008 and there were three surgeons, three other surgeons in there, Doctor Crain, Doctor Revel, Doctor Shubert and Doctor Randall. But in 2009, Presbyterian conducted it's own investigation into Doctor Randall's practices and concluded based on it's investigation that they wanted to terminate their relationship with Doctor Randall. And I think as I pointed ou,t we didn't know this or it wasn't known to Piedmont at the time of this peer review. But it is important because if you look at - and it's exhibit four - they talk about Doctor Revel who has been a surgeon in Rock Hill since 1982. And he identified Doctor Randall as being rough on tissue and causing multiple complications and he reported those to Presbyterian.

It is also - and they said that it was just one

surgeon but there was also Doctor Corey Crain who was one of Doctor Randall's partners who has been a surgeon since 1985 and he said he's operated with Doctor Randall fifteen to eighteen times and noted that Doctor Randall wasn't careful, he didn't handle tissues well, he wasn't respectful to tissues, he was always in a rush and it led to multiple complications. So that's the investigation by Presbyterian which he says is because his relationship with Presbyterian that this peer review was instituted. But in fact Presbyterian concluded basically the same thing this peer review panel did a year later.

And in fact the relationship with Presbyterian didn't even exist at the time of the peer review so the allegation about there being some retaliation to his relationship with Presbyterian was just really there is no evidence of that. And that's all I wanted to point out. Thank you, Your Honor.

MR. GRIFFIN: Just briefly responding to what Mr. Todd raised. The reason that Mr. Randall had to separate from Novant was an insurance issue and they couldn't get insurance for Doctor Randall because he was taking some difficult cases at Presbyterian, he was sued and it was a malpractice issue and that was the point.

And we are, all these cases are the same cases that are being discussed about and the point is that they were

reviewed. And all of these are factual issues. They were reviewed. They were peer reviewed at Presbyterian and the panel kept saying we want a general surgeon. We want a general surgeon, let's let Doctor Randall have his day in court. Doctor Patterson and Doctor Edwards denied that and that's why. Thank you.

THE COURT: All right, so how can I help you?

MR. DAYHUFF: I have an idea but.

THE COURT: Well here's how it looks. Its just a mess to let it go on to trial cause we don't' really have an answer. The federal law preempted state law and so forth. So I think recognizing all the problems, just prepare an order granting summary judgment. I'm not saying I'm gonna sign it. I'm inclined to sign it but I want you - you got to premise it on the federal law preempts the state law. If it doesn't you clearly win. And I also sympathize cause you take away a persons right to practice you know you take away his right to practice, but, I think if I grant summary judgement we'll get a quicker resolution than the other way and save lots of money. And I think that Doctor Edwards was a little precipitous on taking that action and I want you to acknowledge that in your order but still it overrides and then you got your position on that if it comes up. Because Patient JR did not just happen. That's the thing. That happened months ago.

MR. GRIFFIN: Yes, sir.

THE COURT: I recognize - I'm conversing on all that and if you had a South carolina case applying that federal statute to it I'd probably just deny summary judgment and let the chips fall. Now I have no sympathy with his position, Mr. Griffin's position on they had it in for him because of the practice and all that. But you can raise that in trial if you get that far but me being in the business carrying weight with me, then I'm not a reasonable juror either. I'm a very experienced litigator and so forth and a long time judge. But still that's a position he can raise. Actually where our hospital administrator I suspend anybody who doesn't have malpractice insurance whether you got bylaws that say that or not and I'm sure that was in Doctor Patterson's mind but I'm not making that fact. I'm just - it goes to trial you can raise that.

Defamation they just one is what they reported wasn't what they reported. To get sustained if you can get sustained even if Edwards acted precipitously he had due process and he being Randall has no problem with anybody on the panel being biased, and be sure to point out they had two surgeons on there but not general surgeons. He can raise that and I don't feel that's necessary since they didn't have any general surgeon in the area that was not kicked out by the filings.

And then I need you to also mention that he didn't think his expert was too good. Randall talking about his expert. You showed me I read everything you all didn't mention. And I hate to throw him out of this court but I hate to spend two weeks in trial on this when it may be not necessary and the Supreme Court reverses it and then you all will probably settle it anyway because you don't want a big record of this. Not that I grant summary judgment on policy reasons but sometimes if it helps everybody in this case but then you all can zero in and address it and if it is tried we would have - know what to charge the jury. But I'm not saying I'm gonna sign it. I'm just being inclined.

MR. DAYHOFF: Thank you, Your Honor.

THE COURT: Now Edward was backed up even though he may have been wrong in saying they were in — he was backed up by the peer review. I know you all's position on all that.

MR. GRIFFIN: Yes, sir.

THE COURT: Its like when Monte's buddy Henry McKelvy when he was in private practice he argued some bank case in front of me and fortunate I had represented the bank so I understood two banks were suing each other and we tried two cases. When Henry handed up fifty-seven charges on statutes and things and the other side handed up about the same and the trial judge has got no chance on that unless

he knows something about it so I charged making the decision as to whether the receiving bank the alleging bank - and then Henry lost both cases. And Nat Greer was on one and Bill Toal was on the other. Henry said I got to have to appeal on these cause you didn't charge on the statutes. I said I know but if I charge one wrong I'd been reversed anyway. Well Henry then gets elected judge the Supreme Court decision comes down and they affirm. I don't engage in vain glory . . . You know Henry it looks like the Supreme Court affirmed on those charges I gave and without batting an eye he said what you all would have said, like they understand the law.

So there you go. But you all do appreciate I understand the issues. If it were a one day trial I would probably let it go.

MR. GRIFFIN: Yes, sir.

THE COURT: All right.

(COURT IN RECESS AT 11:00 A.M..)

CERTIFICATE OF REPORTER

State of South Carolina)
)
County of York)

I, Wanda Nelson, Official Court Reporter for the Sixteenth Judicial Circuit for the State of South Carolina, do hereby certify that the foregoing is a true, accurate and complete Transcript of Record of the proceedings had and evidence introduced in the trial of the captioned case, relative to appeal, in the Court of Common Pleas for York County, South Carolina, on the 3rd day of March, 2014.

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

/Wanda Nelson

Wanda Nelson, CVR
Certified Verbatim Reporter,
Official Court Reporter,
Notary Public, in and for
The State of South Carolina.

My Commission Expires: 1/21/2021

DATE: April 28 / 2014

STATE OF SOUTH CAROLINA)
) IN THE COURT OF COMMON PLEAS
COUNTY OF YORK) SIXTEENTH JUDICIAL CIRCUIT
)
) CASE NO.: 2012-CP-46-167
Robert Randall, M.D.)
Plaintiff,) **MOTION AND ORDER INFORMATION FORM AND COVERSHEET**
vs.)
)
Amisub of South Carolina, Inc., et al.)
Defendant.)

Plaintiff's Attorney:	Defendant's Attorney:
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☒ **MOTION HEARING REQUESTED** (attach written motion and complete SECTIONS I and III)
☐ **FORM MOTION, NO HEARING REQUESTED** (complete SECTIONS II and III)
☐ **PROPOSED ORDER/CONSENT ORDER** (complete SECTIONS II and III)

SECTION I: Hearing Information

Nature of Motion: Motion for Summary Judgment
Estimated Time Needed: 1.5 hours Court Reporter Needed: ☒ YES/☐ NO

SECTION II: Motion/Order Type

☐ Written motion attached
☐ Form Motion/Order

I hereby move for relief or action by the court as set forth in the attached proposed order.

Signature of Attorney for ☐ Plaintiff /☒ Defendant — September 13, 2013 Date submitted

SECTION III: Motion Fee

☒ PAID – AMOUNT: $ ____
☐ EXEMPT: (check reason)
- ☐ Rule to Show Cause in Child or Spousal Support
- ☐ Domestic Abuse or Abuse and Neglect
- ☐ Indigent Status ☐ State Agency v. Indigent Party
- ☐ Sexually Violent Predator Act ☐ Post-Conviction Relief
- ☐ Motion for Stay in Bankruptcy
- ☐ Motion for Publication ☐ Motion for Execution (Rule 69, SCRCP)
- ☐ Proposed order submitted at request of the court; or, reduced to writing from motion made in open court per judge's instructions
  Name of Court Reporter: ____
- ☐ Other: ____

JUDGE'S SECTION

☐ Motion Fee to be paid upon filing of the attached order.
☐ Other: ____

JUDGE CODE ____
Date: ____

CLERK'S VERIFICATION

Collected by: ____ Date Filed: ____
☐ MOTION FEE COLLECTED: $ ____
☐ CONTESTED – AMOUNT DUE: $ ____

SCCA 233 (11/2003)

STATE OF SOUTH CAROLINA COUNTY OF YORK	)	IN THE COURT OF COMMON PLEAS SIXTEENTH JUDICIAL CIRCUIT
Robert Randall, M.D., Plaintiff, v. Amisub of South Carolina, Inc. d/b/a Piedmont Medical Center, Nathaniel Edwards, M.D., and Richard Patterson, M.D., Defendants.	)	Civil Action No. 2012-CP-46-167 **MOTION FOR SUMMARY JUDGMENT**

Pursuant to Rule 56(c) of the South Carolina Rules of Civil Procedure, Defendants move for summary judgment on their claim for the damages immunity provided by the Health Care Quality Improvement Act and on all the causes of action asserted against Defendants in Plaintiff's Complaint. The grounds for this motion are set forth in a memorandum of law filed contemporaneously with this motion.

Respectfully submitted,

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September 13, 2013

CERTIFICATE OF SERVICE

I, the undersigned Administrative Assistant of the law offices of Nelson Mullins Riley & Scarborough LLP, attorneys for Defendants, do hereby certify that I have served all counsel in this action with a copy of the pleading(s) hereinbelow specified to the following address(es):

Pleadings:

CONSENT MOTION TO SEAL

DEFENDANTS' MOTION FOR SUMMARY JUDGMENT

DEFENDANTS' MEMORANDUM IN SUPPORT OF MOTION FOR SUMMARY JUDGMENT (UNDER SEAL)

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Jane M. Heinzelman

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Administrative Assistant

September 13, 2013

STATE OF SOUTH CAROLINA	)	
	)	IN THE COURT OF COMMON PLEAS
COUNTY OF YORK	)	SIXTEENTH JUDICIAL CIRCUIT
Robert Randall, M.D.,	)	Civil Action No. 2012-CP-46-167
Plaintiff,	)	
v.	)	**MEMORANDUM IN SUPPORT OF MOTION FOR SUMMARY JUDGMENT**
Amisub of South Carolina, Inc. d/b/a Piedmont Medical Center, Nathaniel Edwards, M.D., and Richard Patterson, M.D.,	)	
Defendants.	)	

SUMMARY OF FACTS

This suit arises from a physician peer review action at Piedmont Medical Center. This peer review action began when a focused review of Dr. Randall's cases revealed that Dr. Randall was experiencing a large number of bad outcomes caused by his poor surgical judgment and technique. During abdominal surgeries, Dr. Randall was all too often perforating his patients' organs, and his rough and hurried handling of abdominal tissue was causing unnecessary complications.

Dr. Randall's technical surgical errors were made worse by his failure to timely appreciate and repair the injuries he caused, resulting in his patients experiencing excessive bleeding, life-threatening infections, extended hospital stays, and, in the worst cases, death. As an anesthesiologist on Piedmont's medical staff succinctly put it, Dr.

Randall had become a physician who caused the "general concern that a routine case could become something very different." Baker Dep. at 9:19-10:10 (Ex. 1).[1]

Because Dr. Randall's surgical care was so clearly falling below the standard expected by his peers, the physicians on the Medical Executive Committee ("MEC") unanimously recommended terminating Dr. Randall's abdominal surgery privileges. Shortly after the MEC's recommendation, the Chief of Staff learned that Dr. Randall had experienced yet another bad outcome. This time, a patient experienced a massive eleven-unit blood loss caused by a surgical misadventure that accompanied Dr. Randall's removal of the patient's gallbladder.[2] Faced with this latest case, the Chief of Staff felt he had no choice but to suspend Dr. Randall's abdominal surgery privileges to avoid imminent harm to Piedmont's patients. The MEC unanimously affirmed the suspension imposed by the Chief of Staff.

Dr. Randall challenged the MEC's recommendations. Thereafter, Dr. Randall's surgical care was reviewed by a five-physician hearing panel, an Appellate Review Committee, and ultimately Piedmont's Board of Governors. All of these bodies voted to affirm the termination of Dr. Randall's abdominal surgery privileges. Dr. Randall's peer review action at Piedmont was over, and this lawsuit began.

Discovery revealed that the peer reviewers at Piedmont were not the only ones who recognized that Dr. Randall was having serious problems with surgical judgment

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[1] This anesthesiologist also testified that he insisted upon using a larger gauge IV when working with Dr. Randall because on his cases "there seemed to be some tendency for some blood loss at times that wasn't expected and things of that nature." *Id.* at 9:1-14.

[2] This case came to the attention of the Chief of Staff because the patient's husband raised concerns about the care his wife had received. Dr. Randall described the husband as wanting to "fix" the complaints of his "southern porcelain princess." Hearing Tr. at 423 (Ex. 2); Hearing Panel Decision at 19 (Ex. 3).

and technique. In response to an internal investigation, physicians in Dr. Randall's medical practice reported the following:

> Dr. Randall's "outcomes were less than optimal."
>
> "[P]atients have not been prepared properly for procedures under Dr. Randall's care."
>
> Operating Room nurses reported that Dr. Randall's "cases are now bloody and there are numerous take-backs."
>
> Dr. Randall experienced "lots of personal complications – 'more than his share.'"
>
> When working with other surgeons on cases "Dr. Randall would 'take the case over,' handle tissues roughly and create unnecessary complications."

Meeting Mem. 7/1/09 (Ex. 4). Dr. Randall's surgical care had become so compromised that his partners insisted that they would no longer participate in follow-up care of Dr. Randall's patients, and one partner said he would leave if Dr. Randall remained in the practice. *Id.* at 2. Ultimately, Dr. Randall was terminated by his medical practice because the malpractice risk of continuing to employ him became too great. Randall Dep. at 32:8-33:23 (Ex. 5).

Discovery also revealed that two of the cases under review in Dr. Randall's peer review action became the subject of medical malpractice suits. Dr. Randall's insurer paid over one million dollars to settle one, and Dr. Randall concedes malpractice was committed in the other. Randall Dep. at 118:20-119:17.

Dr. Randall's Complaint in this suit alleges that his peer review action at Piedmont was a conspiracy perpetrated against him. Dr. Randall has engaged in discovery on this conspiracy claim, and discovery is now over. Rather than a conspiracy, discovery has confirmed the existence of a thoughtful and thorough peer

review action undertaken by physicians, administrators, and board members who acted to protect patients and to provide Dr. Randall fair process. Because Defendants participated in a legitimate and clearly necessary peer review action, *and nothing more*, Defendants are entitled to the damages immunity provided by the Healthcare Quality Improvement Act and summary judgment on the individual causes of action in Dr. Randall's Complaint.

STATEMENT OF FACTS

I. THE PARTIES

Defendant Piedmont Medical Center is a South Carolina corporation that operates an acute care hospital in Rock Hill, South Carolina. Defendant Dr. Nathaniel Edwards is a cardiologist, who at the time of Dr. Randall's peer review action, was Piedmont's Chief of Staff. At the time of Dr. Randall's peer review action, Defendant Dr. Richard Patterson was the Chief Medical Officer at Piedmont. Dr. Randall is a general surgeon who joined Piedmont's medical staff in 1982. Dr. Randall's abdominal surgical privileges were suspended in 2010 and terminated in 2011, and his remaining surgical privileges expired when Dr. Randall chose not to seek reappointment to the medical staff. Randall Dep. at 71:1-72:10 (Ex. 5).

II. DR. RANDALL'S PEER REVIEW AT PIEDMONT

A. 2006-2007 peer review

The peer review action that is the subject of this suit is not the only focused peer review Dr. Randall has experienced while on the medical staff at Piedmont. In 2006, the physicians on Piedmont's Peer Review Committee reviewed 21 of Dr. Randall's

cases and, thereafter, had these same cases externally reviewed by a surgeon.[3] Randall Dep. at 77-80 (Ex. 5); Peer Review Minutes 12/18/06 (Ex. 6).

Because both the internal and external case reviews found problems with Dr. Randall's surgical judgment and technique, the Peer Review Committee and Credentials Committee imposed, with MEC approval, a year-long retrospective review[4] of 100% of Dr. Randall's open hernia and carotid surgery cases. *Id.*; Ltr. 12/21/06 (Ex. 7); MEC Minutes 1/8/07 (Ex. 8). This focused review of Dr. Randall's cases occurred during 2007, and after Dr. Randall's cases received acceptable scores during this review period, the focused review was terminated in 2008. Peer Review Minutes 5/7/08 (Ex. 9).

B. 2009-2010 peer review

In 2009 and 2010, Dr. Randall's patient care again became the subject of a focused review by the Peer Review Committee when Dr. Randall began experiencing troubling complications in several new cases. Hearing Tr. at 15-16 (Ex. 2). The Peer Review Committee sent these new cases for external review. *Id.*

On June 10, 2010, after the results of the external reviews were received, Dr. Edwards, Chair of the Peer Review Committee and Chief of Staff, brought these cases to the Credentials Committee for consideration. Edwards Dep. at 21:9-22:10 (Ex. 10); Credentials Minutes 6/10/10 (Ex. 11). The Credentials Committee, chaired by Dr. Jenkins, concluded that the new cases manifested some of the same deficiencies that

[3] External reviews are case reviews conducted by physicians who are not on the hospital's medical staff and who do not reside or work in the hospital's service area.
[4] A retrospective review is accomplished by reviewing the patient's medical record after the care at issue has been rendered.

were observed in Dr. Randall's 2006 cases, including particularly rough handling of the bowel and the failure to recognize when patients needed to be returned to the operating room. *Id.* On July 13, 2010, after meeting with Dr. Randall to discuss the cases under review, the Credentials Committee recommended that Dr. Randall be reappointed for one year -- instead of the standard two years -- and further recommended concurrent review of 100% of his abdominal and herniorrhaphy surgery cases for six months. Credentials Minutes 7/13/10 (Ex. 12).

The Credentials Committee's recommendation was subsequently reviewed by the MEC, and the MEC recommended reappointing Dr. Randall for one year, but increased the monitoring period. MEC Minutes 8/9/10 (Ex. 13). The MEC also determined that further investigation of Dr. Randall's patient care would be conducted. *Id.*

C. **Ad hoc committee review**

The additional investigation of Dr. Randall's surgical care contemplated by the MEC was primarily conducted by an Ad Hoc Committee that consisted of members of the Peer Review Committee, the Credentials Committee, and the MEC. Edwards Dep. at 16:21-25 (Ex. 10). In September 2010, the Ad Hoc Committee provided Dr. Randall with the external reviews of the cases at issue and asked him to provide a written response addressing each case. MEC Minutes 9/13/10 (Ex. 14).

After considering the external reviews, the pertinent portions of the medical records, Dr. Randall's written responses, and Dr. Randall's oral presentation regarding the cases, the Ad Hoc Committee recommended to the MEC that Dr. Randall's privileges to perform abdominal surgery be revoked. Ad Hoc Minutes 9/27/10 & 10/4/10 (Ex. 15); Ltr. 9/28/10 (Ex. 16); Randall Dep. at 89:4-22; 92:14-24 (Ex. 5).

Notably, the Chairman of the Credentials Committee, Dr. Jenkins, a good friend of Dr. Randall's who had previously recommended only monitoring, supported this new recommendation because he had become convinced that more needed to be done to protect patients. Jenkins Dep. at 70:8-71:11 (Ex. 17).

D. MEC review

On October 11, 2010, the MEC convened to consider the recommendation of the Ad Hoc Committee. MEC Minutes 10/11/10 (Ex. 18). The MEC members reviewed the external reviews, the medical records, and the statements of Dr. Randall regarding the cases under review. *Id.* The MEC also considered additional cases that had recently been reviewed by the Peer Review Committee and the external reviewer, and data that demonstrated Dr. Randall had experienced more unplanned returns to the operating room than other surgeons on the medical staff. *Id.*

The MEC ultimately concluded that the surgical judgment and technique exhibited by Dr. Randall in the cases under review fell below the standards of the medical staff, and, therefore, Dr. Randall's abdominal surgical privileges should be revoked. *Id.*; Edwards Dep. at 97:9-98:3 (Ex. 10). In a letter dated October 15, 2010, the Chief Executive Officer of Piedmont provided Dr. Randall notice of the MEC's adverse recommendation and notice that he had the right under the medical staff bylaws to challenge this recommendation. Ltr. of 10/15/10 (Ex. 19); Randall Dep. at 95:5-96:2 (Ex. 5).

E. Suspension

Shortly after the MEC made its recommendation, Dr. Edwards was made aware of a recent complaint made by the husband of a female patient whose gallbladder had

been removed by Dr. Randall. Edwards Dep. at 55:22-56:8 (Ex. 10). Dr. Randall's surgery resulted in this patient losing 11 units of blood and having an extended stay in critical care. *Id.* at 57:8-16. In response to this new case and the previous cases, Dr. Edwards summarily suspended Dr. Randall's abdominal surgery privileges. *Id.* at 55:9-21. Dr. Edwards took this action because he believed that a suspension, that would take effect immediately, was necessary to protect patients from imminent harm. *Id.* at 58:16-24.

In a letter dated October 15, 2010, Dr. Randall received notice of the suspension and the reasons it was imposed. Ltr. of 10/15/10 (Ex. 20); Randall Dep. at 123:9-124:16 (Ex. 5). This letter also informed Dr. Randall that he had the right under the medical staff bylaws to address the MEC before the MEC considered whether to continue, terminate, or modify the suspension. *Id.* at 126:2-14. By letter dated October 18, 2010, Dr. Randall was sent copies of the external reviews of the more recent cases that had been considered by the MEC and the data regarding unplanned returns to the operating room. Ltr. of 10/18/10 (Ex. 21).

On October 25, 2010, Dr. Randall met with the MEC regarding the suspension.[5] MEC Minutes 10/25/10 (Ex. 24); Randall Dep. at 137:12-139:1. During this meeting, Dr. Randall addressed all the cases previously under consideration, the additional cases considered by the MEC on October 11, the data on unplanned returns to the operating room, and the case that triggered his suspension. *Id.* After Dr. Randall had presented

[5] Dr. Randall brought legal counsel to this MEC meeting. McKay Dep. at 102-103 (Ex. 22). When Dr. Randall's counsel was informed that the medical staff bylaws did not provide for legal counsel at this meeting -- for either the reviewed physician or the MEC -- counsel departed. *Id.*; Patterson Dep. at 58:10-25 (Ex. 23).

to the MEC, he was excused from the meeting, and the MEC deliberated. Thereafter, the MEC unanimously voted to continue the suspension. *Id.*

By letter dated October 28, 2010, Dr. Edwards informed Dr. Randall that the MEC had voted to uphold his suspension. Ltr. of 10/28/10 (Ex. 25); Randall Dep. at 139:5-24 (Ex. 5). This letter also informed Dr. Randall that he had the right to challenge the suspension. *Id.*

F. Hearing

Dr. Randall requested a hearing to challenge the MEC's adverse recommendations regarding his medical staff privileges. Randall Dep. at 140:22-25. Thereafter, Dr. Randall received a hearing notice that identified the Hearing Officer, Dawes Cooke, Esq., and the proposed Hearing Panel. Hearing Not. (Ex. 26). The notice also provided Dr. Randall with a detailed description of the grounds for the adverse actions including a list of the ten cases at issue. *Id.*; Randall Dep. at 142:8-143:17. None of the physicians selected to serve on the Hearing Panel were economic competitors of Dr. Randall. *Id.* Dr. Randall was afforded the right to object to the service of any of the individual physicians on the panel and to have counsel represent him at his hearing. *Id.*

Dr. Randall did not object to any individual hearing panel members, but he did object that his panel did not contain a general surgeon. Randall Dep. at 148:11-21; 150:22-152:19; McKay Dep. at 117:21-118:20; 126:4-6 (Ex. 22). Piedmont's medical staff bylaws prohibit service on the hearing panel by the reviewed physician's economic competitors, partners, or physicians who had participated in the patient cases under review. Med. Staff Bylaws at Art. VIX, § 3.A (Ex. 26). When these criteria from the

bylaws were applied, there were no general surgeons on Piedmont's medical staff eligible to serve on the hearing panel, and therefore, Dr. Randall's objection was overruled by the Hearing Officer. Hearing Tr. at 7:5-13 (Ex. 2). Hearing Panel Decision at 6, ¶¶ 32-34 (Ex. 3); Edwards Dep. at 76:6-15 (Ex. 10); Patterson Dep. at 66:6-15 (Ex. 23). The Hearing Panel did, however, include an oral surgeon and an orthopedic surgeon. Hearing Panel Decision at 24-25.

On February 16 and 17, 2011, Dr. Randall's peer review hearing was conducted.[6] At the hearing, both Dr. Randall and the MEC had the right to call witnesses and submit documents into evidence regarding the cases at issue. McKay Dep. at 146:2-7 (Ex. 22); Randall Dep. at 144:13-145:7 (Ex. 5). Both sides exercised that right. Eight witnesses were called, including each side calling a surgeon who offered expert opinions regarding the cases under review. Hearing Tr. at 186-187; 484. Dr. Randall offered the following critique of his own expert witness:

> It was real apparent that he'd not very well reviewed the cases. He really didn't know them. He got up and they would ask him certain questions, and he wouldn't know or had to fumble through. He was not a very effective witness.

Randall Dep. at 157:4-10.

Numerous exhibits were entered into evidence including the relevant medical records, external reviews of Dr. Randall's cases, and minutes from the various hospital

[6] The MEC requested and was granted two continuances by the Hearing Officer. Dr. Randall's counsel consented to the first continuance. McKay Dep. at 141:12-142:10. The Hearing Officer found "good cause shown" for the second continuance because the MEC's expert unexpectedly and belatedly informed the MEC that he would not be available to testify at the hearing. Order for Postponement (Ex. 28); Patterson Dep. 68:13-69:18; Med. Staff Bylaws at Art. VIX, § 4.C. (permitting continuance of the hearing beyond 90 days after the adverse action for "good cause shown.")(Ex. 27).

committees that considered the cases at issue. The hearing generated a 482 page transcript. After the presentation of evidence, the Hearing Panel deliberated.

On April 16, 2011, the Hearing Officer issued the Hearing Panel's "Decision, Findings of Fact and Conclusions." Hearing Panel Decision (Ex. 3); Randall Dep. at 155:10-156:1 (Ex. 5). The Hearing Panel unanimously decided that the MEC's recommendations to revoke and suspend Dr. Randall's abdominal surgery privileges should be upheld. Hearing Panel Decision at 21 (Ex. 3). The Hearing Panel's Decision included the following conclusions:

> Substantial evidence supports the conclusion that Dr. Randall has demonstrated a persistent pattern of judgment error and lack of technical proficiency with respect to abdominal surgery.
>
> The evidence reasonably supports that these errors of judgment and skill led to the deaths of certain patients or caused others to suffer complications and prolonged hospitalizations. The outcomes for the patients at issue were adverse and severe in terms of morbidity and significant mortality.
>
> The evidence reasonably supports that Dr. Randall did not demonstrate that he appreciated the severity of the problems that existed in his surgical performance.

Id. at 19.

G. Review by Appellate Review Committee and Board of Governors

On May 6, 2011, Dr. Randall appealed the Hearing Panel's Decision to Piedmont's Board of Governors. Randall Dep. at 159:4-12. Piedmont's Board an Appellate Review Committee to consider Dr. Randall's appeal. After considering written briefs, oral arguments and the hearing record, the Appellate Review Committee upheld the Hearing Panel's Decision. Appellate Review Cmttee. Rep. at 7 (Ex. 29). The Appellate Review Committee reported their recommendation to the full Board.

After considering the findings of the Hearing Panel and Appellate Review Committee and reviewing the hearing record, the Board affirmed the termination of Dr. Randall's abdominal surgery privileges. Final Decision of Governing Board. (Ex. 30). MEC and Hearing Panel recommendations. On July 12, 2011, the Board issued its final decision. *Id.*; Randall Dep. at 161:11-162:16 (Ex. 5).

III. DR. RANDALL'S SUIT, CAUSES OF ACTION, AND DISCOVERY

On January 13, 2012, Dr. Randall filed this suit asserting conspiracy and defamation causes of action against the Defendants. Complt. at ¶¶ 61-75. Dr. Randall alleges that his peer review action was a conspiracy undertaken to retaliate against him for selling his surgical practice to a competing hospital or, alternatively, for providing testimony in his malpractice cases that was unfavorable to Piedmont. *Id.* at ¶¶ 12-21.

Dr. Randall served a comprehensive set of written discovery upon the Defendants and deposed all the witnesses he desired to depose including Piedmont's Chief Executive Officer, Chief Medical Officer, and the Director of Medical Staff Services. Dr. Randall also deposed the Chief of the Medical Staff and many of the physician members of the committees that participated in his peer review action. As Dr. Randall has now had an opportunity to conduct discovery regarding his claims, Defendants respectfully submit that this case is now ripe for consideration of Defendants' motion for summary judgment.

ARGUMENT

I. THE HEALTHCARE QUALITY IMPROVEMENT ACT IMMUNIZES DEFENDANTS FROM DR. RANDALL'S CLAIMS FOR DAMAGES

A. The Healthcare Quality Improvement Act ("HCQIA")

If a professional review action (more commonly known as a "peer review action") at a hospital complies with certain conditions, hospitals, physicians, and others are entitled to immunity from claims for monetary damages that arise from peer review activities.

> If a professional review action of a professional review body meets all the standards specified in section 11112(a) of this title . . .
>
> (A) the professional review body,
> (B) any person acting as a member or staff to the body,
> (C) any person under a contract or other formal agreement with the body, and
> (D) any person who participates with or assists the body with respect to the action,
>
> *shall not be liable in damages* under any law of the United States or of any State (or political subdivision thereof) with respect to the action.

42 U.S.C. § 11111(a)(1)(emphasis added); *Moore v. Williamsburg Reg. Hosp.*, 560 F.3d 166, 171 (4th Cir. 2009); *Wieters v. Roper Hosp. Inc.*, 2003 W.L. 550327 **4 (4th Cir. 2003).

A hospital and its medical staff are entitled to immunity from damages if the peer review action at issue was taken:

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

> (4) in the reasonable belief that the action was warranted by the facts known after such reasonable effort to obtain facts and after meeting the requirements of paragraph (3).

42 U.S.C. § 11112(a); *Hein-Muniz v. Aiken Reg. Med. Ctrs*, 2013 W.L. 3359277 **1 (4th Cir. 2012).

Congress granted peer reviewers this immunity to encourage physicians to engage in peer review and take action to protect patients, including suspension and revocation of privileges, without fear of reprisal in the form of suits seeking monetary damages. *Oksanen v. Page Mem. Hosp.*, 945 F.2d 696, 704 (4th Cir. 1991)(noting that Congress intended HCQIA to protect peer reviewers from the threat of damages, and further that Congress expressly recognized "'[t]here is an overriding national need to provide incentive and protection for physicians engaging in effective professional peer review.'")(quoting 42 U.S.C. § 11101(5)). Rigorous peer review coupled with the reporting of sanctions to a national databank is a core component of federal policy to protect patients from incompetent or potentially dangerous physicians who could otherwise move from hospital to hospital without discovery and disclosure of their past problems. 42 U.S.C. § 11101(2).

Providing further protection to peer review participants, HCQIA provides a *statutory presumption* that the peer review action at issue satisfies the four prerequisites for damages immunity.

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

42 U.S.C. § 11112(a)(emphasis added).

B. HCQIA summary judgment standard

The statutory presumption provided by HCQIA shifts the burden of proof and persuasion at the summary judgment stage onto the physician plaintiff. Thus when considering whether HCQIA immunity applies, the physician's evidence of non-compliance with the HCQIA standards is weighed against both the presumption that each standard of HCQIA has been satisfied and the evidence of compliance with the standards offered by the peer reviewers. Summary judgment for the peer reviewers is appropriate unless a reasonable jury, viewing the facts in the best light for the plaintiff, could conclude that the plaintiff has shown *by a preponderance of evidence* that defendants' actions fail to satisfy the HCQIA standards. *Moore*, 560 F 3d. at 175; *Gabaldoni v. Washington Cty. Hosp.*, 250 F.3d 255, 260 (4th Cir. 2001).

A physician plaintiff thus cannot avoid summary judgment merely by raising a genuine issue of material fact as to whether one of the HCQIA standards was satisfied. *E.g.*, *Moore*, 560 F.3d at 175-77 (affirming summary judgment for defendants on HCQIA immunity); *Wieters*, 2003 W.L. 550327 at **6 (affirming summary judgment holding that the physician "failed to rebut the presumption of the HCQIA that the hospital complied with its requirements."); *Hein-Muniz*, 2013 W.L. 3359277 at **3 (affirming summary judgment for defendants on HCQIA immunity).

C. Defendants satisfy the HCQIA standards

As set forth more specifically below, Defendants have satisfied the HCQIA standards because Dr. Randall's peer review action was undertaken to protect patients and help ensure quality care is provided at Piedmont. The peer review action included a thorough investigation of the facts and appropriate notices and fair hearing

procedures, and the ultimate decision to terminate Dr. Randall's privileges was reasonable considering the facts discovered during the action.

1. Dr. Randall's peer review action was undertaken in the reasonable belief that it was in the furtherance of quality healthcare

The first standard of HCQIA is satisfied if, looking at the totality of the circumstances, the peer review action was undertaken by Defendants "in the reasonable belief that quality healthcare was being furthered." 42 U.S.C. § 11112(a)(1). HCQIA calls for a "generous application of the concept of reasonableness" at the summary judgment stage similar to the "typical judicial review of administrative decisions and of such things as internal procedures for terminating membership in voluntary associations." *Lee v. Trinity Lutheran Hosp.*, 2004 W.L. 212548 at *7 n. 5 (W.D. Mo. 2004), *affirmed* 408 F.3d 1064 (8th Cir. 2005); *see also Freilich v. Upper Chesapeake Health, Inc.*, 313 F.3d 205, 212 (4th Cir. 2002)(describing the HCQIA reasonableness standard as one that "embodies the discretion that health care professionals have traditionally exercised in determining whether or not their peers meet a requisite level of professional competence.").

This HCQIA standard does not require, however, that the peer review decision be correct or that the decision actually improve the quality of health care. *Imperial v. Suburban Hosp. Ass'n Inc.*, 37 F.3d 1026, 1030 (4th Cir. 1994). As long as the record contains evidence that would support a reasonable belief that the action in question would restrict incompetent behavior, would protect patients, or otherwise further quality healthcare, standard one is satisfied. *Gabaldoni*, 250 F.3d at 261.

Defendants satisfy standard one of HCQIA because the record reveals Dr. Randall's peer review action was undertaken to ensure quality care and patient safety, and this action was entirely reasonable in light of Dr. Randall's serious and well-documented problems with abdominal surgery. The physician members of the Peer Review Committee, the Credentials Committee, the Ad Hoc Committee, and the MEC carefully reviewed Dr. Randall's surgical care. *Supra* Stmt. of Facts at § II.B-E. These physicians found that Dr. Randall's abdominal surgery privileges should be terminated because his surgical judgment and technique was substandard. *Id.* Additionally, the surgeon who performed the external reviews of Dr. Randall's cases and the surgeon called to testify by the MEC at Dr. Randall's hearing found Dr. Randall's abdominal surgical care deficient. *Id.*

After Dr. Randall challenged the MEC's recommendation, the Hearing Panel, the Appellate Review Committee, and the Board reviewed this matter and upheld the MEC's recommendation. *Supra* Stmt. of Facts at § F-G. Simply put, the record of this peer review action contains overwhelming evidence that this peer review action was undertaken in the reasonable belief that it was in furtherance of quality health care.

Dr. Randall's counsel has now deposed many of the peer review participants, and their testimony provides additional confirmation that the peer review action was undertaken in the reasonable furtherance of quality healthcare. Dr. Edwards, the Chief of Staff, testified as follows:

> Q: Why did you vote to revoke – to recommend the revocation of privileges?
>
> A: Because I was concerned that there had been a -- there had been a body of cases in which there were problems with pre-operative assessment, intraoperative technique, and post-operative care, as

well as – I think, that meeting, we also had the return-to-OR data suggesting a high volume of return to OR. And, during the whole process, we had – I don't recall other cases coming in that were of concern from any other general surgeon. We continued to have a large volume of cases coming in with Dr. Randall, and they continued to come in throughout the process more – more. And they were raised by physicians, hospital employees, as well as patient families. So it wasn't all coming from one source.

Edwards Dep. at 97:9-25 (Ex. 10). Dr. Patterson, the Chief Medical Officer, offered the following testimony:

Q: . . . Why did the MEC take the action that they took, the revocation –

A: Right –

Q: -- the recommendation of revocation?

A: The general sense of – of my listening to their concerns was that the gravity, the number of complications, the similarity, suggesting technique deficiencies and lack of insight into the difficulties.

Patterson Dep. at 91:6-14 (Ex. 23). Dr. Paxtor, a member of the MEC, testified as follows:

Q: . . . You mentioned there was some sentiment. "Gosh why can't we just pass this [Dr. Randall's problems with surgical care] on to others?"

A: Yes.

Q: Why didn't you pass it on to others?

A: You are asking me personally?

Q: Yeah.

A: Because I felt a responsibility to do something for the patients and the community.

Paxtor Dep. at 80:13-20 (Ex. 31). Dr. Singhi, a member of the MEC, offered the following:

> Q: Why did the MEC vote to uphold the suspension of his privileges?
>
> A: I think the question has been and that's for the Peer Review Committee – after reviewing several cases, it was felt that his surgical procedures in regards to abdominal surgeries, including herniorrhapy, was suboptimal, had a lot of complications, and from patient's safety point of view, there was unanimously agreed and recommended that his privileges should be suspended effective immediately.

Singhi Dep. at 33:4-15 (Ex. 32); *see also* Baker Dep. at 67:5-11 (Ex. 1)(Dr. Baker, MEC member, voted to uphold summary suspension because of his concern for the safety of Piedmont's patients).

In opposition to Defendants' overwhelming evidence that this peer review action was undertaken in the reasonable furtherance of quality healthcare, Dr. Randall will presumably repeat his allegation that this peer review action was a conspiracy against him. Dr. Randall's allegations, however, are not relevant to the appropriate analysis under HCQIA.

The test under HCQIA is whether an *objectively reasonable basis* existed for the peer review action in question. *Freilich*, 313 F.3d at 212; *Imperial*, 37 F.3d at 1030. The sufficiency of the basis for the peer reviewers' action -- not alleged personal bias, malice, or bad faith on the part of the peer reviewers -- is relevant under HCQIA. *Id.; see also Sugarbaker v. SSM Health Care*, 190 F.3d 905, 914 (8th Cir. 1999)("[T]he subjective bias or bad faith of the peer reviewers is irrelevant."); *Austin v. McNamara*, 979 F.2d 728, 734 (9th Cir. 1992)(alleged personal animosity of peer reviewers is "irrelevant to the reasonableness standards of § 11112(a). . ." because "[t]he test is an

objective one, so bad faith is immaterial."); *Lee v. Trinity Lutheran Hosp.*, 408 F.3d 1064, 1072 (8th Cir. 2005)(allegation that peer review action was "crusade" against physician irrelevant to HCQIA analysis); *Bakare v. Pinnacle Health Hosps.*, 469 F. Supp. 2d 272, 287 (M.D. Pa. 2006)(alleged bad faith and anticompetitive motives for peer review action irrelevant to the question of whether action was taken in a reasonable belief that it would further quality health care). Therefore, even if Dr. Randall's peer review action were based upon personal animus, bad faith, or malice, which it was not, this would have no effect upon the HCQIA analysis.

Though it is not relevant to the appropriate HCQIA analysis, it should also be noted that there is no evidence that supports the proposition that Dr. Randall's peer review was a conspiracy against Dr. Randall.

> Q: And – that complaint alleges that you participated in a conspiracy, through this peer review process, to harm Dr. Randall? Did you understand that?
>
> A: Yes.
>
> Q: Have you participated in any – in any kind of conspiracy to harm Dr. Randall through peer review process?
>
> A: I have not.

Edwards Dep. at 93:21-94:4 (Ex. 10).

> Q: Have you engaged in any kind of a conspiracy to harm Dr. Randall through this process?
>
> A: I have not.

Patterson Dep. at 92:17-24 (Ex. 23).

> Q: Dr. Edwards, your chief of staff, do you have any concerns about his participation in this process?

A: I do not. I thought he was deliberate, disciplined, upright. And this was hard duty and he did his best by it.

Id. at 97:12-17. Dr. Jenkins, a good friend of Dr. Randall's and the Chairman of the Credentials Committee, offered the following testimony regarding the allegation of conspiracy:

Q: Do you believe that any of these folks that were sitting around at this meeting and the prior meeting [peer review meetings about Dr. Randall], deliberating and making these recommendations and decisions – do you have any concerns that they were motivated by bad faith?

A: Bad –

Q: Bad faith? Bias?

A: No. No. I don't think so.

Q: Okay.

A: I think it was their true opinions.

Jenkins Dep. at 68:4-14 (Ex. 17); *see also* Benson Dep. at 33:19–34:22 (Ex. 33)(Dr. Benson, MEC member, did not observe or hear Dr. Edwards or Dr. Patterson do anything inappropriate or unfair during the MEC's consideration of Dr. Randall care).

While Dr. Randall certainly makes unsupported allegations of bias against Dr. Edwards and Dr. Patterson, Dr. Randall concedes that the peer review bodies that voted in favor of terminating his privileges, and the bodies that reviewed and upheld these recommendations, were not acting in bad faith. Randall Dep. at 96:18-98:6 (Ex. 5)(disagrees with conclusions of MEC but has "no problem with the motivations for their action"); 158:3-11 (Hearing Panel was not motivated by animus or bias); 163:5-164:8 (neither Appellate Review Committee or Board acted with animus or bad faith). Put simply, even if Dr. Edwards and Dr. Patterson acted out of bias or bad faith, which

they did not, the concession that these bodies acted in good faith makes Dr. Randall's allegations of conspiracy against these individuals immaterial.

The record of the peer review action and the testimony from the peer reviewers reveals that undertaking peer review of Dr. Randall was objectively reasonable under the circumstances. Dr. Randall's contentions in opposition are irrelevant and immaterial, and they certainly fall far short of the preponderance-of-the-evidence showing necessary to overcome the presumption HCQIA provides to Defendants. Defendants should be found to have satisfied standard one of HCQIA.

2. Defendants engaged in a reasonable effort to obtain the facts of the matter

Standard two of HCQIA requires that the peer reviewers engage in a reasonable effort to obtain the facts relevant to the peer review action. 42 U.S.C. § 11112(a)(2). A peer review action that consists of multiple levels of investigation and review generally satisfies this element of HCQIA. *Moore,* 560 F.3d at 175-76; (three-tier peer review process after suspension held to satisfy standard two); *Imperial,* 37 F.3d at 1029. The hospital's Board, the ultimate decision-maker in a peer review action, is entitled to rely upon investigation conducted by the previous levels of the peer review process. *Gabaldoni*, 250 F.3d at 261-62.

The internal record of this peer review action and the testimony obtained in this case establish that Dr. Randall's peer review action was a multi-level process that included more than an adequate investigation of the facts. Dr. Randall's surgical care was reviewed on the Peer Review Committee, the Credentials Committee, the Ad Hoc Review Committee, and the MEC. These multiple levels of review involved numerous

physicians considering the relevant medical records, external reviews, and Dr. Randall's written and oral comments. *Supra* Stmt. of Facts at § II.B-E.

Defendants' peer review process included a two-day hearing that allowed Dr. Randall and the MEC to present witnesses, offer documentary evidence, and cross examine each other's witnesses. *Supra* Stmt. of Facts at § II.F. The Appellate Review Committee then accepted briefs and oral argument of counsel before the matter was ultimately considered and decided by the Board. *Supra* Stmt. of Facts at § II.G.

Dr. Randall offers a single criticism of the investigation. He believes that the input of Dr. Crain, Dr. Schroeder, and Dr. Revell should have been obtained. Randall Dep. at 189:5-25 (Ex. 5). This claim overlooks the fact that the input and opinions of Dr. Crain and Dr. Shroeder were, in fact, obtained when these physicians testified at the Hearing. Hearing Tr. at 46:5-49:4; 175:11-179:16 (Ex. 2). Additionally, to the extent that Dr. Randall believed that Dr. Revell's input was material, he had the ability to call him as a witness at the hearing, but he failed to do so.[7] Dr. Randall's criticism of the investigation is, therefore, of no moment.

The entirety of this peer review investigation -- consisting of three separate levels that included review of hundreds of documents, taking of sworn testimony, and appellate argument -- was without question a reasonable investigation. Defendants should, therefore, be found to have satisfied the second HCQIA standard.

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[7] Considering the opinions his partner expressed during Novant's internal investigation, calling Dr. Revell as a witness would not have helped Dr. Randall. Meeting Mem. 7/1/09 (Ex. 4).

3. Defendants provided adequate notice and hearing procedures

In order to obtain immunity under HCQIA, peer reviewers must provide a physician adequate notice and hearing procedures during the peer review process. 42 U.S.C. 11112(a)(3). The peer review participants are deemed to have satisfied this HCQIA standard if they meet the safe harbor requirements set forth in § 11112(b) or these requirements are waived by the physician. *Wieters*, 2003 W.L. 550327 at **6 (describing subsection (b) as a "safe harbor" for the notice and hearing elements of HCQIA).

Dr. Randall received timely and appropriate notices that complied with the requirements in subsection 11112(b) at every stage of his peer review process. *Supra* Stmt. of Facts at § II.B-G. The notices provided a reasonable description of the adverse actions imposed and recommended, the basis for the actions and recommendations, and the notices outlined Dr. Randall's rights to request a hearing before a panel of his peers, call witnesses, cross examine witnesses against him, and introduce evidence. *Id.* Importantly, Dr. Randall concedes that he received proper notices during his peer review action. Randall Dep. at 188:13-22 (Ex. 5).

With respect to hearing procedures, Dr. Randall was provided the right to have legal counsel represent him at his hearing, and his counsel was able to call and cross-examine witnesses and offer documentary evidence in support of Dr. Randall's case. Hearing Tr. (Ex. 2). The Hearing Panel did not contain any of his economic competitors. Dr. Randall was provided a written report of the Hearing Panel's Decision and notice of the Board's Final Decision. *Supra* Stmt. of Facts at § II.F-G.

Importantly, Dr. Randall concedes that the hearing procedures provided to him were fair. Randall Dep. at 188:23-189:4 (Ex. 5).

Dr. Randall contends that his peer review process was flawed because: (1) there was not a general surgeon on the Hearing Panel; (2) the hearing was not scheduled within 90 days of his suspension; and (3) his attorney was not permitted to participate at an MEC meeting. If a physician's claim of flawed procedures does not implicate a safe harbor element in standard three of HCQIA, it is irrelevant. 42 U.S.C. § 11112(b); *Moore*, 560 F.3d at 177 (physician's claim of a defect in hearing procedure rejected because alleged defect did not affect defendants' ability to satisfy safe harbor). HCQIA's safe harbor does not require that a physician with the same specialty area as the reviewed physician serve on the hearing panel,[8] nor does it require that the hearing occur within 90 days after the adverse action. 42 U.S.C. § 11112(b). While HCQIA's safe harbor does require the reviewed physician be permitted to have legal counsel during the peer review hearing, the safe harbor does not require counsel during MEC meetings. 42 U.S.C. § 11112(b)(3)(C)(i). Dr. Randall's claims, therefore, are of no moment.

Defendants' notices and procedures fit squarely within the safe harbor. Dr. Randall's criticisms of the process are irrelevant under HCQIA. Defendants should be found to have established compliance with standard three of HCQIA.

[8] It should also be noted that including a general surgeon from Piedmont's medical staff on the Hearing Panel would have *violated* HCQIA standard three. 42 U.S.C. § 11112(b)(3)(A)(iii).

4. Defendants' action was taken in the reasonable belief that it was warranted by the facts known

The fourth standard of HCQIA is often considered in conjunction with the first as they are clearly related. *Gabaldoni,* 250 F.3d at 263, n.7. The fourth HCQIA standard is satisfied if the Defendants could have reasonably believed that the action taken was warranted by the facts available. *Imperial v. Suburban Hosp. Ass'n Inc.*, 862 F. Supp 1390, 1400 (D. Md. 1993). "[T]he role of the federal courts 'on review of [peer review] actions is not to substitute our judgment for that of the hospital's governing board or to reweigh the evidence regarding the . . . termination of medical staff privileges'." *Bryan v. James E. Holmes Reg. Med. Ctr.*, 33 F.3d 1318, 1337 (11th Cir. 1994)(internal citations omitted). A plaintiff must show the facts relied upon for the peer review decision were so obviously mistaken or inadequate that reliance upon them was unreasonable. *Meyers*, 341 F.3d at 471.

With Dr. Randall the peer reviewers at Piedmont were presented with a physician with a series of cases with bad outcomes. Dr. Randall's peers, after an exhaustive peer review process, concluded that Dr. Randall's poor surgical judgment and technique caused these bad outcomes. The peer reviewers' decision to terminate Dr. Randall's privileges could not be "obviously mistaken" under these circumstances. Defendants, therefore, satisfy standard four of HCQIA.

In conclusion, Defendants offer an overwhelming quantity of highly probative evidence establishing that the peer review action in question satisfied the four HCQIA standards. Dr. Randall does not have evidence upon which a reasonable jury could find, by a preponderance of the evidence, that Defendants failed to meet the HCQIA

standards. Dr. Randall has, therefore, failed to overcome the statutory burden with which he was faced, and Defendants are entitled to the immunity from damages provided by HCQIA. Defendants' motion for summary judgment on HCQIA immunity should be granted.

II. SUMMARY JUDGMENT SHOULD BE GRANTED ON DR. RANDALL'S CAUSES OF ACTION FOR ADDITIONAL REASONS

A. HCQIA moots Dr. Randall's causes of action

The remedy Dr. Randall seeks pursuant to his conspiracy and defamation causes of action is the recovery of damages. Compl. at ¶¶ 65 and 75. Defendants, however, are immunized from his claims for damages by HCQIA. Therefore, even if Dr. Randall had evidence to prove his causes of action, which he does not, such an effort would be futile as Dr. Randall can no longer obtain the damages he seeks pursuant to these claims. Summary judgment is therefore appropriate because HCQIA immunity has mooted these causes of action.

B. Dr. Randall's conspiracy cause of action fails

A civil conspiracy requires: (1) a combination of two or more persons; (2) for the purpose of injuring the plaintiff; and (3) causing plaintiff special damages. *Kuznik v. Bees Ferry Assocs.*, 342 S.C. 579, 610, 538 S.E.2d 15, 31 (Ct. App. 2000). A civil conspiracy, however, cannot arise "in the context of a principal-agent relationship by virtue of the relationship such acts do not involve separate entities." *McMillan v. Oconee Mem. Hosp., Inc.*, 367 S.C. 559, 564, 626 S.E.2d 884, 886-87 (2006).

When a hospital's medical staff, administrators, and other agents conduct a peer review action they are considered a single person and therefore cannot conspire.

Moore, 560 F.3d at 178; *Oksanen*, 945 F.2d at 699 ("[T]he Board of Trustees and the medical staff of Page Memorial comprised a single entity during the peer review process. Because an entity cannot conspire with itself, the Board and the staff lacked the capacity to conspire."); *Cohn v. Bond*, 953 F.2d 154, 159 (4th Cir. 1991)(holding medical staff are hospital's agents when undertaking credentialing for hospital and therefore defendants could not conspire for antitrust purposes)..

Dr. Randall alleges that Dr. Patterson, the Chief Medical Officer at Piedmont, and Dr. Edwards, the Chief of Staff at Piedmont, are the conspirators in this peer review conspiracy. Randall Dep. at 172:2-7 (Ex. 5). Because these physicians were both agents of Piedmont for the purpose of conducting Dr. Randall's peer review under medical staff bylaws, there is no "combination" of Defendants legally capable of conspiring, and, therefore, this claim should fail.

Finally, and most fundamentally, Dr. Randall's civil conspiracy claim also fails because there is no evidence that the Defendants engaged in conspiratorial conduct for the purpose of injuring him. *Moore,* 560 F.3d at 178 (conspiracy claim failed as physician had no evidence "that formal peer review process was 'conspiratorial' in any real sense of the word"). Simply put, this claim fails because discovery confirmed that Dr. Randall's peer review action was just that – a legitimate and necessary peer review action.[9]

[9] If Dr. Randall's peer review action was really corrupted by a conspiracy involving Dr. Patterson and Dr. Edwards, surely Dr. Randall's counsel would have raised the existence of this conspiracy to the Hearing Panel, the Appellate Review Committee, and the Board. Dr. Randall's counsel made no such assertions. McKay Dep. at 160:13-163:13 (Ex. 22).

C. Dr. Randall's defamation cause of action fails

A defamation claim requires a plaintiff to establish: (1) a false and defamatory statement was made; (2) unprivileged publication of the statement to a third party; (3) the publisher was at fault; and (4) either the statement is actionable irrespective of harm or the publication of the statement caused special harm. *Williams v. Lancaster Cty. Sch. Dist.*, 369 S.C. 293, 631 S.E.2d 286, 292 (Ct. App. 2006).

Dr. Randall's defamation claim is based upon Piedmont's submission of a report to the National Practitioner Databank ("NPDB") concerning the suspension of Dr. Randall's privileges. Compl. at ¶ 68. However, Dr. Randall testified at his deposition that the report Piedmont made to the NPDB is factually accurate. Randall Dep. at 181:9-183:13 (Ex. 5). Because Dr. Randall concedes the statement upon which his defamation claim rests is true, this claim should fail.[10]

CONCLUSION

For the reasons set forth above, Defendants respectfully request that the Court grant summary judgment in their favor on HCQIA immunity and summary judgment in their favor on Dr. Randall's causes of action.

[10] Even if the NPDB report were false and defamatory, which it is not, because Piedmont is required by federal law to report Dr. Randall's adverse peer review action to the NPDB, 42 U.S.C. § 11133, Piedmont's report to the NPDB is privileged and cannot constitute defamation. *Swinton Creek Nursery v. Edisto Farm Credit, ACA*, 334 S.C. 469, 514 S.E.2d 126 (1999).

Respectfully submitted,

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September 13, 2013

Index to Exhibits to Defendants' Memorandum
in Support of Their Motion for Summary Judgment
Case No.: 2012-CP-46-167

Tab	Exhibit Description
1	Excerpts from the deposition of Bob Baker, MD taken on Aug. 12, 2013
2	Transcript of the Peer Review Hearing held on Feb. 16-17, 2011
3	Decision of the PMC Hearing Panel dated March 30, 2011
4	Meeting Summary dated July 1, 2009 regarding meeting between Tom Zweng and Dr. Randall's partners
5	Excerpts from the deposition of Robert Randall, MD taken on July 19, 2013
6	Minutes of Piedmont Medical Center ("PMC") Peer Review Committee meeting held on Dec. 18, 2006
7	Dec. 21, 2006 Letter to Robert Randall, MD from Robert Alexander, MD, Chair of the PMC Peer Review Committee
8	Minutes of PMC Medical Executive Committee meeting held on Jan. 8, 2007
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10	Excerpts from the transcript of the deposition of Nathaniel Edwards, MD taken on July 26, 2013
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13	Minutes of PMC Medical Executive Committee meeting held on Aug. 9, 2010
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16	Sept. 28, 2010 Letter to Robert Randall, MD from Nathaniel Edwards, MD
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Tab	Exhibit Description
24	Minutes of PMC Medical Executive Committee meeting held on Oct. 25, 2010
25	Oct. 28, 2010 Letter to Robert Randall, MD from Nathaniel Edwards, MD
26	Dec. 17, 2010 Notice of Hearing and Grounds to Robert Randall, MD from Nathaniel Edwards, MD
27	Excerpts from Piedmont Medical Center Medical Staff Bylaws
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33	Excerpts from the deposition of Christopher Benson, MD taken on July 24, 2013



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State of South Carolina	)	
	)	
County of York	)	
Robert Randall, M.D.,	)	2012-CP-46-167
	)	
Plaintiff,	)	
	)	
vs.	)	Deposition
	)	
Amisub of South Carolina, Inc. d/b/a/ Piedmont Medical Center, Nathaniel Edwards, M.D., and Richard Patterson, M.D.,	)	of
	)	Robert Wayne Baker, MD
	)	
Defendants.	)	
	)	
	)	
	)	

Deposition of Robert Wayne Baker, MD, taken before Susan A. Wyant, a notary public in and for the State of South Carolina, commencing at the hour of 2:14 p.m., Monday, August 12, 2013, at the office of Piedmont Medical Center, 222 South Herlong Avenue, Room D - Ground Floor, Women's Tower, Rock Hill, South Carolina.

This deposition contains confidential peer review information.

Reported by
Susan A. Wyant

A Didn't make any formal complaints to anybody. I know that, you know, as far as me, personally, I would -- at -- at a certain stage, I would be a little more careful on my IV access and stuff on some of his cases just because there seemed to be some tendency for some blood loss at times that wasn't expected and things of that nature.

Q And -- and what do you mean by "more careful on your IV access"?

A Well, if I normally might have a 20-gauge, I might insist on a larger IV.

Q And why would you need a larger IV if there was more blood loss, for example?

A In order to replace fluids or blood.

Q Okay. And you said you didn't formally make any complaints. Was there a -- was there anonymous or -- method by which folks could submit questions or concerns about a physician's care?

A No. I noticed a trend where our anesthetists weren't as excited about being assigned to his room --

Q Okay.

A -- after a certain point.

Q And when did you noticed that trend developing?

A Gosh. I -- I can't say an exact time period. It

was over a number of years, I believe, that I saw more and more people that wouldn't be happy with their assignment.

Q And -- and what was the -- what was the basis, as you understood from what they told you, that they were dissatisfied or not happy with being assigned to operating room with Dr. Randall?

A Gosh. I can't remember any specifics. I think it was just a general concern that a routine case could become something very different.

Q Okay. And can you think of any instances where you were personally involved where a -- a routine case of Dr. Randall's turned out to be something very different?

A I don't remember any specific cases. No, sir.

Q Okay. So from your personal experience, did -- did -- did you have the -- some level of unhappiness when you were assigned to an operating room where Dr. Randall was performing surgery?

A I think my -- like I said, I think my planning for cases and all changed at a certain point with Dr. Randall in terms of, you know, you -- you just want to make sure everything was lined up perfectly, as you do in any case, but more so just because, you know, we saw more blood loss and -- and issues in

Q Okay. Good. So that's -- you understood that that was an option available --

A Yes, sir.

Q -- to you?

Okay. Good. At that meeting, why -- you voted in favor of upholding the summary restriction?

A Yes, sir.

Q Why did you do that?

A I think at point there was enough concern expressed about safety of patients.

Q Okay. And were you comfortable that those of your colleagues that were participating in this deliberation and decision-making -- that they were motivated by the same concern that you had?

A That would be my assumption, yes, sir.

Q Okay. All right. Did you observe anything that caused you to have a concern that your colleagues were motivated by some desire to retaliate against Dr. Randall?

A No, sir.

Q All right. Did you observe anything that would cause you to believe that they were motivated by some sort of bias against Dr. Randall?

A No, sir.



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BEFORE THE PIEDMONT
MEDICAL CENTER HEARING COMMITTEE

IN THE MATTER OF

ROBERT D. RANDALL, JR., M.D.

CERTIFIED COPY

DATE: February 16, 2011
TIME: 5:57 p.m.

LOCATION: Piedmont Medical Center
222 S. Herlong Avenue
Rock Hill, SC

REPORTED BY: Joy R. Dick, Court Reporter

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HEARING OFFICER: I'm Dawes Cooke. I'm your hearing officer, and probably the court reporter would like it if we started by going around the room and having everyone introduce themselves.

COURT REPORTER: I've got everyone.

HEARING OFFICER: Good.

Then why don't we start by putting on the record any agreements that you have as to evidence of procedure. My role here is really as a facilitator, according to your bylaws. I'm supposed to see that both sides get a fair opportunity to present the case and resolve any evidentiary matters. I'm also at the disposal of the panel should you need any legal advice. I'm not allowed to vote, but at your discretion I'm permitted to participate in you deliberations if you need help.

Procedurally, we won't be making a decision tonight. You'll be hearing all the evidence. And then under the rules, both sides have ten days to file any briefs or closing statements; and then within 30 days, then you're supposed to make your deliberations and issue a written order with your findings and conclusions

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set out.

Any questions about the procedure?

(No response.)

HEARING OFFICER: All right. Then so what about any evidence hearing issues?

MR. MCKAY: I don't think so. I think we've agreed to the medical records for use by the parties of the hospital. I don't think there's any issue with those.

There are some review reports that were done, I think, last summer by some unnamed physicians that I assume the hospital relied upon in their -- some of the actions. I think insofar as -- insofar as the hospital utilized them to make decisions, I don't think that's technically objective.

(Off-the-record conference.)

MR. MCKAY: I think the meat of the opinions set forth, I would have a hearsay objection on. But I think as far as the hospital procedurally utilizing those, I don't think I would have a problem with those. I think the documents themselves, they have a lot of experts.

HEARING OFFICER: Do you have a position on that?

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MS. KREBS-MARKRICH: My name is Julia Krebs-Markrich. I'm a lawyer with Reed Smith. We've been asked by the medical executive committee -- in the case on behalf of the medical executive committee.

We have a series of exhibits that are in a binder that we'd like to introduce, that do include these exhibits to which Jay just made reference. We will put on evidence explaining them in context. We also have a live witness.

And what I'd like to suggest, if it's all right, that each side deliver into the record at this point the respective exhibits, and through our respective witnesses and testimony and later argument, we can debate the utility of those documents.

HEARING OFFICER: Is that all right?

MR. MCKAY: I think that's fine. I think we've stated our position.

HEARING OFFICER: As a preliminary matter, let me say that the rules do allow the parties the opportunity to question any of the panel members as to any bias or prejudice.

Does anybody have any questions for any of the panel members, or for me for that matter?

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MR. MCKAY: Yeah. I'd like to know if anybody has any bias or prejudice against Dr. Randall, if they do.

HEARING OFFICER: I'm hearing nothing.

MR. MCKAY: The only other issue that came up, we had asked that a general surgeon be put on the panel because we are dealing with general surgery, abdominal surgery issues, and we understand -- we sent something raising an objection.

HEARING OFFICER: I saw that. I'm not sure there is anything that can be done, but your position is reserved on the record.

For the panel's benefit, as I understand, this is for termination of privileges, correct, so I'm looking at your hearing rules on section -- let's see, hearing and appellate review procedure, Section G says that in such a situation the body or committee whose adverse action occasioned the hearing shall have the initial burden to present evidence in support thereof. Thereafter, the burden shall shift to the practitioner to support his/her challenge of the adverse action by a preponderance of the evidence, that the grounds therefore lack any substantial

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factual basis or conclusions drawn therefrom, are either arbitrary, unreasonable, or capricious. In all cases the hearing committee shall rule against the practitioner unless the hearing committee determines that the practitioner has met his or her burden of proof.

Do both sides agree that this standard that applies to this hearing?

MS. KREBS-MARKRICH: Medical executive committee agrees.

MR. MCKAY: That's what the bylaws state.

HEARING OFFICER: I'm not supposed to have any regular affiliation with the hospital or the attendant, for that matter, which I don't, and I handle matters like this.

Do you have any questions for me from either side?

MR. MCKAY: No.

HEARING OFFICER: Either side want to make an opening statement?

MS. KREBS-MARKRICH: I'm wondering can we first provide the documents?

HEARING OFFICER: Sure.

While she's doing that, does anybody on

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the panel have any questions about the procedure?
MR. MCKAY: We sent our documents to the hospital. I assume they've been provided, but I don't know that they have or not.
MS. KREBS-MARKRICH: We have not provided them.
MR. MCKAY: I sent them to Ms. West at the hospital. She's been sending us stuff.
HEARING OFFICER: Should there be copies here?
MR. MCKAY: Well, there's no way I can deal with that now. We'll deal with it tomorrow.
HEARING OFFICER: Jay, what do you want to do about your documents? Check on that tomorrow?
MR. MCKAY: Yeah, I sent them to Ms. West.
HEARING OFFICER: Could you check with Ms. West tomorrow?
MS. KREBS-MARKRICH: I think the understanding was you would provide copies.
MR. MCKAY: This is the first time I've been in this position with this hospital.
HEARING OFFICER: We'll have all day tomorrow.

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MS. KREBS-MARKRICH: The medical executive committee has recommended to the board that the abdominal surgical principles of Dr. Randall be revoked, and the evidence that we will present this evening will show that that recommendation was made after consideration by the various peer review committees of the hospital, review of medical records, and discussions with Dr. Randall.
And Dr. Edwards will testify as to the procedures that were utilized and the things that was behind that recommendation.
Shortly after the recommendation for revocation of abdominal surgical privileges was made, there was a case involving a patient Russell. Dr. Edwards will testify on that basis of that case. He invoked his authority under the bylaws of the medical staff to suspend Dr. Randall's abdominal surgical privileges summarily, that means without a hearing. So what we're doing tonight is reviewing the recommendation for revocation of the abdominal surgical privileges as well as a summary suspension.
Dr. Edwards will testify as to the rationale. And you'll see in the documents that

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are in front of you the correspondence that was exchanged between Dr. Edwards and the committee.
You'll also see some of the review reports that Dr. Edwards discussed. You'll also see the review of -- excuse me. The minutes of the medical executive committee and peer review committee and credentials committee, all of which relate those to procedures which led to this recommendation for revocation and the action of summary suspension.
Following Dr. Edward's testimony, Dr. Paul Skudder will testify. Dr. Skudder is a board certified general surgeon, board certified vascular surgeon, and also has surgical and critical care. He will testify as to his views regarding each of the cases that are before you, and whether in his expert professional opinion they provided a fact basis for the actions by the medical executive committee.
Mr. Cooke has already gone through the burdens that each side has in terms of what its presentation is. Our burden is to show that there was a factual basis for the medical executive committee's recommendation that at all times the evidence will show that these actions were based on

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considerations of patient safety, quality of care, and with the knowledge at all times of what the implications of these proceedings are for Dr. Randall.
But in the end, the medical executive committee will show that it believes its actions were warranted by the -- it was warranted after the review process that has taken place.
With that, unless Mr. McKay wants to, we are ready to begin.
MR. MCKAY: My name's Jay McKay. I'm an attorney in Columbia.
Dr. Randall has practiced at the hospital over 20 years. He's trained from Davidson College and went to Bowman Gray at Wake Forest Medical School, and then did his surgical training up there. He is board certificated. He's been recertified twice.
We submit that the actions by the board were without proper foundation, and these were very difficult cases, and that the actions were arbitrary or unreasonable.
Dr. Randall has been reported to the databank. He has other job offers in other areas. He cannot work anywhere because of that. Basically

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his career is absolutely ruined. We would like to get his privileges reinstated so that the databank can be notified and he can go work elsewhere.

He has no interest really continuing to work here at Piedmont, but that's basically where we are. We'd like to get the databank, another finding, another filing with them so that he can get work elsewhere, because he would not be able to work anywhere with that, with the databank error reporting of his abdominal surgery privileges being lifted.

His other surgery privileges, if you're a general surgeon, abdominal surgery is not -- it's not efficient or effective to do amputations or removal of limbs, so we're here to try to get some relief for Dr. Randall getting reinstated, get the databank notified and let him move on to his career. He's still got one child in school and he needs to go back to work somewhere.

Thank you.

HEARING OFFICER: Thank you. You want to call your first witness?

MS. HUTTO: We'd like to call Dr. Nathaniel Edwards.

NATHANIEL EDWARDS, MD

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being first duly sworn, testified as follows:

DIRECT EXAMINATION

BY MS. HUTTO:

Q. My name is Cindy Hutto. I'm an attorney with the firm of Nelson Mullins Riley & Scarborough, and I practice in Charleston, South Carolina. And I'm here with Julia Krebs-Markrich representing the medical executive committee. And right now we'd like to hear from the chief of staff to talk about the process that was gone through that you referred to by the MEC.

Dr. Edwards, could you give your name, please.

A. It's Nathaniel Carter Edwards.

Q. And your position at the time in this case?

A. I was chief of staff in 2010.

Q. Did you hold any other positions?

A. The chief of staff also is the chair of the peer review committee, chairman of the peer review committee.

Q. And how did you become familiar with the cases involving Dr. Randall?

A. The first I heard of them was when I became chair of peer review in early 2010, and the

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cases had come up from the fall of 2008 to the early summer of 2009, and had been sent to outside review by the prior year's peer review committee. And they had all come back, and they were towards the end of the year those were back. And the peer review committee decided rather than start with that peer review committee, starting the process and then having members switch on January 1st, including the chairman, they would delay it until 2010, so that's when I first heard about it.

Q. And what were the nature of the concerns?

A. There had been, as I recall, nine cases that had been sent up to external review that had come about during that seven-month period. And as the peer review committee went through them, the primary concern that came up, and the patterns that seemed to develop, were of inadequate preoperative assessment in terms of planning, which patient should be operated on, what procedure should be done.

And intraoperatively, the issues seemed to be with rough handling of the bowel, inadvertent holes being punched in the large and small bowel, and then recognizing when things were weren't going

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well and switching plan intraoperatively or calling for help.

And then postoperatively a concern that there was not enough active involvement or early recognition of signs and symptoms in the patient that should prompt a return to the operating room.

And there had been a series of occasions that had come up in 2006 for Dr. Randall -- and I didn't see those in detail, but at the peer review committee we did look at the minutes of the meeting, and the summary of the cases then were this similar kind of problem, similar concerns, kind of same patterns as before, and that was concerning.

Q. And do you know why the cases were sent out for external review?

A. I don't specifically know. I know in our bylaws, the reasons that we usually send cases out, or if there are -- there's no one in the medical staff who can be unbiased in their review of the case. And Dr. Randall -- the general -- the general surgical staff was small, and so most people would be either a former partner or a competitor.

Also, if there's a concern in the

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bylaws, a concern that there may be a large or an adverse action, that's another reason to consider an external review.

Q. Do you recall who the outside reviewers were in these cases?

A. The two companies were AMR, Advanced Medical Reviews, and the other company was AllMed.

Q. And do you recall when the outside reviews were completed?

A. We started looking at peer review in April of 2010, so I don't know exactly when they were completed. But that's when we looked at them, in our April and May meetings peer review in 2010.

Q. And could you look at Exhibits 25 through 31 in the notebook there in front of you?

A. (Complying.)

Q. Were those the cases?

A. The first seven were the ones that we were looking at in April and May.

Q. And then what occurred?

A. So the peer review committee looked through the data and deliberated at length, and we took our -- and essentially what we do is we score each case based on quality, utilization, management of the patient, and if there are any behavioral

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issues. And the lowest score -- the best grade you can get is a one, meaning no problem. Any cases that have a two or greater, these are these seven. I think there have been nine. Two of them were scored as all ones. These seven, I found the problems and I presented these to the credentials committee in June of 2010.

Q. And could you look at Exhibit 43 in the notebook?

A. So the minutes from the credentials committee on July 13th, at this point -- do you have a question or do you want me to just go forward?

Q. Is that where that was referred to, the credentials committee that you're referencing?

A. No. Actually it was earlier. It was in June that I went to credentials committee and made a presentation. And then these exhibits --

Q. Was that 45, perhaps?

A. Yes. Exhibit 45, right.

Q. Okay. And then so you reported the concerns to the credentials committee and then after that?

A. So after that the credentials are in the minutes of the first one you had me turn to.

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The credentials committee, Dr. Randall in July was able to go before the credentials committee and be heard, and their recommendation at that time -- I think he was coming up for his -- we go on a two-year cycle for our privileges, and so the recommendation was to continue privileges, which he was up for, I think, and then to review his cases for six months on an ongoing basis, and that he was safe to continue operating.

And then Dr. Jenkins, who was on the credentials committee came to the medical executive committee, and I think that may have been in August.

Q. Can you take a look at Exhibit 41?

A. Okay. Is there another one? That's peer review, and that's an executive medical review meeting.

But at that point, he came before the medical executive committee and told us their findings. And in the medical executive committee, at that time the members of the medical executive committee did not feel that that was going to be an adequate response and were concerned; and Dr. Jenkins, who was on the credentials committee said there was a lot of knowledge that the peer

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review committee had, having gone through these cases in great detail for those two months.

Some of the members of the medical executive committee had served on peer review the year before, so some of them were very familiar with these cases. The credentials committee members were not familiar with the cases, so the medical executive committee at that point asked that we form an ad hoc committee, which would include the credentials committee, the peer review committee position and the medical executive committee position, so they could all be in one room together and discuss things.

And Dr. Randall was notified of that and given the opportunity to -- or asked to give us a written summary of his view on each individual case to compare it with the other data that we have.

MR. MCKAY: Could I take about two minutes? Sorry.

(A recess transpired.)

THE WITNESS: So at that point the medical executive committee asked the ad hoc committee to be formed, that was made up of the physician members of the peer review committee, the

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medical executive committee and the credentials committee.

Dr. Randall prepared written information for us to look at regarding these cases, these seven cases. He had the charts from the primary chart from the patient's hospital stay, and Dr. Randall came before the committee and made a presentation.

BY MS. HUTTO:

Q. Could I ask you, during this period of time was there any additional cases that came to the attention of the committee?

A. Yes. And I may get the timing off on these, but there were three additional cases beyond the first seven that we looked at in the peer review committee that came through, and those were taken into consideration.

I think that Dr. Randall had the opportunity to speak to, but not write and be prepared for two additional cases on top of the seven. There were two more that had been brought to that meeting that he just off the top of his head let us know what his thoughts were on those two.

Q. And you mentioned that Dr. Randall was

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invited to make a written presentation?

A. And oral.

Q. And oral.

Would you take a look at Exhibit 40. Is that what you're referring to?

A. It's not 40 in my book -- wait, this is the executive committee minutes.

Q. Which is reflected in the minutes in Exhibit 40?

A. Yes, I'm sorry. I thought you meant the actual documents that he gave us.

So Exhibit 40 in mine is executive committee minutes from September 13. Okay. I'm sorry. That's right. So this was September 13 that we looked at the written data from Dr. Randall, so it wasn't until he was invited to come speak before the committee after that.

Q. And if you look at Exhibit 16 -- sorry, we're having to flip around a little bit.

A. Yeah, this is the document he prepared.

Q. And Exhibit 17, what is that document?

A. Yeah. This is the letter that I wrote to him to inform him of our desire to have him write his summary of his cases and then come to speak to the committee, the ad hoc committee on

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September 27.

Q. Okay.

A. So he came -- yes, I got ahead of myself.

On September 27 we had the meeting of the ad hoc committee and Dr. Randall came to make his presentation, and I think it was at the conclusion of that meeting that the ad hoc committee decided to recommend revocation of privileges to the medical executive committee.

Q. And that was the ad hoc committee, correct?

A. Yes, right.

Q. And was Dr. Randall informed of that?

A. And he was. He was.

Q. If you look at Exhibit 15?

A. Correct. That's right.

Q. So the ad hoc committee is recommending revocation, so what occurs from there?

A. I'm sorry. I think that it was on October 4. On October 4th we met, and that may be when Dr. Randall made the verbal presentation to us.

Q. If you'll look at Exhibit 38?

A. Yes, that's right. So this was when

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Dr. Randall made the oral presentation to the group. And then the medical executive committee met -- this is Exhibit 37 on October 11, so a week later, and we -- this recommendation from the ad hoc committee was presented to the medical executive committee.

At this point we did look at those two additional cases that you asked about earlier, because they had come back from the external peer review at that point.

And at the ad hoc committee meeting on October 4, when Dr. Randall presented, the ad hoc committee asked the medical staff office to pull together information on unplanned returns to the operating room within 30 days of original surgery for all the general surgeons so they could get a baseline comparison. And in that data we found out that Dr. Randall's rate of return were far above the other surgeons.

So on October 10, after reviewing all those facts and data, Dr. Randall's written and oral presentation, the return to OR data, the primary data from the charts and the external review, the MEC voted to restrict Dr. Randall's privileges performing intraabdominal surgery, where

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the problems were occurring, and allowed him to have a hearing and continue to practice until the hearing had convened.

Q. And then?

A. I will say during that meeting -- well, there was discussion of all different options that we had, and there was a strong sense in the meeting that Dr. Randall's privileges should be summarily suspended at that point; but we ultimately decided to restrict and allow the process to go forward to give him another opportunity to let due process unroll.

And then after that, just a few days later, a case came to me as chief of staff. It originated with a woman's husband lodging a complaint about a lady who had come in with a cholecystitis and postoperatively had an 11-unit bleed, a massive bleed, and he was concerned about the postoperative care his wife had received, as was I.

At that point, I, as the chief of staff, had the right and felt an obligation summarily to suspend Dr. Randall's privileges. And he was allowed to come before the MEC.

The MEC met a few days later, as in our

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bylaws that the MEC has to meet and either revoke, modify, or uphold the summary suspension. So Dr. Randall was able to come before the committee to be heard. And that meeting -- you could probably point me to it -- the summary suspension was around the 15th and the meeting was maybe on the 25th, I think, of October, the MEC meeting.

And after a presentation, the medical executive committee voted unanimously to uphold the suspension.

Q. With the case that you just mentioned, you mentioned a couple of concerns. I mean, what was it?

A. The issue was even in the cases that we reviewed in 2006, the issues seemed to be operations in and around the liver, in the portal structures of the veins that go into the liver from the intestine, of having trouble dissecting that area. And this was a surgery that had a complication in that area.

And we also were concerned about postoperative management and quickly returning to the OR when needed. And this patient had a massive bleeding event, and it was felt by me and by the medical executive committee, it echoed the patterns

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we had seen before.

And there was concern in the MEC meeting, in which the recommendation was going to be made to the board to restrict privileges, that it -- you know, that it might not be safe -- people were concerned that it really wouldn't be safe for Dr. Randall to continue operating because other people could be harmed and there could be danger, and then this occurred and that's why the summary suspension was put into place.

Q. What was the imminent danger? What was the feeling in your mind at that point?

A. Well, there had been many adverse outcomes, dangers, and even deaths, and we thought that that could happen to another patient imminently.

Q. If we could point back out, you mentioned an issue with Dr. Randall in comparing data to his returns to surgery and some comparative data. If you could look at Exhibit 10, the last page there.

A. Yeah. This is the data that the medical staff office pulled together at the request of the ad hoc committee, and Dr. Randall's referred to as RR; the other surgeons are surgeons

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one through five. They did a number of patients who returned to OR, unplanned return to OR within 30 days for 2008 and then the first half of the year of 2009.

And in that January-July time frame, there were -- Dr. Randall had eight patients who returned to the OR on an unplanned basis in a month, whereas the highest other surgeon was two, two, a two, a one, a one and a zero. And then the number of actual returns, one patient could go back more than once, was 26 for Dr. Randall, zero, one, two, two and one.

So he was the only one who had multiple returns to OR per patient. Each other surgeon had one return to OR when a patient went back. So those seemed to be way out of line, and it confirmed the committee's concern that -- in medicine, in my opinion, we don't have a very good ongoing way of measuring quality. In some specialties it's better than others.

In cardiology, which I practice, it's gotten pretty far along, and I get -- my patients who come up with heart attack and heart failure, how I'm doing, am I prescribing medicines that need to be -- in general surgery, as far as I'm aware,

there's nothing along those lines.

So the only thing that we get coming to peer review are things that really rise to very high levels, to a point that a patient, staff member or a doctor lodges a formal complaint. There's a pretty high barrier for doing that.

And the question was does this just happen to be a bad series of cases, and we felt with the number, no other surgeon had that number of complaints coming through the peer review process.

And then looking at it another way, just to look at returns, OR had more data, it seems to be that Dr. Randall really stood out there too.

Q. So, could you explain to the panel the reasons that the committee felt it was -- you know, the basis for their adverse recommendations?

A. Well, all the data we looked at, these returns to the OR, the pattern, recurring themes of difficulties in preoperative assessment and planning, postoperative care and intraoperative surgical technique.

And, you know, the focus always was on having a safe environment in which patients can come in and be operated on and not worry about

having an adverse outcome. And that was the main reason that we recommended the revocation.

I think the feeling was among -- a very strong feeling among all the members that spoke at the medical executive committee was that there really was -- the next patient could have an adverse outcome or death, and it was our obligation, in order to be able to sleep at night, to suspend the privileges summarily to prevent that.

Q. How did you feel or how did the committee feel in receiving information from Dr. Randall on the multiple occasions that he had a chance to explain the cases to the --

A. Very thoroughly. I think the sense was we didn't discuss it in length, but the sense was that there was a little bit of lack of recognition of the problems that existed and a tendency to gloss over some problems.

The woman who had the 11-unit bleed, which admittedly he didn't have a chance to prepare for, that was one of the extra cases that we talked about, but he mentioned that it was just a little bit of bleeding, she had a little bit of bleeding but did fine. But 11 units didn't seem it was a

little bit of bleeding.

There was a general sense that there was a lack of appreciation for the severity of the problems that existed, and I think that concerned the members as well in terms of if you're not able to recognize that a problem is there, it's hard to correct it.

Q. And ultimately what was the conclusion of the MEC?

A. Was that Dr. Randall should not practice and his suspension should be -- privileges should be suspended, if that's what you're asking.

Q. And the conclusions that you reached, those were based on the facts that you received?

A. Like I said, all the facts that we had in front of us, the external review, primary chart data, and return-to-OR data, Dr. Randall's testimony, written, all those facts were taken into account.

Q. And in view of the MEC, were there concerns related to the significance of the cases?

A. Yes. Yes. I'm not sure exactly what you're asking, but we were concerned about if the patient, the adverse outcomes were severe, they were not minor, if that's what you're asking, in

terms of morbidity, people dying, and significant mortality, if that's what you're asking, yes.

MS. HUTTO: Thank you for your time. Answer any questions that Mr. McKay may have.

CROSS-EXAMINATION

BY MR. MCKAY:

Q. Dr. Edwards, you're a cardiologist, correct?

A. Yes.

Q. Not a general surgeon.

A. Yes.

Q. Not holding yourself out as having any expertise in general surgery.

A. That's correct.

Q. Don't know general standards for surgery?

A. (Witness moves head up and down.)

Q. Don't do any laparoscopic surgeries, don't operate on bowels or gallbladders, that sort of thing?

A. That's correct.

Q. You have a medical practice as opposed to a surgical practice?

A. (Witness moves head up and down.)

Q. The two cases that seem to tip this

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over for Dr. Randall, the two later cases, the 11 units of blood and then the patient was returned multiple times to the OR, correct?

A. I don't think anything tipped it over. I think it was the summation of all of the cases, that those fit along with the whole pattern.

In terms of the recommendation of the MEC to recommend to the board revocation of privileges, I don't think there was any one thing that tipped it over.

Q. Well, Exhibit 43 is a board meeting in July of 2010 and the recommendation was not to -- was to allow Dr. Randall to continue on with privileges; is that correct?

A. This is the credentials committee meeting. This was not the medical executive committee or the board of the hospital. Exhibit 43 refers to the credentials committee, that's correct.

Q. And the actual language from the hospital records, that the physician committee members felt that Dr. Randall was safe to continue performing surgery.

A. Correct.

Q. It was noted they have observed him to

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be more aggressive in returning patients to the OR when it is indicated than some other general surgeons in that group, but basically at that time they felt he was safe to keep his privileges, did they not?

A. That's what I'm referring to. Those physician committee members were two doctors, Dr. Earl Jenkins and Dr. Norm Taylor. That was what I was saying, those two physicians came back. Dr. Jenkins came back and made this presentation to the medical executive committee, but in his presentation said, you know, as we've thought about this, as I've thought about this, I think we weren't right essentially. That's paraphrasing, but we didn't really have the knowledge of the cases that you did, and that's why the ad hoc committee was developed so we could go back and address it in more detail and more thought.

They had, as far as I know, maybe two meetings relative -- and what they had was the peer review's recommendation to them that scoring of those cases, but that was -- and Dr. Jenkins said I don't think we got this right. And I don't want to put words in his mouth, but that's about it.

Q. Now, the case you mentioned with the

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11 units of blood, that was a lady who had a gangrenous gallbladder, right?

A. Cholecystitis, yes.

Q. Gangrenous?

A. Uh-huh.

Q. She also had some mental problems, I believe, and ended up pulling out her ENT tube and had aspiration pneumonia. That's the same case?

A. Yes.

Q. And this bleed that she had was over three or four days, was it not?

A. Yes.

Q. And it seems like you were faulting Dr. Randall for taking patients back to surgery. In this case you're faulting him for not taking the patient back to surgery?

A. Right. The general thing was, yeah, it's a question of who should go back and when, and that some patients may have gone back who shouldn't and others didn't go back who should.

Q. And this patient actually recovered fine.

A. She did.

Q. Didn't have to have a second surgery and the risk of anesthesia and the risk of other

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procedures?

A. That's correct.

Q. And so the medical management turned out to be the best management in not putting her through another surgery; and, in fact, getting three days of giving some blood your recovery time is going to be much shorter from that than from having a large open exploratory surgery?

A. That, I don't know. I guess always how things turn out, it's going forward, you can make a better judgment once things are done. Had she not done well and that large hematoma got infected, then you could say that was a bad decision.

Q. That's the thing about medicine, you have to make judgments at the time.

A. That's correct.

Q. And we all wish we had hindsight.

A. Yeah.

Q. And we all wish we could pick our patients.

A. Yes.

Q. But in any event, the other patient was the 29-year-old lady with severe cerebral palsy, who had basically been bedridden her entire life with multiple returns to surgery; is that correct?

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A. Yes.
Q. Okay.
A. You say other patients. She was one of many patients. I'm not sure what you mean by the other patients.
Q. And that patient ended up somehow tearing a tube loose that had been sewn into her bowels and she ended up having a bleed. She did that herself, correct?
A. Yes.
Q. It was sutured in on the outside and on the inside, however she did it, who knows, but she did it.
A. Correct.
Q. She also pulled out other tubes that had been placed in her during her hospital stays.
A. As far as I know.
Q. She ended up getting peritonitis; is that correct?
A. Yeah.
Q. And these multiple returns for surgery for her were not because of a surgical misadventure, they were actually planned returns to clean her out because she ripped these tubes loose inside of herself and she ended up getting

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peritonitis. These were planned returns because she was mentally incompetent.
A. Well, in this case the feeling was her stomach was up in her chest, and Dr. Randall pulled it down and closed the defect in the diaphragm. And his response to the -- or his assessment, one of the critiques was that the G-tube, the feeding tube should have been placed at the time of the original surgery, which would fix the abdominal wall and hold it down so it wouldn't move back up.
In his review he said yes, that was --
Q. It's an option.
A. Well, I think he said that that was -- he shouldn't have -- he should have done that the first time, is what his statement was. That's what I was referring to. As the surgery's planned, there are things done that shouldn't have been.
There was a lady who had -- I guess there are expert witnesses to go into more detail. But there was one man who had prior appendix surgery at an outside hospital and had complicated multiple infections, multiple abscesses, and came in with gallbladder problems, cholecystitis and inflamed gallbladder; and Dr. Randall did the gallbladder surgery, but also dissected apparently

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down around all that inflamed mass because there had been a cystic mass on the CT scan.
Again me as a non-surgeon, I know in medicine that if there's things that are causing problems, I would fix the problem, but I wouldn't expect -- again not being a surgeon -- that I would go start dissecting in an area that had a lot of adhesions already, and that I would -- if I saw this mass -- and I'm assuming he went down there looking for cancer or something going wrong, a new abscess, but I would expect all that to be here, all these adhesions and fibrosis from before.
So that was another case in which the question was what's the right surgery. I don't know which patient it was who had her appendix taken out at the time of some other operation, which again if it's not causing a problem, don't go after it. A lot of questions about planning and that kind of thing.
And then this issue of the perforation in the bowel, and those certainly were mentioned as occurring during surgery. There was a problem of stabilizing anastomosis, in which there was a breakdown in the anastomoses and a return to OR was planned on that.

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Q. That's just a risk of surgery?
A. Well, the feeling at least of the expert, outside review expert, was that it was a technique issue.
The young man who died, who was in his 30s, after having his appendix removed, came in with an appendicitis, had an uneventful appendectomy. Went home and came back two days later with abdominal pain, ended up dying. And he did have multivessel coronary artery disease, but he had -- I think this is one that the pathologist -- I went back and looked at the actual pathology report.
The way the appendix had been cut, the appendiceal stump was where the stool was leaking out, and that infection brought about his demise. So it was very concerning to the MEC to see these kinds of things going on.
Yes, there are cases -- I'm not saying every problem identified with every case -- the one that you brought up are fairly brought up, but there was an overall pattern of things that were very concerning to the MEC.
Q. Well, let me ask you this. No doctor guarantees that they will cure a patient, correct?

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A. That's correct.
Q. And basically what you do is you want to employ your education, training and skill on that patient --
A. That's correct.
Q. -- and hope they do well.
But if they don't do well, and you've employed your training, education and skill, even if the patient dies or gets worse, you've still complied with the standard of care; is that correct?
A. Well, if you don't do the surgery properly, no. The standard of care doesn't mean I'm just going to do my best. I went to school and I learned and I'm going to do my best, if that's what you're trying to say. That doesn't imply standard of care, no.
Q. If you've acted within the standard of care and the patient gets worse, it's not the physician's fault; is that correct?
A. Well, certainly you do the best you can, you do the operations that are indicated and you use good technique. But there are people that do a better job than others although you're operating within the standard of care. And there

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are times when you don't operate on somebody that you say this person's very complicated, maybe they should go -- as I do frequently with my heart patients, you need to go to a larger hospital where they have the tools that are needed or have more expertise.
As you said earlier, it would be nice if we could all select our own patients. To some degree you can. You could say this is something I'm comfortable with; here's one that looks very complicated, maybe I should send them somewhere else. That's an option.
Q. A lot of times you don't know how complicated it is until you get in there?
A. Well, you know what the preexisting -- went they walk in the door. And a lot of these patients, though some of them were -- not all -- some of them were very healthy. But the ones that are ill, you can foresee -- not everyone's the same walking in the door, they have a lot of other illnesses and prior surgeries, adhesions, and you may say this one needs to go somewhere else and find a better place for them.
MR. McKAY: Thank you. That's all I have.

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HEARING OFFICER: Any reply?
REDIRECT EXAMINATION
BY MS. HUTTO:
Q. Dr. Edwards, the question that Mr. McKay had about credentials, the credentials committee was part of the ad hoc committee that you referred to?
A. That's correct.
Q. So the credentials committee was brought in as part of the process; is that correct?
A. That's correct. And when the votes were made about the recommendation for revocation of privileges, Dr. Taylor and Dr. Jenkins, it was a unanimous vote, so they voted for that; although they said previously -- we think it's stated in the minutes that Mr. McKay referred to -- we think it's safe to continue operating. After further review of the data and looking at more facts, they voted to recommend revocation of privileges.
Q. That was the ad hoc committee recommendation?
A. Yes.
Q. Okay. Thank you.
Just if you could look through Exhibit 41?

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A. Another point, while we're looking at that, if you don't mind, in terms of Mr. McKay's statement of my not being a general surgeon, that's true, but I'm a physician. And we did have on the medical executive committee -- and I may have said this before -- pathologists who are used to dealing with pathology and seeing it, anesthesiologists who are in the operating room and familiar with surgery; surgical subspecialists, who have general training. So it wasn't as if it was a group of medical doctors making a decision who didn't have any knowledge about surgery.
And again, the OBGYN surgeons are very close to the abdomen, in there frequently, and know about that kind of thing. Their comments are very useful during the discussion.
Q. Exhibit 4, 6, and 7, if you could just confirm that those are your correspondence to Dr. Randall.
A. Yes, they are.
Q. And Exhibit 11?
A. Yes.
MS. HUTTO: Thank you very much.
THE WITNESS: Thank you.
HEARING OFFICER: Anything else?

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MR. MCKAY: No.
MS. KREBS-MARKRICH: Our next witness is walking out the door. He will be right back.
HEARING OFFICER: While they're fetching that witness, it's a procedural question. I think it was Dr. Powell who may be on call tomorrow night and he said he might have a problem being here. I was flipping through the rules and I notice there needs to be at least five members tomorrow.
What do you want to do about this in the event that we might not have a quorum tomorrow?
MR. MCKAY: If it comes up, we'll just have to address it.
MS. KREBS-MARKRICH: I think the bylaws also specify as long as the majority of the panel is present, the panel can proceed.
HEARING OFFICER: Okay.
MR. MCKAY: This is Dr. Crane. This is one of the witnesses we can take out of order. It won't take five minutes with him. Do you want to take him now? He's on call tomorrow night.
HEARING OFFICER: Any objection calling him?
MS. KREBS-MARKRICH: There's no

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objection. We do have to get through Dr. Skudder.
HEARING OFFICER: Okay.
MR. MCKAY: I was going to call Dr. Cory Crane, if I could.
CORY CRANE, MD,
being first duly sworn, testified as follows:
DIRECT EXAMINATION
BY MR. MCKAY:
Q. Would you state your name and your medical address?
A. Cory Crane, and business address is 1721 Ebenezer Road, Rock Hill, South Carolina, Suite 175.
Q. And you're a board certified general surgeon?
A. Yes.
Q. Licensed in South Carolina and North Carolina?
A. Yes.
Q. And you've been recertified?
A. Yes.
Q. Now, you worked with Dr. Randall in his former practice for approximately a year and a half; is that correct?
A. Yeah, about two years.

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Q. About two years?
A. July of 2008.
Q. Before that, you've been on staff here as a general surgeon for probably 20 years or so, haven't you?
A. Twenty-five years.
Q. Twenty-five years. So you've known Dr. Randall as a fellow general surgeon for 25 years?
A. Correct.
Q. And prior to y'all working in the same practice, you occasionally work together on cases?
A. Yes.
Q. One would assist the other from time to time?
A. To be honest with you, I don't remember operating with Bob before we -- before we joined in July of 2008 for a year or so. We were cross-covering our practicing and taking calls for each other, and then we started assisting each other from time to time.
Q. Okay. And you are familiar with his surgical skills and surgical medical judgment; is that correct?
A. Yes.

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Q. Is it your opinion that Dr. Randall is a competent general surgeon to practice general abdominal surgery?
A. Yes.
Q. Is it your opinion he practices within the acceptable standard of care?
A. Yes.
Q. Is it your opinion, to a reasonable degree of medical certainty, Dr. Randall is not a danger to his patients?
A. Yes, that is correct.
Q. And is it your opinion to a reasonable degree of medical certainty that Dr. Randall should be allowed to continue at this facility with surgical privileges?
A. Yes.
MS. KREBS-MARKRICH: Ms. Hutto and I have been asked to present the medical executive committee case.
CROSS-EXAMINATION
BY MS. KREBS-MARKRICH:
Q. Dr. Crane, are you familiar with any of the cases that are at issue here tonight?
A. No. I don't know what cases are at issue.

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MS. KREBS-MARKRICH: I have no questions.

MR. MCKAY: We'd ask Dr. Crane be excused.

HEARING OFFICER: Fine. Thank you.

MS. KREBS-MARKRICH: Medical executive committee would like to call Dr. Skudder.

HEARING OFFICER: All right. Dr. Skudder.

PAUL SKUTTER, MD

being first duly sworn, testified as follows:

DIRECT EXAMINATION

BY MS. KREBS-MARKRICH:

Q. And now, Dr. Skudder, could you state your name for the record?

A. My name is Paul Skudder.

Q. And what do you do, Dr. Skudder.

A. I'm a board general surgeon and a board certified vascular surgeon and a practitioner of surgical critical care. I practice in this time in eastern Massachusetts. I've been in the practice of surgery since 1985 when I completed my training.

Q. I'd like you to look at MEC Exhibit 60.

A. I guess you're addressing me, yes.

Q. Please.

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A. This is my curriculum vitae.

Q. So, Dr. Skudder, you say you're certified in general surgery. Are you also current with your certification?

A. Yes, I've recertified twice.

Q. In surgical care?

A. Ditto.

Q. And vascular surgery, is that the same?

A. Yes.

Q. As a vascular surgeon, by the MEC you were asked to review the records in the case. Could you -- you're a vascular surgeon primarily?

A. At this point in my career I do primarily vascular surgery.

Q. And what are the general considerations that would support a vascular surgeon reviewing the records of a general surgeon?

A. Well, every vascular surgeon is a general surgeon first. I can't enter vascular surgeon training until I'm certified in general surgery.

The first half of my practice was more or less equally mixed; and then as time went by I became gradually more specialized in vascular surgery, as many people have.

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I think in addition to the purely clinical experience, I have a certain background in work such as this, which probably began when I sat much as you gentlemen did here, as a member of a hearing committee; and my hospital reviewing, not a clinically identical situation but a similar fair hearing process that involved the revocation of privileges of a surgical pathologist several years ago, many years ago.

Following that I evolved through many layers of medical staff leadership in a 500-bed full-service hospital, including medical staff leadership, but also credentials committee, and peer review committee, and I moved, if you will, from the role you're sitting in now to a role more like Dr. Edwards' role, an oversight type of role.

In that period of time I was also president of my county medical society. I've gone on to be vice president of regional specialty societies, etc.

I also -- in ways I can't even remember how it began -- several years ago was contacted by this AllMed organization and began performing peer reviews for them.

I can't give you a number of how many

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of these I've done, but it's dozens.

And in addition to that, I have had -- been asked from time to time to act as an expert witness in medical malpractice cases, which are of course a little bit different environment than this is, but in some ways utilize the same skill set, if you will.

Q. But would it be fair to say that based on your work in hospitals and in medical societies and as reviewers for AllMed, that you are basically familiar with the concepts and principles underlying --

A. The extent is to provide an objective analysis. In this particular scenario it's nice because I don't have any vested interest in the outcome whatsoever. These are painful scenarios. I have a certain sympathy to the hospital's viewpoint, having sat on hospital leadership, and the need to -- whether it be a liability risk management need or simply an ethical, moral need, in a particular community hospital such as this, to present to the public a safe product in every department.

At the same time I'm very sympathetic to the physician's viewpoint in that this is

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clearly a career-threatening event to one individual in this room.

These are painful things and they can be hard to work through. They need to be worked through precisely in the sense that one must resist the temptation to equate outcome with process.

What I mean by that is a patient can have an outstanding outcome but have been very poorly treated; and, conversely, a patient can have a terrible outcome despite good treatment. So one must look at the work one has done as best one can by trying to analyze the process in a real-time scenario rather than the outcome in a retrospective, or hindsight, scenario.

This can be very challenging because the records tend to be either incomplete, illegible or so bloody voluminous that getting through them all is a pipe dream.

Q. Well, in your clinical role, do you operate in the abdomen?

A. Oh, yes. We certainly have ample opportunity to engage in the abdomen as vascular surgeons. And although I'm sure counsel will point out that it's been many years since I actively practiced gallbladder surgeries and some of the

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other procedures done here, the volume of cases in my personal experience is substantial.

Q. What about dissection? Are you familiar with dissection?

A. Yes, ma'am. General surgeons, vascular surgeons, and, frankly, any other surgeon is accustomed to the need for care of dissection and the techniques in doing it.

Q. How long have you been doing AllMed reviews?

A. I am going to have to look that up. I guess eight to ten years.

Q. Did you perform one of the reviews for AllMed in the case?

A. Yes. The review of a patient by the name of H[redacted] C[redacted]a July 19th, 2009, was my work. I did not realize until I was called again by the physician who was the principal in the AllMed organization, about five weeks ago, asking me if I would accept this role. I didn't realize -- he had to call to my attention that I had previously seen one of these cases. I did not recall that.

Q. So Dr. Skudder, when you were asked by the MEC to review these cases, what had you

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reviewed in preparation for your testimony today?

A. I have reviewed the charts of the individual cases.

Q. So are those charts that related to -- I'm going to give the patients' names here. Patients C[redacted]r, C[redacted] E[redacted], J[redacted] and M[redacted] P[redacted], R[redacted], S[redacted], W[redacted] [redacted] the cases that are on the patients. Have you reviewed these cases?

A. Yes, ma'am.

Q. What else have you reviewed?

A. I have reviewed the ten outside reviewer documents that reviewed these cases.

Q. I just want to make sure that the panel is following.

If you would turn to, I believe it's starting with Exhibit 25.

A. Number 26 is the one that I did two years ago.

Q. Okay. But you have reviewed Exhibits 25 through 34, which are the outside peer review?

A. Yes, ma'am.

In addition to that, I was provided with a written document that sort of came in two versions authored by Dr. Randall. The first

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version dated September 16, I believe, and the second December 21st. This is, for lack of better language, Dr. Randall's own review of these ten cases.

The difference between the two is that they were not all reviewed -- they were not all addressed in the September 16 document, and he added, appropriately, the review of the remaining two or three cases to the December 21st document.

For completeness sake, in addition to that, I have with me a three- or four-page extraction of the clinical highlights of each case that I drew up myself. This is my own work. It was not provided to me by anyone else. It is essentially, although it's in typed format, amounts to my own personal notes after going through all these reams of material.

Q. Now, the MEC is offering your testimony here as an expert witness. Have you formed any opinions generally regarding these ten cases?

A. I have. And maybe first I'll mention that there are certain opinions that I have not formed largely because I was not asked to form them. Quite frankly, it's probably not appropriate.

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I have not formed any opinion about what action should or should not be taken. That was my charge. I was asked to render opinions about the clinical findings and the surgical care, opinions that address the basic issue of quality of care, and also address the issue of standard of care. And of course those are related but not identical things, aren't they.

And I have not formed opinions of any individual, Dr. Randall or anyone else's conduct outside of these ten cases, because this is what I was provided.

I also acknowledge that the hospital charts, which with the exception of one case, Mr. Wilburn, are charts of a single admission. Some of the patients had multiple admissions, and I do not have charts of the multiple admissions, which may or may not impact on decision-making.

And, finally, although I was provided with reams of chart work -- I don't know if I'd have found the time to review them, but I was not provided with any of the images, CT scan images, chest x-ray images, upper GI series images, et cetera.

I was provided with the radiologists'

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interpretation of the images, but I think there's a lot of times when the surgeon needs to look at these as well as part of clinical care. These were not provided.

Then you asked me what opinions did I form. These are ten ugly cases. There are bad outcomes involved in them. And I stated previously that one should not equate outcome with process; but in many occasions those outcomes are appreciated with processes of care or care processes that went on.

Q. Does the mere presence of a complication mean that there was substandard care?

A. It does not. As I said before, bad outcomes, complications can certainly occur in the context of very good medical care; and the converse is also true, good outcomes can occur in the context of very poor medical care.

Q. In the course of your review, did you also take into account particular circumstances of the patients, that they may have been predisposed to certain complications that they may have?

A. The question you asked revisits my comments earlier regarding the importance of trying to look as much as I can in real-time, as

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though I was the physician taking care of the patient rather than looking at it retrospectively, already knowing the outcome, how would I myself have cared for that patient.

Because the standard of care is not a pinpoint thing, it's a range of responses to a given clinical situation. So what options would the reasonable physician have taken in response to these situations in the clinical context that that particular patient presented with.

Q. In your review of the ten cases, did you come to any conclusions regarding general themes about how these cases might be viewed as far as for analytical purposes, in the analytic context?

A. I concluded that -- as I stated before, it's an ugly group of cases. There are technical questions, failures, errors, look at it either way, look at it with any of the language involved with any of them.

Some of these can be grouped together into a couple of different types of technical errors. Others are a little more random, if you will. And, likewise, there are several cases which suggest that judgment was outside of the pattern of

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judgment that most general surgeons would follow.

Q. If you could direct your attention to the case involving Ms. R[redacted]. Ms. R[redacted] is in the notice of hearing which is at Exhibit 4. Ms. Russell.

A. My attention is so directed.

Q. Ms. R[redacted] is case ten. And this is the case that Dr. Edwards just testified was the situation that led him to impose the summary suspension of Dr. Randall's abdominal surgical privileges regarding him.

Have you had a chance to review the rest of the record?

A. I have.

Q. And have you formed any reasons or thoughts about that?

A. Well, I have.

Q. Could you tell us what they are?

A. To do that I need to summarize the case just a little bit as well. This is an individual who suffered an 11-unit bleed into the peritoneum following a laparoscopic cholecystectomy for a severely inflamed gangrenous gallbladder. I believe in Dr. Randall's response letter, he mentioned a 10-unit bleed. Quite frankly, the

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difference is immaterial and I don't think it really matters.

Q. If you look at the discharge summary, page 37 to 39.

A. The procedure was done laparoscopically and was not converted to an open procedure despite multiple statements in the operative record and in Dr. Randall's letter of December 21st, 2010, regarding the technical difficulty associated with the severity of inflammation.

When the procedure was reviewed by an outside physician other than myself, the outside reviewer came down very hard on this decision, and I think to a large degree that is justifiable, although I also acknowledge that the decision to convert from closed to open is a uniquely -- is a judgment that can only be made by the individual on scene.

Nonetheless, based on the descriptions of the complexity of the dissection, I think many surgeons would have converted to an open procedure.

Q. Do you have your computer before you?

A. (Witness moves head up and down.)

Q. The operative note is pages 160 to 162. Is that what you mean?

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A. Now, does everybody -- can everybody else do this?

Q. Yes.

A. This does take a moment. 162, you said.

Q. Pages 160 to 162, that was the operative note. You were talking about the difficulties, and I just wanted to make sure that this was tied to your opinion.

A. I don't want to read the whole report into the record, but I will begin at the top of page 162, I think is where I am.

There was a large inflammatory mass involving the omentum in the colon, covering the area of the gallbladder. The gallbladder was acutely inflamed and necrotic. A portion could be dissected free. The gallbladder tore secondary to necrosis.

And the note continues in many ways stating the same things regarding the severity of the inflammation. I have no doubt that that was the case, and I believe the pathology report supported the severity of the inflammation in this case.

If we turn to Dr. Randall's letter of

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December 21st, which is really our only other source of information about this case, he stated in that letter the surgery was technically difficult, secondary to severe gangrenous cholecystitis, but I was able to identify all the anatomy.

So tough case, chose to do it closed.

See if I can get back to my train of thought a little bit. This is why I brought notes, I'm sorry.

The bleeding after the case, the 11 units of bleeding was attributed by Dr. Randall to bleeding from the liver bed, the raw surface of the liver from which the gallbladder is removed. Although this is not established, patient also showed some evidence of sepsis and had a small subhepatic abscess later in her course. She recovered after a period of critical illness in the ICU.

So in my opinion, technical concerns surround a number of things, including what is the origin of the bleeding. And judgment concerns surround the choice not to open the case despite these technical difficulties described, and the decision not to reoperate as the patient was bleeding 11 units over the next two to three days.

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As Dr. Edwards pointed out earlier, this patient did have a good outcome, at least she survived. But we need to point out that that's not a guarantee of a good outcome. Her course was probably actually longer than it would have been had she had an uncomplicated open cholecystectomy.

And 11 units, let's put that in perspective, that's about a gallon and a half hematoma in the belly, leaves the patient at risk for multiple complications, whether it be a small inoculum bacteria converting that into a really large abscess, as well as likely bowel compression; ileus on the basis of this; the potential for jaundice or other complications as the bilirubin is reabsorbed; potential for kidney insufficiency also associated with the reabsorptive process.

The fact that she got through doesn't mean it was good care, is my point here.

Nonetheless, judgment concerned involved a choice not to open despite the technical difficulties and the decision not to reoperate.

The only imaging we have regarding the bleeding is the CT which shows a hematoma below the liver. No surprise there. Again I didn't see the images. That's the report.

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There's no study or intervention to sort out the true source of the patient's bleeding. Dr. Randall's December 21st letter states unequivocally that the bleeding was from the liver bed, which is certainly a potential source of such bleeding, but is equally certainly not the only potential source.

Other sources might include the cystic artery or other vessels in the fleura hesperus. Attribution of the bleeding to the liver bed could in some sense be a little bit self-serving. The bleeding from the liver bed, it doesn't imply a failure of ligation as bleeding from a cystic artery might, nor does it imply the potential for a collateral injury to unintended structures and gastroduodenal arteries, et cetera.

As such, it may serve to divert attention from potential technical problems that occurred during the procedure.

In addition, bleeding from a raw surface like the liver bed may be a little bit more likely to stop bleeding spontaneously and can be difficult to repair surgically, so attribution to this sort may be used to justify a conservative approach.

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The problem of course is that I find no evidence available to support the attribution of bleeding to this source as opposed to the potential of competitive sources.

And, finally, as pointed out by the outside reviewer, the patient remained at risk following discharge for potential complications related to the hematoma. And we have no data regarding her follow-up. She may not have had none of these complications or she may have had them.

So, in summary, from my viewpoint, technical error is in making something bleed 11 units. Judgmental error, maybe, maybe not, open the patient instead of doing it laparoscopically. And I think allowing a patient to bleed 11 units, again, virtually the entire blood volume, without considering the exploration or actually performing exploration in my opinion is a judgmental error.

Q. Was it reasonable in your opinion, Dr. Skudder, for medical staff to be concerned about Dr. Randall not reexploring the patient before the 11 units of blood was lost?

A. It was reasonable to be concerned and it would have been unreasonable not to be concerned.

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Q. Would this have any implications for patient safety?

A. I think it clearly had implications for the safety of this patient.

Q. Did you look at other cases? You said that Randall reflected -- excuse me, the R[redacted] case reflected both a judgment concern and a technical issue.

As you looked at the other cases, were there other themes that you could detect a pattern that you could discern?

A. Well, I think I would say that those are two general patterns. Within the technical concerns, I was concerned, as I went through the cases, about handling of bowel and particularly handling the blood supply to the bowel.

Dr. Edwards used the comment rough handling of bowel, which may or may not be the same thing.

I was also concerned about injuries to hollow organs, bowel and bladder, which seem to be a little bit of a pattern through this.

And then finally I thought in many ways the letter that Dr. Randall authored was well-written; but despite that, I feel that it

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reflects a certain stance that none of these problems are real, a certain refusal to confront the reality of what is happening, which to me has -- is another pattern worth noting.

Q. Dr. Skudder, I'd like to direct your attention to the cases that involve the devascularization of the bowel during the course of the procedure, and I'm looking in particular at the H[redacted] case, the E[redacted] case and the C[redacted] cases. Is there any unifying theme among these?

A. Well, I think that in each of these three cases, we saw unexpected necrosis of the bowel, and in each of the three cases it is described in the operative notes and what pathology we have as being ischemic or being consistent with ischemia. And none of these three patients had other identifiable sources of bowel ischemia.

And I was forced to conclude after reviewing the work, the body of the evidence in these charts, that the localized -- and it was always localized to the area where the operation had been performed -- the localized ischemia was the result of the surgical manipulation. In other words, the bowel had in some sense to a greater or lesser degree, been devascularized during these

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procedures.

Q. I'd like to talk to you specifically about the H[redacted] case, case number 7 in the charges.

A. Again I have a couple of paragraphs of sort of prepared notes, and bear with me.

This is a patient who died after developing necrosis of the cecum following an appendectomy. It has been described in the chart in many places as uneventful. Well, there's almost certainly technical issues at play here, so it was actually not uneventful.

My own suspicion is that the right colic artery was injured or ligated during dissection around the appendix at the base of the cecum. And I think the operative note gives us a clue as to this, and I commend Dr. Randall for being so detailed in some of his operative notes.

Page number on that operative note --

Q. Is 388?

A. -- 388 in the H[redacted] case.

Q. The admit note is 385. The op note is 388.

A. It's the op note I want to go to right now.

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Q. Now, this is a 34-year-old gentleman; is that correct?

A. Yes, ma'am.

The top of page 389 begins with a long paragraph, and about 10 or 12 lines down it is a relatively unremarkable sentence in some ways: Arterial bleeder was encountered from the mesentery, and this was oversewn, ya-da-ya-da, with two separate sutures.

Not an unusual way to handle a bleeder and nobody's going to say it was a bad way to handle a bleeder. It is a little bit unusual that a single bleeder -- it's a little bit unusual in my experience that a single bleeder is of enough note to be commented upon in the operative note. Normally, ligation of the mesoappendix is just part of the operation, and a single bleeder like this doesn't get called to attention.

What this indicates to me is that this may have been more than a routine bleeder. Maybe I'm wrong, but that's what it indicates to me, and more than routine trouble to get it ligated.

I couple that, then -- acknowledging the risk of reasoning backwards, I couple that with the fact that the patient shows up two days later

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with signs and symptoms that aren't clear at first, but in the end are associated with necrosis of the cecum.

And there is actually one way this all fits together, and that is in ligating this little bit of unusual bleeding -- or maybe it was more than a little bit of unusual bleeding -- the blood supply to the right colon to the cecum was interrupted. In other words, this wasn't really the mesoappendix; it was actually the mesocolon. Was not a mesentery of the appendix, but it was actually a mesentery to the colon.

Q. What happened to this patient?

A. Well, the patient was readmitted with recurrent abdominal pain, was in the hospital for several days, following which he underwent reoperation.

At that operation, he had -- well, let me just sort of go through some of this, but that operation he had a necrotic cecum, underwent a right colectomy, and he expired soon after. He was very septic before the second operation.

So going on with what I was saying, I suspect that the right colic artery was injured or ligated during dissection of the mesoappendix, the

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dissection actually being into the mesocolon.

Judgment in doing this appendectomy was totally appropriate as was judgment in reoperating the patient.

I'm a little bit concerned as to Dr. Randall's response to the case in his December 21st letter. He states, quote: There's absolutely no way, unquote, that devascularization of the cecum could have occurred, and yet to me I think the time of -- I think his op notes describes how it could have occurred, and I think he should at least acknowledge that that's a possibility. I guess there's some uncertainty that's what certainly what happened, but at least acknowledge that this is possible.

This of course flies in the face of the operative findings. The cecum was necrotic. Dr. Randall attributes the cecal necrosis to a low-flow state, accompanying patient sepsis after he was readmitted.

The problem with this is that the patient's abdominal symptoms prompting his readmission occurred long before he was septic, long before he had any opportunity to have a low-flow state. He came in with a hurt belly first

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and then got septic.

Furthermore, if we have a low-flow state, generally we see nonlocalized, generalized patchy ischemia throughout the bowel, and mostly in the small bowel. This is not what this patient demonstrated. This patient demonstrated well localized right colonic necrosis in the distribution of the right colic artery following ligation of a bleeder that may or may not have been the right colic artery.

So it actually fits together in a way that works intellectually, et cetera, and in a way that works looking at it prospectively and is supported by looking at it retrospectively.

The patient's finding of localized ischemia clearly reflects a different process than a low-flow state.

Another outside reviewer looked at this case and did not recognize the bowel devascularization as an issue, but it does seem rather clear to me. I'm again, as I say, a little bit concerned about the surgeon's reluctance to at least acknowledge that this is a possibility.

There's another issue in Dr. Randall's letter to the medical staff and that deals with

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timeliness of reevaluation in coming back to the second operation.

Dr. Randall points out in his letter that there were others responsible for the care of the patient during most of the second admission. He states that he was not informed of the patient's readmission. I have no way of verifying this or not verifying it, nor do I intend to try. I believe, however, that this reflects an institutional or systemic issue, possibly a personal issue with the people that were caring for the patient, and the continuity of care and communication in my view was substandard.

These issues may or may not be attributable to any degree to Dr. Randall. They might be germane to the outcome in that an earlier exploration might have saved the patient, but they are not germane to the initial technical problem that led to the cecal breakdown.

In other words, it's fair for Dr. Randall to point out that the outcome may have been worsened by poor communication that he was not in control of. However, that poor communication wouldn't have mattered if he didn't have the first technical problem in the first place.

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Q. For purposes of the record, what was the technical problem?

A. The technical problem has got to be in some sense damage to or devascularization of the right colon and the cecum. This did not happen by itself and it does not fit a pattern of a, quote, low-flow state on a temporal basis or an anatomic basis.

Q. For the benefit of the panel, when you refer to Dr. Randall's letter, you are talking about what is the medical executive committee's Exhibit 16?

A. That's actually --

Q. That is the September version of the letter and there was a later version?

A. There is a later version. The panel really should have that because it includes several cases that are not on it.

As I say, it's well written; and in this particular case many of the points it makes are very appropriate about the lack of timely communication among the medical staff, which is an issue bigger than and different than Dr. Randall. But it doesn't take the heat off the technical issue that occurred.

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Q. If I could ask you to look at the E[redacted]case, which is case number 7 in the notes. This is a patient who presented on 1/30 with abdominal pain following surgery.

Could you describe to the panel what this case was about and what your views are concerning it?

A. A patient with what seems to be a partial bowel obstruction was brought immediately to surgery. At exploration he underwent a sectional small bowel resection. He then suffered an anastomotic breakdown, a breakdown of the anastomosis where the two sections of bowel are attached to one another.

He was reexplored. A gross anastomosis was resected and a new anastomosis was performed. This anastomosis also broke down. And finally the patient underwent an extensive bowel resection. He had an end enterostomy and a mucus fistula, in other words, two ostonies; is likely left with short bowel syndrome and a disability associated with that, and will probably undergo a reattachment operation elsewhere.

I have concerns about the initial judgment to operate in this individual.

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Q. And why is that?
A. This was a high-risk morbidly obese patient. His bowel obstruction, according to the reports of the CT scan -- and this is a CT scan I truly wish I could see myself -- was partial. There was no clearly defined, quote, transition point where big bowel in front of the obstruction gets little, and that's at a CT, a very important CAT scan diagnostic feature of bowel obstruction.
In addition to that, Dr. Randall described at the operation that he could get his fingers through the anastomosis, which would say it was not obstructed, but that he felt that there was material obstructing it. In other words, there was kind of heavy thick stool obstructing it. Normally we hope to get that better without an operation.
Now, this judgment is not a straightforward black-and-white situation, and it's unfair for me to sit here and say that it was.
In general, a bowel obstruction, if it is a total and complete bowel obstruction, requires surgery to get it better; though many patients, many patients who had prior surgery with bowel obstruction will resolve their bowel obstructions with a period of bowel rest and gastric emptying

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with an NG tube, during which time they're supported with IV fluids.
Needless to say, the higher risk profile the patient has the less attractive surgery is and the more attractive a conservative approach is.
This patient's morbid obesity would probably, alone, without going into any other problems he had, put him in a group where a conservative approach would be attractive to many surgeons.
At the very least I can state that a conservative approach based on the information in medical records, based on the information in the medical record and the report of the CT -- which again I didn't get to see myself -- a conservative approach would clearly have been within the standard of care.
I cannot make an unequivocal statement that operating on him right away was outside the standard of care.
By the way, in addition to what I've already mentioned, the patient had eventual hernias. Eventual hernias is a gap in the abdominal wall where it was sewn together at the

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time of his gastric reduction surgery for his morbid obesity. Very obese patients have a tremendous risk of eventual hernias, and it's not a bit surprising these were here.
The CT scan makes clear that some of these, although they were very large, contained only properitoneal and subcutaneous fat and can't really be regarded as an imminent threat to the patient's life; and even though you couldn't reduce them, and they were there for technically incarcerated, these don't justify urgent or immediate surgery. In fact they had probably been there for a long time.
It is fair to say that the CT scan also said that there was -- and I'm not going to pull up the report here, but you can look it up -- a very small, unquote, amount of small bowel in one of the hernias, so that technically the surgeon can state that that bowel was at risk for incarceration and necrosis and a potential threat to the patient's life. And to some degree that might be used to justify the early surgery.
But you can tell how I feel. I think that while early surgery could be acceptable in this patient, most surgeons would likely have

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chosen a more conservative approach, and at the very least a conservative approach is clearly within the standard of care.
Going on -- where the hell was I.
I have concerns regarding the technical performance of the anastomosis. Small bowel anastomoses have a very low risk of breakdown. Many surgeons will go through their entire career without a breakdown of a small bowel anastomosis.
Colonic anastomoses have a higher risk of breakdown. In two consecutively performed small bowel anastomoses, they both broke down in this patient, and each time Dr. Randall described in his op note, at the time of the redo surgery, that there was localized ischemia in the vicinity of the anastomosis.
There's nothing to suggest that this patient had broad ischemia on a broader scale. There's no etiology fathomable for localized ischemia in this area except to say that the bowel was manipulated in such a way, too many mesenteric branches taken down or too much local trauma to the bowel in the preparation to the anastomosis, leading to local ischemia immediately around the anastomosis, leading to the inevitable conclusion

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that the bowel margin during dissection and preparation were devascularized enough to culminate in an anastomosis failure.

The reproducibility of the event in this patient coupled with the cecal ischemia following dissection of the mesentery in Mr. W[redacted] the prior patient, and in the events in the case that we will describe next, demonstrate, in my view, a pattern of lack of expertise in handling the mesenteric blood supply in the bowel margins.

In this case, the prior outside reviewer -- and I have no idea who this gentleman is, where he's from, what his name is or anything about his background. The prior outside reviewer does see things the same way.

Additional support for this mechanism of an anastomotic failure is gleaned from Dr. Randall's 12/21 letter to the medical staff. Here he states that the second anastomosis failed on its anterior portion.

To me the clear portion clearly relates to the ante mesenteric wall of the anastomoses, the side of the anastomoses furthest away from the blood supply and therefore most vulnerable to

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ischemia.

Dr. Randall goes on to defend his manner of the ensuing small bowel fistulae, he's correct in stating that surgical management of the fistulae, which occurred when the anastomosis broke down is within the standard of care. It's also true that the outside reviewer, who criticized his choice to use surgical management severely, is correct in stating that conservative management is within the standard of care.

Discerning the optimal choice for management of enterocutaneous fistulae, which are exceeding difficult to manage, is difficult, and discerning the optimal choice can challenge the judgment of even the most experienced among surgeons.

I am more sympathetic to the prior reviewer's view of this issue that a conservative approach might have been best at first. However, I do not believe that Dr. Randall's choice of surgical management of the enterocutaneous fistula was a deviation at a standard-of-care level; and on that basis I disagree with the first reviewer.

The development of the fistula occurs only as a result of the repeated technical problem

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with devascularization of the bowel at the site of the anastomosis.

Q. Dr. Skudder, that's a lot of information --

A. I count on these doctors, all these surgeons.

Q. -- that have not gone through this record.

What was the fundamental technical flaw here?

A. The technical flaw has something to do with handling of the bowel in such a way that twice in a row a small bowel anastomosis falls apart, when small bowel anastomoses almost never falls apart, and both times the operating surgeon goes back and says it's because I don't have enough blood supply to the anastomosis.

Q. And is it borne out by the record that there was some superseding problem here other that a technical issue?

A. There is nothing in the record to suggest any other etiology for the breakdown of these anastomoses.

Q. Was it even necessary to repair the anastomosis in your judgment?

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A. Well, eventually, yes. That's getting into this complicated issue of when the anastomosis breaks down, the patient developed what's called an enterocutaneous fistula, which you bowel contents leaking through the skin of the wound.

Q. But the initially, the initial decision --

A. Oh, the initial decision to operate?

Q. Yes.

A. On the basis of partial small bowel obstruction, okay. You were asking about technical.

This is judgmental opinion. In my opinion, a conservative approach from the get-go would clearly have been within the standard of care. That answers your question by saying no, it was not necessary.

The corollary to the question is, was it clearly outside the standard of care to operate, and I don't think that I can answer that in as affirmative a way. I think most surgeons would be conservative with this patient, but the election to immediately operate upon him -- and he might be outside the borders a little bit, but I think you're within the broad definition of standard of

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care.
Q. Do the patients --
A. Can I get a drink of water? You're making me talk too much.
MS. KREBS-MARKRICH: Can we take a short break?
HEARING OFFICER: Sure.
(A recess transpired.)
BY MS. KREBS-MARKRICH:
Q. Dr. Skudder, just two last questions about the B[redacted] case. In your professional judgment, do you have an opinion as to whether the record clearly reports the need to redo the anastomosis on January 30, the first operation. And the question is, does the record clearly report the need to redo it?
A. No.
Q. In your professional judgment, is a small anastomosis a common site of anastomotic breakdown?
A. A small bowel anastomosis, no.
Q. And when it does break down, what are the conclusions as to what you do on this particular case? Can it be attributed to failure?
A. In this case failure of technique is

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the compelling conclusion. It should be pointed out that there are a list, well established list of potential reasons for anastomosis failure. Of course one is technique and devascularization. Others include the fact that there is some gross abnormality of the bowel as a whole, that you've resected a malignancy but you didn't get all of the cancer so you've got cancer at your margin.
If you've resected an infected segment of bowel and you didn't take all that out so you tried to sew an infected bowel, a patient with distal obstruction, so stuff that's flowing through can't get past, the anastomosis will lead to an anastomotic breakdown. Irradiated bowel will lead to an anastomotic breakdown. Severely malnourished patients, et cetera, are at higher than other individuals.
But you just can't make a cogent case for any of these alternative explanations in this patient, A; and then B, the surgeon himself -- again I commend Dr. Randall for the accuracy or at least the completeness of his operative notes, states in his own operative notes that there was localized ischemia. It helps us understand the issue.

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Q. I'd like you to turn your attention to the C[redacted] case, which is case number 1 in the notice. This was a patient who presented with a left-sided colon obstruction; is that correct?
A. Correct. I'm going to try -- I think in the last cases I might have jumped into analyzing them without summarizing exactly what happened.
In this case an individual was admitted into the hospital with abdominal pain and obstruction of the sigmoid colon a short distance above the rectum. He underwent a perfectly appropriate operation to take care of this, which left him with a colostomy.
The day after the operation the colostomy was noted to be nonviable, translate: Gangrenous, dead, ischemic, or necrotic, and the patient underwent a total abdominal colectomy, and I believe had a reasonable recovery from that point, although I also believe he was referred elsewhere for final reconstruction.
So from an analytic viewpoint, when patients present with sigmoid colon obstruction, they can be very sick, and they're also somewhat hard to manage. This case was sent to an outside

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reviewer, and this is one case where I differ in a very significant way with the outside reviewer's analysis.
The outside reviewer made the case that none of these problems would have happened had the patient undergone a diverting loop colostomy first, leaving all the sick stuff down in the pelvis, or had the patient undergone a placement of a temporary plastic colonic stent.
I believe the outside reviewer was trying to make the case that the choice of operation that Dr. Randall made was outside the standard of care, and I couldn't disagree with this reviewer more.
Fifty years ago a diverting colostomy would have been the standard of care, and I guess it still is within the standard of care. But I think for 30 years, general surgical training has emphasized the fact that in these patients that if it's at all possible to resect the diseased segment at the first operation, that should be done. That's what Dr. Randall did. It's called a Hartmann's operation. He did it well. It was a demanding and a difficult operation. We know this, A, because he said so in his op note; and, B,

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because it always is.

These are tough. You've got to safely get a very inflamed bowel out of the pelvis without injuring ureter, bladder, seminal vesicles, et cetera, et cetera.

And having done that, one staples off the rectal pouch or sews it off, removes the diseased segment and brings out a proximal colostomy. The patient then recovers for several weeks and you put him back together.

The issues in the case occurred with bringing out the colostomy. Once again, Dr. Randall's operative note is very informative.

Anybody know what page that is in the C[redacted] thing?

Q. It is --

A. First op note.

Q. Page 29 of the C[redacted] record.

A. Correct.

By the way, you'll note at the beginning of the op note, Dr. Randall says, secondary to probable diverticular disease versus malignancy. This is exactly correct. Even with a preop colonoscopy, you never know for sure that this process is benign. Most of these are

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diverticular disease, 19 out of 20, but one out of 20 will be a malignancy.

In either case there's almost certainly micro perforation of the bowel leading to this degree of inflammation, swelling, abscess, micro abscess formation, and bowel obstruction. And that was certainly true in this case, but you still don't know whether you're dealing with a cancer.

The op note goes on to say -- we're going to have to go to the second page of it. It's at the bottom the op note starts of page 29 of the electronic record and it is the bottom of page 30.

Q. The last two sentences of that record on the operative note?

A. That will be page 30. We're getting ready to bring out the colostomy at that stage of the operation. Some mobilization of the splenic flexure was done, but this was markedly dilated, the splenic flexure was very high and I was afraid of entry into the colon.

Now, I've been there. That's true. That can be very hard to bring down. That can be very hard to free up. It can be difficult to see especially if it's very dilated.

At this point Dr. Randall makes an

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intraoperative decision. He says I'm not going to bring down the splenic flexure, I'm going to abort what I was doing and bring his descending colon out as a colostomy. Fair enough.

Q. So was there a technical problem?

A. Yes. Well, outcome-wise there's a big problem. The next day the colostomy is gangrenous, it's nonviable, it's dead, it's ischemia. Its blood supply is interrupted and it is not viable.

The patient then, appropriately, with good judgment, is brought back to surgery. The belly is reopened. Dr. Randall identifies a significant portion of the colon as nonviable and proceeds to do an total abdominal colectomy, giving the guy an end ileostomy. By the way, he didn't have to do anything more in the pelvis.

This is why I so significantly disagree with the first reviewer's opinion. He blames everything on the way Dr. Randall did or did not handle the pelvis. He didn't have any problem with the pelvis. This is a problem at the noninflamed end, the easy end, the end where we're bringing out the colostomy.

By the way, the patient did pretty well afterwards, and presumably will have his ileum

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reattached to his rectum, so you could say he ends up the same way he would have with the original planned operation. The problem is of course an ileoanal anastomosis or ileorectal anastomosis is going to leave him with a lot of diarrhea unless he gets one of these complicated ileal pouches, which have a significant complication rate associated with them. But if it works, the patient will have less diarrhea. There is a clear change in the patient's long-term outcome because of this second operation.

So what do I think about all this? The ischemic transverse colon and splenic flexure that developed the following day, once again we see no data to support the risk of spontaneously occurring ischemia. The ischemia of the splenic flexure of the transverse colon is most likely associated with the aborted dissection around his splenic flexure, which was carried out with the intent to mobilizing it to bring out a tension-free transverse colostomy, as Dr. Randall described.

For a combination of reasons, primarily some difficulty associated with mobilizing the splenic flexure, he abandoned these efforts and chose to bring out a descending left colostomy. He

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described this left colostomy as being tension-free.

Any surgeon with experience in this area knows that the transverse colostomy would have been looser and would have more easily traversed the abdominal wall especially if the patient were obese.

I'm not saying that a descending colostomy is outside the standard of care. I'm saying that a transverse colostomy is easier and less prone to certain complications.

The manipulation, the aborted manipulations to mobilize the splenic flexure most likely resulted in the nonviable colostomy the following morning. Once again, the section resulted in ischemia and necrosis of the valve, this time involving the left colon in the region of the splenic flexure.

There is an alternate, though less likely, explanation, being that the descending left colostomy was not as loose and tension-free as Dr. Randall believed it was when he brought it through, that it was somehow distorted and twisted with enough severity that that compromised the viability of the bowel and it became necrotic on

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that basis.

By the way, as I said before, the patient did recover after total abdominal colostomy with a compromised outcome. This patient also had an incidental appendectomy.

Incidental appendectomy refers to the fact that at the time of the first operation, Dr. Randall opted to remove the appendix. This is a procedure which has always been controversial during surgery. The goal, of course, is to eliminate the likelihood that the patient can ever get appendicitis in the future, hence the argument in favor of doing the procedure.

On the down side is the fact that appendectomy stumps can leak and there can be localized complications from doing that procedure, and the statistical risk of any individual getting appendicitis for the rest of their life is actually pretty low, despite the fact that appendicitis is reasonably common.

I'm not going to take total sides on the overall controversy in this forum. What I am going to say is that this is not the patient that most surgeons would judge is right to do this. You do this in patients that are biased toward being

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younger and who are destined to an uncomplicated operation anyway.

You don't want to add the risk of further complication. You do it in patients who don't have a dirty, contaminated abdominal field, which obviously you do in this case based on a big inflamed, infected pelvis mass, because you don't want to take the chance of spreading infection over to the right colon.

The incidental appendectomy in my opinion was a substandard judgment in this particular individual. As I said before, not every error results in a change in outcome for the negative. This patient had a total abdominal -- the appendix would have gone out with the rest of the colon. Anyway, it had absolutely no consequence in this patient, but nonetheless the judgment was not proper.

Q. Do you have an opinion as to what generally accepted techniques in the construction of the colostomy give an opinion as to whether it would have broken down had those techniques have been used?

A. I believe it would not have been broken down. But I will append to that remark the fact

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that ischemic and necrotic colostomies occur with a higher frequency than do right colon necrosis after an appendectomy and a higher frequency than small bowel and anastomosis breakdown.

Of these three complications, which in my mind are the three devascularization complications, this one might usually occur in three or four percent of patients, whereas the others would be one in a thousand, if you follow what I'm saying.

This is the least unlikely of the three. There's a little higher chance that this one could have occurred by itself. But to me the real issue is that I'm presented with three cases. In all three of them, if you look at the whole temporal consequence and all of the available data that you can bring to bear, in each of the three, it appears that there's otherwise unexplained local ischemia and necrosis of bowel shortly after an operation on the bowel, and it died and something bad happened to the patient, and there's no other explanation for it.

Q. Other than surgical technique?

A. Other than surgical technique.

Q. I want to direct your attention to the

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cases involving patients C[redacted], H[redacted], W[redacted] and P[redacted]. Do you have an opinion as to whether there's any sort of general theme associated with these four cases?

A. These four cases don't show the same type of devascularization injuries. However, they do show what appears to be direct trauma and injury to hollow organs, three of them bowel and one of them bladder.

Q. Okay. Let's look at the C[redacted] case, 2 in the notes, and the op note is on page 27 through 30.

A. From the perspective of full disclosure, this is the patient that I did the initial outside review. So, if you will, this is the only patient that hasn't had two outside reviews. They were both me.

Q. Can you tell us about what this case involved, the laparoscopic cholecystectomy?

A. This is a patient who came in with evidence of gallbladder disease, who had also had a remote or a relatively long-time prior appendectomy. When he hit the emergency room with right-sided pain, remembering that both the gallbladder and the appendectomy are on the right

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side, his CT showed some evidence of inflamed gallbladder as well as abnormalities in the vicinity of the prior appendectomy.

The patient was appropriately brought to surgery, a cholecystectomy was performed laparoscopically. All that's appropriate as far as I'm concerned. He had a cholangiogram which did not show any crises, did not show any common duct stones or any need for further biliary surgery.

In the course of this, he also underwent an effort to do an adhesiolysis or lysis of adhesions in the right quadrant where the appendectomy had been.

By the way, I noted that Dr. Edwards was very critical of that when he sat here earlier. I'm not so sure that that was a wrong thing to do. Again I've not seen the CT scan. The CT scan may or may not have shown enough evidence to justify doing this. I don't know, so I will not express an opinion one way or the other.

Q. What happened to the patient, Doctor?

A. In the section of that right lower quadrant, the bowel was perforated. That didn't turn up right away. That turned up when the patient was reexplored a few days later.

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And to be quite honest, this is another case wherein Dr. Randall's response of December 21st, he refers to significant issues regarding who may or may not have been responsible for the postop care, whether they acted in the patient's best interest or simply baby sat or held the patient until he became available himself.

Once again, I'll make a statement I made before: There may be institutional or systemic or personal issues involving everyone participating in the care during that time period. But unless there was still the technical problem that originated at the beginning, and by the time Dr. Randall got back, explored the patient, he found the unrecognized bowel perforation, had to do a major bowel resection, and this patient expired with sepsis actually the day of the second operation. He was very, very sick by the time he went back to surgery.

Once again there's the confounding issue of poor patient care in the interval, poor patient care provided largely by others than Dr. Randall. I don't know enough about the other coverage schemes to comment on whether he may or may not share any responsibility for that, whether

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it's an institutional problem -- you do have a pattern here, guys, of poor coverage on your surgical patients to some degree. I have no comment on that.

But the point is that although that may have contributed to the bad outcome, the patient still wouldn't have died if you hadn't have perforated the bowel at the time of the first operation.

It all flows from the technical problem. Care in the interval could have been a lot better, and I'm not sure if he's responsible for that care. But the technical problem at the beginning is what set the whole process in motion.

I want to make another comment. Dr. Randall makes reference in his December 21 letter to the term necrotizing fascitis found in the area where the bowel perforation was. Although this necrotizing fascitis, in quotes, were a separate event in the patient's course, when what we're really looking at, and what's really accounting for the necrosis, the liquefaction in the area of infection in the bowel wall, is the enteric leakage, the bowel leakage and contamination from the bowel perforation at the

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first operation.
I worry whether the use of the term necrotizing fasciitis represents a failure to see the real issue, the bowel perforation as the primary problem; whether it represents an effort to distract attention from the real issue by attributing some of the abnormalities to a totally irrelevant problem that's being -- by using this language. That may not be the case, but it's a concern I have on reading things.
Q. Now, I want to direct your attention to what is Exhibit 16. This is the September 16th version of Dr. Randall's letter. This is the letter where Dr. Randall writes -- and I'm looking at page 4 of the letter -- I agree that the care was substandard.
A. Let me just get to his discussion of this patient. I hate trying to do this stuff from memory when there's so much material. It's just not fair to anybody. Okay.
Okay. It's the last line in his discussion of incident number 6, [redacted].
Do you want me to read it into the record?
Q. No. Let's go on to Mahaffey, which is

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patient eight in the notice.
A. By the way, can I make one comment about that line? I think that when Dr. Randall writes I agree that care was substandard, he was referring to the interval care. I'm not sure he's referring to his own operative care. You've got to ask him that.
Q. Take a look at patient M[redacted].
A. In M[redacted] this is a patient who came in with a giant recurrent hernia. It sounds like it's really giant in the letter of December 21st, and sort of giant in the medical record, so it seems to have gotten a little bit bigger.
He comes in with a really big recurrent hernia, and he also has -- and that's of the right side, and on the left side he has an inflamed, erythemative, hot, tender scrotum. And at a single operation he underwent repair of the big, big hernia with a mesh plug, and then drainage of a collection in the scrotum on the opposite side that turned out to be thick, creamy pus.
A drain was appropriately placed under the skin where the big hernia was fixed on the right side. There was going to be a big dead space there and you want to suck the fluid out, except

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that a day or two later the drain is full of urine.
So the patient gets an appropriate work-up, and it turns out there is a bladder wall injury.
And Dr. Randall had, again, very good operative notes, described in his original operative note the fact that the bladder wall was involved in the hernia; it was herniating through the abdominal wall in the big hernia.
He also states at this time that he looked over the bladder wall and did not see any injury to it at that time, so there was an unrecognized bladder wall injury.
A few days later the patient went back to surgery, combined procedure, Dr. Randall and a neurologist through an abdominal incision. The bladder is repaired, and another attempt is made to fix the hernia with a big mesh plug from the inside rather from the outside.
I don't know if that was successful over the long run. Obviously it was going to be a difficult hernia event. I don't know any follow-up of what happened to the scrotum on the other side.
So issues: First, if you're going to put mesh in something, you don't want to mix it

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with pus. Mesh and pus are not a good combination, unless, I guess, both operations are absolutely overwhelming, compelling emergencies.
Q. Was that the case here?
A. No. Certainly the hernia was not. The hernia is a big long-standing chronic thing. In fact, the H&P for the hernia repair was dictated a week or two before the procedure. That's appropriate, no criticism there.
What that tells us is the repair of the hernia, this wasn't a patient who came into the emergency room with an emergent problem.
The scrotum was described as being tender and swollen in that H&P a week or so preop, and then in the operative note itself -- I'm going to try to go to that so I quote it about right.
Q. The op note is pages 115 to 117.
A. I'm glad somebody's got all this stuff.
There's a place in the op note, I believe, patient profile. So on the top of page 116, we now read he was also noted to have marked swelling and tenderness in the left testicle. That was written a week before in the H&PP, but this is evolving.
There's also induration and erythema,

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which were not described earlier, and he's going to undergo left scrotal exploration.

So, if anything, the scrotum is the more emergent problem that's evolving, at the least suggests the presence of infection. I think that the judgment error here in my opinion was doing the scrotum last after you had already committed yourself to the mesh and all of that business for the nonemergent hernia.

The proper approach here -- and I believe this is a standard-of-care issue. The proper issue here was to drain the scrotum; and given that you found all this thick creamy pus that was described later, get the operation on hold, get the infection cleaned up and come back and fight another day in terms of the hernia.

That's issue number one in this case.

Q. Were there technical issues?

A. Yes. That's a judgment issue.

By the way, that's another one where a judgment error was made, but it had no consequence. In my knowledge the patient never did get a mesh infection or anything else, at least not during the same admission. We don't have any follow-up data on any of these people. We don't know what they

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look like in the office, whether they went to another hospital or anything else.

But at least during that admission he didn't pus out the hernia wound with a mesh infection. So this again maybe -- it's why you can't argue from outcome. Good outcome doesn't mean good care; bad outcome doesn't mean bad care. You've got to look at the process as well.

Other issues --

Q. Are there any technical issues?

A. Technical issues obviously surround the hernia repair and the bladder wall injury. In surgical parlance, this was clearly what we call a sliding hernia. The internal organs are sliding, if you will, out through the hernia opening.

Sliding hernias are always hard to fix, and especially when they're recurrent as this one was. Mesh plug repairs of hernias are well established, very popular because they're successful, but they tend to be most successful in smaller hernias than primary hernias, and more aggressive or more complicated repairs are often necessary as hernias get bigger and as they're recurrent, and particularly they become big sliders.

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And large sliding hernias require what is called a properitoneal repair, which is to say that instead of doing the repair from the outside below the inguinal ligament outside the abdominal wall, one must go through the abdominal wall and fix the hernia from inside the pelvis.

There's various techniques to do that with natural tissue or suture and mesh across it from the inside.

So from a judgmental perspective -- I know you said technical. From a judgmental perspective, as Dr. Randall realized the magnitude of this hernia, even not addressing whether it could have been realized ahead of time, which perhaps a preop CT would have done for him, and also shown the pus in the scrotum, but given all that, as he realized that, there really was no reason not to, through a same incision or a separate incision, add a properitoneal repair to this, where it would expose the bladder wall better, given him a much better chance to identify the technical problem, which was he nicked the bladder and didn't recognize it, and at the same time allowed a definite properitoneal repair at that time, which was eventually done later and

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apparently worked well.

So that sort of summarizes the complication of technical and judgmental errors here.

The outside reviewer --

Q. What was the consequence of the technical error done?

A. The outside reviewer also pointed out another sort of, if you will, medical error in the management of the patient, which was not placing a Foley catheter prior to the procedure, which by emptying the bladder would have reduced pressure and improved the amount of space in which there was to work and lessened the likelihood of the bladder wall injury.

The consequence of course was that by introducing a bladder leak, we introduce an additional potential root of infection, infection which to my knowledge did not occur. Occur, we require the patient to undergo a potentially morbid bladder wall repair in addition to undergoing a second hernia repair.

By the way, not only did the bladder leak but the hernia had broken down within two days.

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Now, I want to go on here again and talk about that other issue, the issue of recognition of problems. Because again I want to refer to Dr. Randall's letter of December 21st, and statements made in this letter caused me again a little bit of concern.

The letter states the hernia was repaired but the bladder could not be returned to the abdominal cavity.

I don't know if this is a problem with typography at the time of -- or dictation language or something, but if the bladder's still sticking out, the hernia's not repaired. So I don't understand how he can tell me at the same time the bladder's still coming out through the abdominal wall but the hernia is repaired, which is what he said in his letter.

Secondly, the statement is made in that letter that the surgeon abandoned efforts at repair of the hernia because of the magnitude of the hernia as he had planned, and he therefore had a planned reoperation with the properitoneal approach above the inguinal ligament.

Quite frankly, this would have been a reasonable decision. It's a difficult decision for

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surgeons to make. He never like to abort and back off, but sometimes it's a good thing to do. You haven't done any harm, you haven't done anything irreversible, and it's always acceptable to come back and fight another day if you believe you can do a better job on the other day for whatever reason.

But there's problems. First, if you're going to do that, I can't imagine you would dictate the op note and now say I couldn't repair the hernia this way and I need to come back another day, I don't think it's safe to go on today. There's nothing that hints at that in the op note.

Second, if you really wanted to do a properitoneal repair, you could have done it right there on that day. There's no documented reason why he couldn't safely had it done that day.

Third, the progress notes following it, admittedly there's some legibility issues with them, part of that may be the surgeon's handwriting, but part of it is also, by the time it goes through a few Xerox machines, it's a little hard to pick up.

But, nonetheless, as near as I can sort out these notes, I don't find anything in these

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notes that even suggests that there is a preexisting decision for a planned reoperation until the bladder injury was identified. Afterwards of course he's going to have a reoperation, there's lots of writing about it at that time.

So the argument that the procedure was aborted and there was going to be a planned reoperation doesn't hold up under analysis of the medical records, and unfortunately creates an impression of trying to minimize the issues and cover up what really went on. That's really what happened. But this is the impression you get, at least I get, when I read something like that.

The letter also fails entirely to address the issue of operating on the scrotum, with pus in the scrotum at the same time you're sticking prosthetic mesh in the groin on the other side.

Q. Go to the Walker case, if you would, which is the patient six in the notes?

A. This was a morbidly obese individual who had repair of eventual hernias, laparoscopically, and ended up with an injury to the bowel where one of the laparoscopic trocars had been passed through the abdominal wall. He got

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enterocutaneous fistulae and had a somewhat complicated course.

The patient, as I said, was morbidly obese. He had a prior gastric bypass. It's common to get eventual hernias with these things, no surprise there. He's got a multiple intracutaneous fistulae after the procedure by Dr. Randall reflecting bowel injury during a dissection.

Q. There was significant dissection in the case; is that correct?

A. Oh, yes, there was. This is a hard case, and I think it may be particularly hard laparoscopically. I'll state right here I've never done a laparoscopic eventual hernia repair.

Some surgeons might question doing this laparoscopically, but it's an acceptable option in many patients and many patients do this. The fact that I haven't done it and some surgeons request it does not mean that it's outside the standard of care.

The patient got sick the day after surgery. Primarily he dropped his hematocrit. His hemoglobin was down to six, and he appeared to be bleeding from a trocar site -- and I can't remember if it was the left or right lower quadrant.

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So back to surgery he goes, appropriately, to find out what's bleeding and stops the bleeding.

We get there and again we've got our old friend again, we've got necrotizing fascitis in the bowel wall.

Q. And are you quoting now from the op note?

A. That's from the op note. And also -- I don't remember if it's in the December 21st letter.

Q. The op notes are pages 58 through 64.

A. The area around the bleeding site where the trocar had been placed was malodorous and there was necrotizing or necrosis of the bowel of the abdominal wall, not in the bowel wall. And the term necrotizing fascitis was then applied.

The wound was explored and the patient was shown to have a colonic injury. Cultures were taken, very appropriately. The cultures came back showing four different fecal organisms. What this patient had obviously was a perforation of the first surgery, I suspect from the laparoscopic trocars.

And so I'm going to bring up -- oh, and so he went on to have his bowel wall infection,

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colocutaneous fistulae and a complicated course. He did not die, and he recovered.

So again I'm going to bring up issues similar to what I have before. One cannot attribute this patient's complications to an unexplained necrotizing fascitis as though this was some unrelated development. The common usage of the term necrotizing fascitis refers to a grand positive affection acquired in a totally different set of circumstances.

Attribution of these complications as necrotizing fascitis in the chart, as well as the December 21st letter, as though it were an unrelated event, suggests the failure to recognize the reality of the situation, that the problem stems from a surgical complication and perforation of the bowel at the time of the original operation.

That's a technical issue there. I don't want to make much of the judgment to do this laparoscopically. A lot of surgeons would do that.

When I sat as a physician on a medical executive committee, we had an episode such as this with multiple bowel perforations on consecutive patients who were undergoing laparoscopic eventual incisional hernia repairs. This is a hard

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operation. It has a bit of a tough track record, but many surgeons do it and it is within the standard of care.

It's also within the standard of care to do it open, clearly, and that was an option that was available. But I'm not going to make a standard-of-care issue out of that judgment.

There is a standard-of-care issue in sticking a trocar in the bowel and not recognizing it. There is also the post procedural issue, again, of attributing this or using language in attributing this to a problem that didn't happen.

Q. You mean the necrotizing fascitis?

A. Yeah.

Q. Do you have an opinion, Dr. Skudder, as to whether two trocar injuries in the same case raises technical questions?

A. Only sort of. It's the same trocar. I mean, it's one trocar that did two things. It was one misplaced trocar as opposed to you got it in two places with two of them.

Q. But it's still technical?

A. Yeah.

Q. If you take a look at the Parnell case, which is case number 4 in the notice, what is that?

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A. This is a patient who had a preexisting neurologic condition. I apologize for forgetting exactly what it was. She had a preexisting ventricular peritoneal shunt, a plastic tube that comes out of the ventricuil in the brain because the patient is hydrocephalus and too much CFS pressure in the brain. Travels down through the neck, plus the rib cage, and dumps the fluid into the peritoneum. This can be life-changing in patients with hydrocephalus that is squashing the brain from all the pressure of the CSF fluid.

They're little flexible tubes, not necessarily easy to see, this, that or the other.

And the patient comes with good evidence for cholecystitis, and, appropriately and with good judgment, is brought to surgery for laparoscopic cholecystectomy. It's not an easy cholecystectomy. Once again, as soon as the cameras go in to do it laparoscopically, there's lots of swelling, et cetera.

In this particular case, Dr. Randall makes a decision that he was criticized for not making in other cases and he immediately converts to an open approach, and nobody's going to argue with this whatsoever.

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He does it after he looks in and sees fluid running around -- he hasn't done much dissection yet, and his op notes describe it as being either bile or enteric contents, so he knows right away, early in the laparoscopic procedure, that he's either injured the gallbladder -- that doesn't matter because that's coming out anyway -- or enteric contents, he's injured the bowel in an effort to get things going laparoscopically.

If he's injured the bowel, it's another trocar injury to the bowel. By the way, that never becomes 100 percent clear in the case whether that's the case or not.

So he converts it to an open procedure, and in so doing he divides the ventricular peritoneal shunt, which is, I imagine, coming down the right side and right through that area.

The patient goes on and gets the laparoscopic cholecystectomy and a colectomy because of a perforation in the colon which is seen at that time, and to my knowledge did not have any major complications after the surgery.

So judgment questions: I think the original reviewer asked the question whether they should have started with an open procedure rather

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than a lap coly. I'm not going to be critical of that. Most surgeons start virtually every cholecystectomy laparoscopically now. I have no issue with that whatsoever.

The division of the VP shunt was made a big issue of in the outside reviewer's report. I personally make very little issue of that. If you are in a dense, porky, indurated, inflamed right upper quadrant, this soft flexible little tube is going to be impossible to palpate, wrapped up and covered in a way you're never going to see it. Yeah, it would be nice if you saw it and didn't divide it, but I don't think there's a standard-of-care issue there by any stretch of the imagination.

I think jumping on the division of the VP shunt in this kind of overall context is a little bit like piling on. It's not fair. I think that could have happened to anybody.

The bowel injury, on the other hand, is real and was well handled. I have no problem with it being handled.

Again, I'm going to turn to Dr. Randall's later letter to the medical staff.

Q. Now, this is also the letter, the same

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language as Exhibit 16 on page 3, if you could look at that version of the letter.

A. And this is P[redacted], right. Let me find the right one here.

Q. Yes.

A. Which one?

Q. It's Exhibit 16 in the book.

A. Right, I'm trying to find which page it is.

Q. Three.

A. Page 3, there it is. He states in the last four lines of his comments: The reviewer makes note of some colonic injury leading to the colon resection when there was no colonic injury noted neither in my operative note -- let's just stop there for a second and let's go to the operative note, which is -- somebody is going to tell me, I hope, what page number.

Q. Pages 19 through 21.

A. By the way, it's 19 through 21 of 877 pages, and some of them are 2500 pages. I mean this was just amazing to try to get through all of this.

Op note, I believe there are three descriptions of colonic injury or at least possible

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colonic injury in here. The first is on the second page of the op note when he states -- this is the last four lines of the first paragraph on the second page, which is page 20 of 877: On taking down the unit structure, it became apparent that there was either gallbladder spilling or possible enteric content, so there was a minimum suspicion of it.

The second is -- okay. The third is at -- in the fourth line of the third page of the op note, a point was selected on the transverse colon to the left side of the perforation, clearly describing a perforation as being there. In between them there's a third one, the second page of the op note, next to last paragraph, third line up: On infection it was evident that what had been entered was a portion of the right colon.

So in the op note, three times the colon perforation is described, and yet when Dr. Randall addresses the medical staff, he states, and I'll read it again: The reviewer makes note of some colonic injury, but there was no colonic injury noted, which I don't know if -- I can't explain that.

And, you know, I just can't explain it,

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I don't want to speculate any further. I've speculated enough on some of these things. But clearly there was a colonic injury and it was well handled. The colonic injury is a technical defect.

This time, however, if one defines the standard of care as acknowledging at least intraoperatively that you can have a technical injury to collateral structures, always more likely in an inflamed situation like this, you recognize it, you fix it, your patient does okay.

This one went the way it was supposed to, but there was a technical problem nonetheless.

The difference between this and [redacted], who died after the appendectomy, and [redacted] who died after the right upper quadrant dissection, and I think Walker who had the necrotizing fascitis with the trocar colon injury, is that this was recognized at the time of surgery and dealt with before the patient got septic and got in trouble and whatnot.

Q. Go, if you would, to the [redacted] case.

A. The context of this patient -- this, as I remember, was a 30-year-old woman, who had, terrible neurologic problems from birth attributed to cerebral palsy. As near as I can tell from the

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record, she is a contracted, nonverbal individual who basically lies in a bed all curled up in contractures, with clearly very, very difficult access to her abdomen, and very importantly in her care and decision-making, probably very limited in her ability to communicate.

She came to attention because of a big hiatus hernia, and at the risk of giving too much of a general surgical lecture on an hiatus hernia, they come in two forms of which the more compelling or more dangerous is the periesophageal hernia, which is what this was. They have a certain risk of torsing or volvulizing in the chest which can present a lethal outcome.

That risk is overstated by the first reviewer, the first outside reviewer who tries to make the case that Dr. Randall deviated from the standard of care by not exploring it as an emergency. This patient had had this hernia as a consequence of her being shriveled up and forcing her abdominal contents up toward her chest probably for a decade or more.

As it turned out, in Dr. Randall's exploration, when he couldn't pull this down laparoscopically, he had to dissect it down and it

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heaved up into the chest and everything else. This was not going to torse and rotate any time soon, and I beg to differ with the first reviewer.

I'm sure there are surgical textbooks that say some of these periesophageal hernias are emergencies, but not this one. And it was fixed, you know, nonemergently. I have no quarrel with Dr. Randall's judgment to fix it.

He chose to fix it laparoscopically, I have no quarrel with that. The morbidity of hiatal hernia repairs laparoscopically is compellingly different than the open laparoscopic hiatal hernia repairs. It is so compellingly different that hiatal hernia repair, which was a rare operation before the laparoscopic era, is now a common operation, and even the anesthesiologists that have some gray hair have seen that change. It's common because it's much less morbid now.

However, in this case, as we pointed out, he couldn't pull it down. And it was a longstanding chronic thing, no big deal. Open up the patient and fix the hernia and basically did it successfully.

So what was the problem that arose. Following the procedure the patient developed

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gastric atony, a-t-o-n-y, atone, no muscle tone, the stomach kind of went limp, became paralyzed. Gastric peristalsis failed. The stomach ceased to push the gastric contents, push the food that the patient ate into the duodenum and jejunum. So the patient's stomach loaded up, she puked, and her nutrition failed.

This is not uncommon after major gastric surgery. It's common enough that it's a big nuisance, and surgeons know this can happen, and I believe this was appropriately recognized by Dr. Randall as the issue.

There are medications that can sometimes address this. A medication called Propulsive, but it was pulled from the market because of hepatic toxicity. But medical treatment of it isn't very beneficial, and many of these patients end up on parenteral nutrition for a period of time, and with time they generally see resolution of their gastric atony.

Emptying the stomach is appropriate because by getting the tension off the gastric wall, it seems to help it recover its muscular tone.

And this patient was a truly lousy

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candidate for an NG tube, and I don't quarrel with Dr. Randall's decision to put in a gastrostomy tube as a second operation. This is a minor operation.

He states in his December 21 letter that he did ask GI to place a peg tube, but they were scared away by the risk profile of the patient.

I could make some comments about that. I've often seen that. It's always safer for the patient to have a more dangerous operation. I mean, GI guys are scared to do something. I hope none of you ever get to a gastroenterologist.

But, in any event, they wouldn't do it so he had to go back and do it. The first reviewer made a point that the standard of care should have included the G-tube at the time of the first operation to help anchor the stomach in the abdomen. No quarrel with that. I think the first reviewer is correct on that.

On the other hand, this had no impact on this patient because the stomach never went back up in the chest; so again this is a deviation, not a huge one, but a deviation without consequence.

He puts in the G-tube, and in this particular patient the gastric atony still didn't

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go away. And there's not a lot of discussion, or at least there's not a lot of legible discussion in the medical record about TPN in this patient to nourish her, but I can envision the problems you would have had keeping a central line in this contracted -- this is a sad case. It's not only ugly, but it's sad -- in this contracted individual.

So Dr. Randall opts to feed the patient with a jejunostomy tube. Again perfectly reasonable judgment, no issues of that whatsoever.

Puts the J-tube in, and now the patient's being fed and we're just going to wait and wait. We don't know how long we're going to wait and gastric atony is going to go away and we're going to pull out the J-tube and feed the patient.

The only problem is that a week or ten days after the J-tube went in, the patient developed evidence of peritonitis, and x-rays were done showing free air in the abdomen and showing that the J-tube, though it still went through the abdominal wall, had been dislodged from the jejunum, so the tube is flopping around loose from the peritoneum. Feedings are going through it into

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the peritoneal cavity, feedings which of course are loaded with sugar and protein, which you and I call food but bacteria call culture medium, and there's a hole in the jejunum where the tube went in, which is leaking out nice contaminated enteric contents.

So you have -- the addition of the tube feedings is like putting kerosene on the Chicago fire. We're having all kind of fun with peritonitis in here.

Now, it's a little hard in 877 pages of nursing notes -- the Sibley case is more than that. The S[redacted] case is 4,571 pages. And I have never found the nurses note that tells me exactly what time the x-ray was done on April 21st, but an x-ray was done on April 21st that confirmed the dislodgement from the J-tube from the jejunum and confirmed that this situation existed.

Q. And that is page 4,076 in the record?

A. That's the x-ray report, and the x-ray has a date on it, but it doesn't have a time on it. So I spent a lot of time, farted around looking for which nurses note would say patient moved to x-ray. But in the 4500 pages, I never found it.

Q. Did you find a consent form?

A. What I did find was that the patient

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had preop orders written for a laparotomy and fixing up this problem at 1630 hours on April 21st. And I found an op note dated April 22nd -- well, that's not helpful because they don't have a time-line I needed. But the anesthesia page does show that surgery began to solve this problem at 1030 hours on the next day, April 22nd. So that is actually precisely 18 hours after the preop orders are written.

I can only conclude that sometime before the preop orders were written, the surgeon knew he had a bowel leak into culture medium in a patient with peritonitis. And I believe that an 18-hour delay in this circumstance is unequivocally outside the standard of care.

I acknowledge that most hospitals -- and I know very little about this hospital except that your physical plant is a thousand times better than any hospital in the northeast. There's a lot of money down there. I believe you're a community hospital, and I acknowledge that most community hospitals do not have OR staff 24/7. At least if they do they've only got one in, and cases get stacked up based on their urgency and the order in which the surgeons book them.

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However, this case should have been very urgent. A major trauma case would have been more urgent, a ruptured aneurysm would have been more urgent, and perhaps a few other things.

But nobody's hip fracture is more urgent than this, and no routine appendectomy is more urgent than this. This is a clear bowel perforation in a patient with established peritonitis. And I cannot believe that no OR was available for 18 hours.

Q. Do you have an opinion as to whether earlier exploration would have led to an acceptable course for this patient?

A. Maybe. And I'm going to qualify that again. You can't argue for outcomes because even though it didn't change the outcome, it was still bad care.

The reason I'm not sure about that is I don't believe this came dislodged on April 21st. I believe it probably came dislodged on the 18th or the 19th, or sometime such as that, because when poor Dr. Randall got in there, she's all loaded with abscesses all over the place.

And the patient's crappy ability to communicate -- pardon my vernacular, but the

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patient's cerebral palsy, she can't talk, she's groaning or whatever, and her peritonitis probably made it very hard to make this diagnosis. And it was probably two or three days old by the time he got here anyway. But that's not no excuse for letting it fester for 18 hours. Three hours, four hours maybe while he waited for an OR, et cetera. And 4:30 at night, okay, if it was discovered at two in the morning, the surgeon said I'll do it at six, you know, and sleeps for a couple more hours.

But 4:30 in the afternoon, there's plenty of time to do it and still get a good night's sleep. This is not a long operation.

Q. Dr. Skudder, I want to get to your summary.

A. Can I say one thing about this case?

Q. Sure.

A. This patient also had an incidental appendectomy. I was very critical in the incidental appendectomy in Mr. Whoever it was, I was very critical about it, Mr. -- the guy with the heart procedure.

Q. C[redacted]

A. C[redacted] In the situation, however, I don't want to -- it's not germane to this

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incidental or the whole concept of incidental appendectomy.

However, if you're a proponent of incidental appendectomy, this patient was as reasonable a patient to do it in as you'll ever see, because once again if she ruptures her appendix in maybe four days before anybody figures it out, and if you're in there doing what is, you know, is procedure, which is not a complicated or infected procedure, and there's a good chance the patient is going to do well, if you believe incidental appendectomy, this was as reasonable a patient that you're ever going find to do it in.

I bring that up because the outside reviewer gave him a hard time about doing that. Not fair.

Q. I want to get to your summary in light of the hour. I'd like you to speak briefly about the Jones case.

A. This is one where we just didn't see enough records to even analyze the case. The patient was described as having had a sleeve gastrectomy two or three weeks before the admission.

A sleeve gastrectomy is a controversial

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procedure for treatment of obesity. In this case it was done for a benign hemorrhagic gastric condition of some sort of which we never really have a good diagnosis, at least in this chart.

The patient comes up again with failure to empty their stomach. We don't get any data whether this is another case of gastric atony like the first patient, or whether there's an actual mechanical obstruction to the ability to empty the stomach.

I happen to suspect the latter, because this sleeveless section could have easily impinged on the gastric outlet, but I don't know it even though I suspect it.

Dr. Randall's response to it supports the fact that it was a mechanical obstruction because he did a mechanical operation to fix it. He did a gastrectomy reconstruction, which did fix the mechanical thing, but there was still gastric atony for a significant period of time after it. But that eventually went away and the patient recovered.

I don't necessarily think there's anything wrong with that except the idea of doing the sleeve gastrectomy really confuses me, but I

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wasn't given that record so I can't say anything about it.

Q. Was it retained --

A. The second issue is that the patient gets some bleeding from an enterostomy site or a puncture site. And Dr. Randall fixes this at the bedside -- I don't have any problem with that -- and stitches it up.

In the course of that he breaks off the tip of a needle. He's at the bedside, and this is literally a needle in the haystack. That's what this actually is. And he chooses to leave the tip of the needle in the subcutaneous tissue or maybe in the muscle of the abdominal wall.

The outside reviewer makes a really big issue out of that, and I think that's totally inappropriate. This needle was not going to hurt anybody. It was not dangerous. I can clearly support the concept it might have been more dangerous to go fetch it. This is a consequence only to risk managers. It is not of any consequence to health, and making a big issue about this is inappropriate.

Q. You have, Dr. Skudder, described several cases involving judgment. You've described

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three cases where there was devascularization of the bowel; you described four cases where there were technical defects.

Have you formed an opinion as to an evaluation of Dr. Randall's surgical techniques?

A. Well, I identify four issues.

Q. Okay.

A. I have four opinions.

Q. Do you have an opinion? All right. Can you tell us what they are?

A. Number one, I have an opinion that in many of these cases judgment is flawed. In some of them it is truly outside what I would define as standard of care. In others it may be within standard of care, but it's kind of over at the edge where only a small number of surgeons would make that particular judgment.

My second and third opinion are really A and B of the same thing. I believe there are significant technical failures, again, some of which are clearly outside of the standard of care. Others may not be.

One group of these has to do with handling of bowel and devascularizing it. Another has to do with unintended trauma, unintended and

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unrecognized trauma to solid organs, specifically colon in most cases, bladder in another. So, two, A and B are technical issues.

And the fourth issue is an issue of insight, if you will, and I don't know how big a role that plays in your decision-making. Remember my charge was to identify the issues.

My fourth issue was an issue of insights into the reality of and nature of the problems, and that opinion is based on the discrepancies I see between Dr. Randall's response or explanation of these clinical scenarios in his letters to the medical staff as compared to what I see and what other reviewers have seen when they review the medical records, and there's a significant disconnect on quite a few of the cases that I pointed out.

There's a wonderful book on that topic. It was written about -- it was entitled Forgive and Remember, Management of Medical Failure, and it was written by a sociologist who attached himself to a surgical intern program. But the book was reprinted and edited, a new version since at least 2000. And it's a little book, easy to read. I think it would be compelling reading for anybody

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doing this work.

It has to do with the fact that if we're going to improve the quality of medicine, the individuals involved in process and outcome improvement need to look at their own performance in an absolutely cold objective way, with no pride, acknowledge where problems have occurred, because if you can't do that, you can't fix it. It requires insight into what's going on, and I think that that's a legitimate fourth opinion.

MS. KREBS-MARKRICH: I have no further questions for Dr. Skudder.

HEARING OFFICER: I tell you what, it's 8:55. He's been testifying for two hours at the very least. We need a few minutes for a restroom break.

And let me address the panel, and I'm very sympathetic with the lawyer who is ready to do his cross-examination and the jurors all look at their watches.

THE WITNESS: The other issue is I'm not available tomorrow.

HEARING OFFICER: Well, that's part B of the problem. Let me look at the panel first and see how you guys are situated as far as your

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staying late and hearing this cross-examination. Are you okay.

MR. RICHTER: I'm on call tonight, and I'm covered until 9:30. If there are no issues and there's nothing going on at that point in time, I'm happy to continue.

HEARING OFFICER: How about if the rest of us take a restroom break while you get your beeper?

(A recess transpired.)

CROSS-EXAMINATION

BY MR. MCKAY:

Q. Dr. Skudder, first of all, the name of your practice is Vascular Surgical Associates?

A. The name of my current practice is Cardiovascular Specialists.

Q. And you're a vascular specialist?

A. Correct.

Q. And the types of surgeries done here, most of them laparoscopic surgeries, you don't even do in your practice, right?

A. I do not at this time, no.

Q. And in your CV you have a number of publications, and almost all of those deal with vascular surgeries, do they not?

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A. The majority do, yes.

Q. Basically those articles don't have any relevance to the cases here today?

A. I think there's one or two that have to do with open general surgery.

Q. Okay. And that's what you generally do as a vascular surgeon, you do open surgery, operate on the branches of the aorta, do bypasses, mesenteric ischemia and that type of thing; is that correct?

A. No quarrel with you.

Q. Stay away from the gallbladder, some of the other organs?

A. Organs like bowel mesenteric ischemia sometimes come out while we're there, and there is overlap in these fields, and you do need to understand that.

Q. And you're being paid for your testimony?

A. I'd like to convince you I did this as a truly volunteer effort, to come see a day over 30 degrees; but no, I'm being paid to do it.

Q. You charge $5,000 a day generally?

A. I think I'm being paid half that for this trip. To be honest, I don't know what I'm

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being paid. You could ask the hospital what they're paying Allied, which I'd kind of like to know, then I can know what kind of cut he's making on it.

Q. And you testified a week ago in a criminal trial on behalf of a criminal; is that correct?

A. I was asked to give expert testimony in upstate New York regarding a vascular injury in a criminal case, that's correct.

Q. All right, sir. And the Troy Record, Troy, New York, I guess?

A. That made the paper; isn't that interesting.

Q. Made the paper. Dr. Paul Skudder paid $5,000 to testify for defense, said the most severe wound, a cut to the neck that severed external jugular vein, would not have been fatal even if she had not received medical attention.

A. There's a certain out-of-context about that, but I'm not going to argue with that.

Q. All right. And you do med-mal work too?

A. I think a good bit probably comes from the context, but I have done med-mal work.

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Q. I've done a quick computer search on you, and it looks like of 27 cases, 21 cases were on behalf of the plaintiff against the doctors or hospital; is that correct?

A. That's very unlikely to be the case.

Q. All right, sir. This is --

A. I would say about two-thirds is actually defense work, and I don't know -- I'm happy to review it case by case.

Q. This says both plaintiffs 21, defendants 7, unknown 1.

A. I will quarrel with that until I get a chance to go over it case by case.

Q. Something we called I-TECHS?

A. That's exceedingly unlikely that that is accurate.

Q. All right, sir.

A. Probably two-thirds of my med-mal work is for a firm called Reminger, who does only defense work.

Q. Reminger, and Reminger out of?

A. Cleveland.

Q. Cleveland?

A. They were the first firm I worked for in 1987, and I would say they alone account for

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two-thirds of my efforts. And I don't know who I-TECHS (ph) is, I've never heard of them, but that is clearly erroneous information. Beyond doubt it's erroneous information.

Q. All right, sir.

Now, you said all these cases were fairly difficult cases that you reviewed; is that correct?

A. I can only base the assessment of difficulty upon the op notes and the comments. Some of them certainly looked like very difficult cases. Others, for example, Mr. W[redacted], the appendectomy, may have been a little bit difficult but does not sound in the record like there was any particular difficulty about that. Whereas, Ms. S[redacted], the 30-year-old contracted little lady, was clearly a difficult case.

Q. All right.

A. I would prefer that you worded that as saying there was a spectrum of difficulty, including some difficult cases.

Q. All right. And in all these cases there's no way anyone, including you, was able to read every letter and every one of these records?

A. I believe I acknowledged that in the

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course of my testimony. It's probably 30,000 pages of information.

Q. You can take snippets here and snippets there and come up with an opinion?

A. I think focusing on key parts of the records, including the history and physicals, consultation notes, operative notes, discharge summaries, physician progress notes and orders will do better than snippets, and is unlikely to result, as you say, in different opinions, in widely divergent opinions.

Though I did honestly and fairly point out during my testimony that I did differ from some of the opinions from some of the outside experts that were hired in the case.

Q. Some of the outside experts the hospital relied on, you differed with their opinions?

A. With parts of their opinions, yes.

Q. All right. And the R[redacted] case, I believe that's the first one you discussed. I think the initial reviewer said she shouldn't have had surgery, and I think you said no, she needed the surgery, whatever?

A. I can't recall exactly what the initial

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reviewer said. My understanding is that both the initial reviewer and I agreed that the judgment to go to surgery was appropriate. The initial reviewer made a very strong case out of the need to convert to open surgery.

Q. The openness --

A. Whereas I regarded that as a judgment that can only be made by the operating surgeon and chose not to express a strong opinion either way on that.

Q. And as far as open versus closed, that's been a controversy in surgery for 20 years, about which is a preferable technique, would you agree?

A. I think in today's world there's little controversy. The closed technique is preferred in most patients until such time as the anatomy cannot be safely dealt with closed.

Q. Okay. And the first case you talked about was the R[redacted] case; that's the lady that had the units of blood, I think, over three days.

A. Correct.

Q. And she got better without reexploring; is that correct?

A. I acknowledged that during my direct

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testimony and I commented many times on the imperfect correlation between outcome and procedure.

Q. And she had a good outcome? You can just answer yes or no.

A. She had an acceptable outcome. I don't know if she had a good outcome.

Q. You don't know if she had a bad outcome?

A. Hell, she walked out of the hospital with a gallon and a half sitting in her belly and at risk for multiple complications. I guess we can argue about what good means. It was acceptable.

Q. All right. Acceptable.

And Mr. W[redacted], we talked about that one. I know everyone's tired, believe you me.

A. You deserve the fairest shot.

Q. Just admit I'm right, we'll go home.

A. I try to do what I've done all the way through, be precise and objective.

Q. All right. Mr. W[redacted] was the patient with the --

A. Appendicitis, 34 years old.

Q. Okay. With the appendectomy, and actually with Mr. W[redacted], the omentum was found to

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be necrotic; would you agree with that?
A. Correct.
Q. And that's unusual not from a bowel injury?
A. The necrosis of the omentum was related to its -- it was a fellow traveller in the infectious process, and it was killed by the inflammation around it. And necrotic omentum is commonly found adherent to perforated diverticulitis or to abscesses of other sorts and whatnot.
It is true that the necrosis of the omentum cannot be directly attributed to the same vascular injury that led to the cecum necrosis.
There you go, you're right.
Q. There you go.
And on Mr. W[redacted], I believe you testified that you also came up with some different conclusions than the initial reviewer that the hospital relied on; is that correct?
A. Well, I added to it -- remember, the initial reviewer is only the one case. And I had the unique privilege of seeing, or responsibility of seeing all of these cases. And sometimes things are more clear with the benefit of multiple cases

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and a pattern.
And I think without seeing the other two cases that showed similar localized focal bowel necrosis adjacent to areas of dissection, one might not have picked up on what happened here.
Q. But Mr. Erickson was the obese patient, you would agree he was a high-risk patient; is that correct?
A. Obesity certainly does increase risks for most types surgery, yes. That actually plays into my first opinion about him which was that a conservative response from the start would have been preferable.
Q. All right, sir. Now, he had a bowel that was obstructed, is that correct, was found obstructed on pathology?
A. I don't think that a pathologist makes that diagnosis.
Q. Well, the pathologist, I believe, testified -- excuse me, the records state that there was a 13-centimeter segment of the small intestine extensive sorosis, fibrosis with adhesions, marked luminal narrowing present.
A. Okay.
Q. That's obstruction.

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A. I would actually disagree with you. I think you actually just read me the confirmation that you are incorrect, because luminal narrowing is not an obstruction. Obstruction is complete blockage. I would amend your statement to say that the pathologist confirmed that the obstruction is partial.
Q. A marked obstruction is enough to cause problems with a patient?
A. Most obstructions will respond to conservative therapy.
Q. And this man actually had -- I believe his bowel had blown up to 10 centimeters because of all the stuff in it; is that correct?
A. That is what's reported, yes. Generally, we have not seen these x-rays ourselves.
Q. And in fact that could also be a cause of the ischemia that caused him subsequent problems, could it not?
A. Bowel distension alone would not generally cause ischemia. When you say could, I need to concede the remote possibility that that could happen, yes.
Q. That's a lot of bowel distension, isn't it?

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A. Well, there are objective evidence based criteria for evaluation of bowel distension, and bowel distension of over 12 centimeters is considered severe enough that it should be operated on, and under 12 centimeters is not considered that, and that's pretty well-established literature.
Q. All right, sir.
I believe with Mr. E[redacted] you testified whether the surgery, you weren't going to say the surgery itself was outside of the surgical standard of care?
A. I addressed that from both sides. I stated that I thought a conservative approach would be preferable, but I also did state that an immediate surgical approach probably did fit within the standard of care. I was critical, but I could not state that it was a clear standard of care violation.
Q. All right, sir. And then Mr. C[redacted] you didn't have much criticisms of Mr. C[redacted]'s treatment, did you?
A. I had a major criticism of the splenic flexure which led to ischemic necrosis requiring the patient to have a second operation, a total

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abdominal colectomy which will leave him with long-term sequela.

Q. But he had a 12-centimeter dilation from stool of his -- yeah, the second surgery he had a 12-centimeter dilation of the distal proximal colon.

A. Which was exactly why he needed a colostomy, which was what was performed. It was the technique of the colostomy that was in error.

Q. And the necrosis again could have been caused by ischemia from just the amount of the dilation from the stool? That's a potential cause of it?

A. The relationship of dilation to ischemia is far less definite than you're trying to point out. The response to -- the reason that dilation is dangerous is because the bowel can eventually split up and perforate.

Now, this gentleman developed necrosis of the stoma itself, described by Dr. Randall, and the stoma itself is clearly decompressed and not isn't anywhere near 12 centimeters, it was probably 1 or 2 centimeters, and the stoma itself necrosed. It's not reasonable to blame this on a distended cecum more proximal. The cecum hadn't decompressed

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because the more distal segment of the colostomy was ischemic and not peristalsing and everything was staying in the cecum.

Q. But in his case the prior appendectomy stump was found to be grossly intact on the second surgery?

A. Are you talking about H[redacted] or C[redacted]?

Q. C[redacted].

A. Correct. And all that tells us is that the amount of distension wasn't enough to blow out the stump, and it tells us the patient did not have a complication from the incidental appendectomy that he didn't need.

Q. Now, Mr. H[redacted], he was the patient with the bladder?

A. Right.

Q. In that case Mr. H[redacted] had prior hernia repair earlier; is that correct?

A. That's correct.

Q. And Dr. Randall got in there and found mesh that had been attached to his bladder.

A. Correct.

Q. And he appropriately backed out of that surgery and elected to go back with a urologist; is

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that correct?

A. I don't believe that is correct.

Q. Second surgery?

A. In the second surgery there was a urologist involved, but your statement involved -- included many other purported facts than just the involvement of a urologist in the second surgery.

Q. First surgery, he basically terminated the surgery without going forward with the repair; is that correct?

A. According to the op note, that's grossly incorrect. That is what Dr. Randall stated in his December 21st letter that disagreed with the operative note. It disagreed with the progress notes after the surgery. It disagrees with everything in the medical records.

It is stated in Dr. Randall's rebuttal letter dated December 21st and September 16th. One is forced to conclude, I'm afraid, sir, that the rebuttal letter is, I guess if I'm going to be polite about it, revisionist.

Q. But he went back a second time with another surgery?

A. He did in fact do that and it was entirely appropriate.

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Q. And as far as you know this patient has done fine long term?

A. I don't have any information about the patient's follow-up. It is fair to speculate that he may have done fine. It's equally fair to speculate he did poorly since I have no information.

Q. Dr. Randall saw him at his follow-up and he would know whether or not the patient was --

A. I guess you need to ask Dr. Randall. Asking me isn't very helpful.

Q. And then the H[redacted] case, you contend that the injury was from a trocar, I believe.

A. Well, the injury seemed to be in the vicinity of -- let's go to the op note. I don't contend anything. I just read the op notes.

MS. KREBS-MARKRICH: Pages 58 through 60.

THE WITNESS: It's the second operation that tells us.

MS. KREBS-MARKRICH: I think that second operation is 58 through 64.

THE WITNESS: So keep going down there.

BY MR. MCKAY:

Q. And we have different pages for

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whatever reason.
A. Page 49 in the -- in the PDF looks to me like where it's going to be.
Q. Can I help you, Doctor? It states: On entering the abdomen, no evidence of intraabdominal contamination or evidence of bowel injury.
A. Would you give us the date of that operative note, sir?
Q. 3/17/09.
A. That is the first operation which, unfortunately, is not the one we're talking about.
Q. That's the second operation, I believe.
A. Second operation is dated 3/25/09, preop diagnosis fecal fistula; postop diagnosis lacerated transverse colon.
Q. I believe that's the third operation.
A. Okay, third operation.
Q. All right, sir.
And the P[redacted] case, you weren't --
A. So the preop diagnosis on that patient is lacerated transverse colon.
Q. That's the third operation?
A. But, again, so if I'm saying that's a colon injury, that's what I'm talking about.
Q. All right. That's a different area

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than he was operating on, the trocar, was it not?
A. It may be. And I will concede there's a possibility it was not a trocar injury, but it was still an unrecognized colon injury that led to necrotizing fascitis and almost killed the patient.
Q. I know it's late.
The P[redacted] case is the one where the line from the shunt got nicked. You didn't seem to have particular criticisms of that. It was a difficult patient, difficult surgery; is that correct?
A. I'm still trying to clarify in my mind your last surgery.
Q. My job's to confuse the issues.
A. If so, you're achieving some benefit there. Okay.
So I'm reading from the note of the second operation, which is dated -- oh, crap, I lost it. The problem is this is a 5,400-page record. Postop diagnosis is necrotizing fascitis, which is transparently the result of a bowel injury in this particular case.
Q. That's the H[redacted] case, I believe you're talking about?
A. Yes, it is. It's the one that we --

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we're still talking about. I think you -- and --
Q. I was talking about P[redacted]
A. And going to the third page of the second op note -- second page of the op note from that date, cultures were taken, the fascia was opened, necrosis was not clear.
Well, the thrust of my testimony earlier was that this so-called obvious necrotizing fascitis, which grew out in the cultures that were taken for fecal organisms, this can only arise from feces; and the patient was a few days later explored and finally the large colonic injury is identified.
The focus of all this is that the whole thing arises from an unrecognized injury and it's not in a mysterious necrotizing fascitis of unknown origin.
Q. And the S[redacted]ase, that's the lady with cerebral palsy around 30 years old.
A. Correct.
Q. I believe the hospital criticized the initial surgery and the type of surgery, and you don't criticize that?
A. Well, the initial reviewer characterized the need for surgery as emergent,

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which it was not. And he also made many other criticisms. It is my intent to be as objective and precise as possible.
Q. You felt the initial reviewer was hypercritical?
A. I felt that some of his criticisms were inappropriate, including his characterization the need for surgery in this individual is an emergency.
Q. All right. And you acknowledge in this patient that she somehow apparently pulled this tube loose that caused her problem. She needed her tube because of her condition. She couldn't eat, and she, however it happened, who knows, but she got the tube out of her bowel. It's just an unusual case.
A. Well, I have seen that, not in my own patients, but I have seen that complication before of J-tubes getting out of the bowel and whatnot. I think it is unusual but it is possible.
Q. This patient -- I --
A. I do not believe that the dislodgement of the tube reflects a problem with the placement of the tube.
Q. You don't know that. I mean, it's

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just -- the patient pulled tubes out of herself. It's in the record; is that correct?

A. Let me repeat what I said because you answered me as if you disagreed with me, and I'm saying I do not believe that the dislodgement of the tube reflects poor care.

Q. Okay. I'm sorry, I misunderstood.

A. My criticism and the criticism of the outside reviewer is once you know the tube is out, and you have enteric contents contaminating culture medium, and enteric medium with free air, you've got to fix it.

Q. And you criticize the delay from recognition to taking her to surgery?

A. Yes, I am. And that was the primary criticism of the first reviewer as well.

Q. And whether it would have made a difference if she had gone into surgery, no one knows, she's still going to have peritonitis, isn't she?

A. Just as a bad outcome can occur with good care, a good outcome can occur with bad care. The process was wrong even if the outcome didn't change.

Q. In med-malpractice you have to prove

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the patient was injured or harmed by the deviation from the standard of care. You understand that, don't you?

A. I do understand that. And if this were a med-malpractice proceeding, that would be germane.

In this particular proceeding, my charge was to analyze the process of care and comment on the strengths and weaknesses in as objective a way as I am capable. My charge was not to determine whether malpractice occurred.

Q. Malpractice didn't occur, but you're contending something that --

A. I'm not making any judgment as to whether malpractice occurred or not. The only judgment I'm making is that the process of care in that delay was outside the -- what would normally be defined as the standard of care.

Q. In the J[redacted]' case, I'm not going to talk about that. A needle broke out, it's not a big deal.

A. And I supported you on that.

MR. MCKAY: Thank you. That's all I've got. It's late.

THE WITNESS: And I've made a real

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effort to be objective here and not to criticize what shouldn't be criticized.

In my private conversations with the attorneys who hired me and whatnot, I made the comment that talking about this needle is like piling on. You don't want to pile on. You want to talk about the real issues, and that's how I feel.

HEARING OFFICER: Anything on redirect?

THE WITNESS: No.

HEARING OFFICER: Does either side have a position whether the panel should be able to ask questions?

(No response.)

HEARING OFFICER: Anybody from the panel have any questions?

DR. THOMAS: I have.

EXAMINATION

BY DR. THOMAS:

Q. Doctor, you've got an orthopedic surgeon, an oral surgeon, biologist, anesthesiologist, an oncologist trying to make decisions about general surgery. As you've gone through these cases you've given an idea as to an opinion. You've spoken about what is your charge, and you are allowed to comment on what action you

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would take maybe is a question for you guys. What action would you take if you were on this panel, and maybe our charge is not to --

DR. SIMPSON: I don't think it's appropriate for him to make that judgment. That's got to be our call.

THE WITNESS: I basically agree with that. The question that you're asking should be directed to the hearing officer as to whether it's in my purview to opine on that at all. Then it would be up to me as to whether I had a -- I'm not sure I want to express an opinion on that. I guess I might have some general opinions, but I'm not the arbitrator of what the rules are of your hospital bylaws.

As I understood it when I was asked to come here, I was told there was a hearing about an individual who had his privileges at risk, and it's a career-threatening event and that's very painful.

And despite what the attorney tried to imply, I really have done surprisingly little work with plaintiffs and I try to be very physician sympathetic.

I was very open about the status of my practice being primarily vascular; and the

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hospital, through the people, through the agency that hires me, I relayed that information. I said make certain they understand it, and the answer was yes, we understand it.

And I said I'm not going to express opinions on how this individual should or should not be treated. I understand my charge. My obligation is to help a hearing panel of non-surgeons sort out what kind of deviations from accepted standard of care might or might not have occurred.

I have tried to do that precisely and objectively as I could, and I believe my opinions would have been exactly the same if the other table was responsible for my paycheck. Maybe it should be half and half, I don't know. That's not my business to decide either.

I look at this with sympathy to both sides of the table in the background I happen to come to with, and I did not make decisions about what perhaps should be done. If the hearing officer thinks it's appropriate I might make a general comment, but only if he thinks it's appropriate.

HEARING OFFICER: Well, my opinion is

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the hospital didn't ask you that question, and the question is broader than what you've been asked to testify about. Bylaws, they can take into considerations all sorts of things you haven't been asked to opine on.

THE WITNESS: I agree with all of those statements.

EXAMINATION

BY DR. SIMPSON:

Q. Could I ask for a clarification? All ten of these cases that were reviewed by independent reviewers, who were board certified general surgeons and all, were from separate entities. Each one was a separate surgeon that reviewed these cases?

A. I don't know that to be the case. Two on them were reviewed, just so you can tell from the letterhead, by people from the agency AllMed.

And just to give you some perspective how that works, I can't remember how I got in touch with that guy, but I've got a contractual relationship with him which allows him to send me cases for compensation and I'll review them. I'm not an employee, but I'm on a panel that will review cases.

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The other eight have a different letterhead that says AMR, which is usually the name of Advanced Medical Review or American Medical Review, or something of that nature.

But as is common, if you look at even my review on Mr. C[redacted] my name is not on it. It says that I'm a board certified general surgeon who reviewed it, and those eight also have no name on them from AMR, I only did one of the two AllMed, so the other AllMed, I have no idea who the hell that is.

Whether the eight for AMR were done by one individual, three individuals or eight individuals, I have no knowledge unless these ladies over here do.

What you can say is at least three different individuals at an absolute minimum were involved.

Q. And my impression on your testimony is that all of these cases, as you sort of summarized it, had -- your four points, again, just re-summarize your four points on what you saw on these ten review cases.

A. The first point I made was about judgment. Should you have waited on that partial

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small bowel obstruction? Should you have opened either the R[redacted] or the other lap coly that wasn't open, but it had complications, C[redacted] You know, again, that's a decision that ultimately can only be made by the surgeon that's there.

But when you're consistently having problems that could have been avoided by the other decisions, you become a little bit concerned potentially about the judgment. His other judgments were correct in difficult situations, and judgments are very hard things to evaluate, but there are serious judgmental concerns in these cases.

And then there's technique. There's a lot of technical complications. An anastomoses that died, bowel that died and became ischemic, I think I know why some of them happened; but, hell, I wasn't there, and I don't know 100 percent for sure. But three of them fit together that they were probably devascularized.

And then there's four or five patients in whom there are bladder or bowel injuries, hollow organs. Admittedly they're surrounded by mesh adhesions; there's mesh adherent to the bladder, et cetera. But surgeons have to work in these areas.

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And once in a while we all know we may injure a hollow organ that's attached to it. It ought to be pretty damn rare when it does happen, as in one of the cases, you should find it and fix it. That was the lap coly lady who had the VP shunt that was cut.

There was also a colon injury that was found and fixed and the patient did fine. If you do injure it, you're supposed to find it and fix it.

To Dr. Randall's credit he says in his op note, he often says I studied the bowel and the bladder and I didn't see any injury.

Now, when I read those, to be honest, I said that's self-serving. Here these retrodictated a week later, after he knew there was a problem so he's covering his butt by putting that into his dictation.

When you look at it, every single op note was dictated on the day of the operation. So I believe he really did look at it and not see it.

Why is he not seeing it when he's having more injuries than you would expect to have. I can't tell you for sure, but you just have to conclude that there's something wrong with the

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dissection around the bowel when you have this many bowel injuries.

The attorney may argue with me whether one of them was from a trocar or scissors later in the dissection, but it doesn't really matter. The point is you're still crashing into those hollow organs and not recognizing it after it happens.

And then the fourth thing I said has to do with the issue of insight. And again it's not my role to help decide how the medical staff is going to handle a difficult situation with one of your own colleagues, who indirectly is my colleague too from far away. None of us are perfect. My surgeries aren't perfect.

But the way I make it better is by coldly acknowledging, oh my God, I did that wrong, and then I have a chance to fix it. And if I don't have the insight to see that I'm making errors and there might be a pattern to my errors, something I could do better, I'm never going to do it better.

And I think that this issue of insightfulness might also play a role in decisions that a medical staff might make in this kind of circumstance.

Q. Just one more.

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A. That's my fourth issue.

Q. Regardless of the fact that you had some disagreements with some of the reviewers, did you find in general those ten reviews agreed with those four principles?

A. I actually did, and my disagreements were always only with part of what went on. For example, just pick out any one of them. The one where the outside reviewer, you know, wants to skewer him for not opening a difficult laparoscopic cholecystectomy. You can't say that that's black and white. That's a judgment decision and whatnot.

But the fact that he doesn't open and then he has the bowel injury and doesn't recognize it, doesn't change the fact that he has a bowel injury and didn't recognize it. And it may or may not have happened if you had opened the case as well and that sort of thing.

I hate to be saying this without looking you in the eye, Doctor. You know I don't like saying it.

But some of the criticisms are to a certain extent piling on.

The other issue of course -- and I pointed this out in response to some of the

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attorneys' questions to me -- is that sometimes when you look at one case, you don't see everything you see when you look at six, if you follow what I'm saying.

Q. I do.

A. So some of the disagreements are to a certain degree innocent, but in general I think most of the reviews are cogent.

In summary, I think if you do read those ten reviews -- and I know this attorney may not want you to read them, maybe they won't be given to you, I don't know. But if you do read those ten reviews and then you read my comments, in general, I think, I'm a little bit gentler than some of those reviews are in general.

But that doesn't mean I don't see issues. I'm a little bit more sympathetic, if you will.

DR. SIMPSON: I have no further questions.

DR. POWELL: My understanding when they asked me to be on the panel was not so much to make a judgment call about judgment or technique, but to sort of oversee that the appropriate bylaws are followed and things were done appropriately,

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because I don't know whether you sit on a 10-centimeter or 11-centimeter. What is the bottom line for our decisions?

HEARING OFFICER: Probably worth repeating and summarizing.

DR. POWELL: I heard you say that, and I want to make sure that we all understand, after all this, what we're looking at.

HEARING OFFICER: That's a good question. And I'm going to let you guys do any follow-up questions in just a minute. Let me summarize this.

It says that -- goes into two different types of cases. There's one standard of proof if it's a matter of not giving somebody privileges or something along those lines. The other is taking away privileges. That's what this is. So the standard of care is point of impact of committee whose adverse actions occasioned the hearing, in this case these folks over here, that have the initial burden to submit evidence and report thereof. Thereafter the burden shall shift to the practitioner to support adverse actions by a preponderance of the evidence that the grounds therefore lack any substantial factual basis, or

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the conclusions drawn therefrom are either arbitrary, unreasonable, or capricious.

In all cases, the hearing committee shall rule against the practitioner unless the hearing committee determines the practitioner has met his or her burden of proof.

Let me add to that. This is what you're going to be asked at the end. Upon conclusion of the presentation of oral and written presentation, the hearing may be closed. Each party shall have the right to submit a written statement within ten days of the close of the hearing, providing arguments and authorities supportive of its position. The hearing committee may thereupon, within 30 days after receiving written submissions of the parties, render a written decision in the matter which shall include a written statement of the basis of the decision.

The hearing committee made the written decision of the record and all documentation of the chief executive officer. The hearing committee's decision shall contain findings and facts which shall be petitioned details to enable the parties, the board, or any appellate review bodies to determine the basis so the committee can review on

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each matter contained in the notice of the charges.

The decision shall be supported by reference in the hearing record and all other documentation.

The basis of decision: The decision of hearing committee shall be based on the evidence produced at the hearing. This evidence may include but shall not be limited to oral testimony of witnesses, briefs or memoranda of points and authority presented in connection with the hearing, any material contained in the medical staff's credential files; any and all applications, references, and accompanying documents, all officially noticed matters, and in any other relevant evidence hearing committee.

The hearing committee shall also be entitled to consider all other information which may be considered pursuant to the medical staff bylaws with connection with application to medical staff and clinical privileges.

That last paragraph is sort of why I didn't think Dr. Skudder should give the opinion about what you should do. You're supposed to take into consideration.

THE WITNESS: Quite frankly, I'm

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uncomfortable about doing that. You know what your options are as well as I do. And basically I think my role here was simply to say that I agree with the thesis of the medical executive committee that there are issues to deal with here.

HEARING OFFICER: To answer your question, your decision is going to be whether the direct recommendations by the MEC to terminate, to revoke privileges lacks any substantial factual basis, or that the conclusions drawn therefrom are arbitrary, unreasonable or capricious. It goes a little bit beyond did they follow procedure, do you have to second-guess to some extent the decision was arbitrary, unreasonable and capricious.

DR. POWELL: Regardless of agreement or disagreement, what are the remedies then depending on what decision we make, and what's Dr. Randall's options given a yes or no vote? Is that addressed in the bylaws?

HEARING OFFICER: Yeah. Yeah. There's a whole section on what happens after this. If you agree with him that the MEC has not proved its case, or he proves its case is not substantiated or arbitrary, or unreasonable or capricious, then I think you issue that as your findings.

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If you agree with the MEC then he has an appellate process. I don't know what he can pursue. Is that a fair statement?

MS. KREBS-MARKRICH: Yes, sir.

HEARING OFFICER: Yeah.

MR. MCKAY: Yeah, that is.

DR. SIMPSON: I have one other question. How did those come to light? Were those brought to light by a prospective review or did these pop up over time? How did these come to light? Richard may know a little bit about how do we get these.

MS. KREBS-MARKRICH: The way I'd like to answer that, we tried through Dr. Edwards to describe what the things were. And as one goes through the records -- and you all will have some time after without us around as you look through the documents. It's the MEC's contention that these cases which were brought forward through peer review committee went their track ultimately ended up through MEC. And when you have more time, the peer review, the MEC notes and minutes, all of these minutes located at the end of the manual and any correspondence at the end of the folder, that's the MEC's explanation of how he got --

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Does that answer your question?

DR. POWELL: Yeah, I understand.

HEARING OFFICER: Dr. Edwards generally described the process, right?

MS. KREBS-MARKRICH: Yes.

DR. RICHTER: So just to paraphrase where the MEC's coming from is this compilation of documents that occurred from reviewing files from 2010.

MS. KREBS-MARKRICH: Some of them are dated in 2008, toward the end of 2008.

DR. POWELL: I wondered, there was a correspondence in there from 2006 and we didn't see any record from that, so Dr. Alexander.

MS. KREBS-MARKRICH: Dr. Edwards was trying to explain there was an earlier process, and that was -- those earlier records were an attempt to demonstrate that.

DR. POWELL: Okay. Thank you.

HEARING OFFICER: Any other questions? And we'll have some more time. Once the hearing's adjourned, I can meet with you guys and talk about what some of these words mean, orders mean.

You're allowed at your discretion to use me as legal advice, but I don't get to vote on

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the outcome.

Any other questions of Dr. Skudder?

MR. MCKAY: No. I have Dr. Schroder, who is on call working all night. He is leaving town tomorrow. I can put him up in less than ten minimums probably as long as we're here.

HEARING OFFICER: Put him up and we'll talk about what's going to happen tomorrow.

CHRISTOPHER W. SCHRODER, MD

being first duly sworn, testified as follows:

DIRECT EXAMINATION

BY MR. MCKAY:

Q. Dr. Schroder, I know everyone here knows you, but give me your name, please, sir.

A. Christopher W. Schroder.

Q. And your medical address?

A. 172107 Ebenezer Road, Rock Hill 29732.

Q. And you're a general surgeon here at Piedmont Medical Center?

A. Yes, sir.

Q. Are you licensed in the state of South Carolina?

A. Yes, sir.

Q. And your license is in good standing?

A. Yes, sir.

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Q. And you're board certified in general surgery?

A. Yes. Yes, sir.

Q. How long have you been in this hospital?

A. Since 1987.

Q. And how long have you known Dr. Randall?

A. Since the day I came here in 1987.

Q. Y'all worked together for a number of years; is that correct?

A. We basically worked together for 24 years, yes.

Q. And you're familiar with the standard of care for general surgery, are you not?

A. Yes, sir.

Q. And you're familiar with Dr. Randall's surgical skills, are you not?

A. Yes, sir.

Q. And you've been in surgeries many times, correct?

A. Many times over the years.

Q. And being in practice, you sometimes get his patients on call and vice versa; is that correct?

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A. Yes, sir.
Q. Do you have direct familiarity with his medical judgment and medical skills?
A. Yes, sir.
Q. Is it your opinion based upon a reasonable degree of medical certainty that Dr. Randall is a competent general surgeon?
A. All the times I've worked with him or he's worked with me or I've taken care of his patients, I've never seen anything to doubt that.
Q. And it's your opinion that Dr. Randall is able to function now as a general surgeon to the standard of care?
A. Yes, sir.
Q. And you have an opinion based upon a reasonable degree of medical certainty that Dr. Randall is not a danger to his patients and he should be allowed to perform general surgery?
A. I've never seen Dr. Randall do anything that would be a danger to his patients.
Q. So it's your opinion he's not a danger to his patients?
A. No, sir.
Q. I know you're tired. That's all I have.

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A. That's okay.

CROSS-EXAMINATION

BY MS. KREBS-MARKRICH:

Q. My name is Julia Krebs-Markrich. I'm working with MEC.

Do you have any knowledge about any of the cases that are issued tonight?

A. No, I do not. I've worked with Dr. Randall on many, many cases. I've watched him operate. I've taken care of his patients. I've watched him do things in the office, do things in the operating room. I've assisted him with cases. He's assisted me with cases. But, no, I've never seen anything that he has ever done that was bad or wrong, but, no, I do not have any actual knowledge of these cases.

MS. KREBS-MARKRICH: I have no further questions.

HEARING OFFICER: Any questions from the panel? Any redirect?

MR. MCKAY: No, sir.

THE WITNESS: The only thing I'd like to say here is that general surgery may be one of the toughest things going out there. The anatomy is constantly changing. Patients are getting

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sicker, they're getting more difficult. I have done some operations in my life that I thought were just amazing, were great, and the patients did absolutely horrible. And I've done operations that I shook my head and said I can't believe I did that poorly and the patient did great.

So I mean there's a lot of things that go on that are well outside our abilities.

Biliary anatomy, for instance, with the pictures they show you in books, only 60 percent of people have that anatomy, 40 percent of people it's totally different. It's just a very difficult thing.

Like I said, I don't have any knowledge of these particular cases, but it's not easy out there these days. It really isn't.

HEARING OFFICER: Any further questions?

DR. SIMPSON: I'd like to know -- you might have to look this up. What percentage of these ten cases were of all the cases you did that year? And admittedly, these were particularly difficult cases. And I'm going to want to see something, you know, when we look at these numbers of re-operations, one patient that was a horrendous

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patient. In the main numbers that's going to skew, so I want to see what your complication rate over your total base was compared to the other general surgeons operating in the hospital during that period of time.

DR. RANDALL: There were two patients that had repeated wash-outs that I had taken over that period of time, bleeding with obvious multiple re-operations. They were planned, and patients that were in here they had planned return to clean out that abdominal wound vacs, splenic flexure, so they were -- that's why that year, that time frame is skewed.

DR. SIMPSON: And the other thing that I saw in here that Neal was talking about is this process started back in 2006. You were under review at that point. I want to know why you were under review, and the entire year of cases that were absolutely perfect and the peer review committee said no problem, go back to work. I think that needs to be addressed what the MEC's thought was on that and where they were going before we can -- what we're being asked to do, and we've just read that, and I'm going to go back and read the bylaws carefully because we have to decide

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that they were absolutely wrong. And we've got to have some kind of basis for that if we're going to make that decision to overturn them.

We'll not make that decision. That decision's been made. We've got to decide that they were egregiously wrong.

HEARING OFFICER: Jay, you'll call Dr. Randall tomorrow to testify.

MR. MCKAY: Yes, I will.

HEARING OFFICER: We'll have more opportunity to ask questions.

MR. MCKAY: Yes, we will.

HEARING OFFICER: Any other questions from anybody that's here?

How many more witnesses do you have for MEC?

MS. KREBS-MARKRICH: We will not call any more witnesses on behalf of the MEC, but reserve the right on rebuttal.

HEARING OFFICER: Jay, what do you anticipate?

MR. MCKAY: I got an expert. Dr. Randall will probably be longer that his expert. I've got some other -- Dr. Alleyne, who's a critical care pulmonologist, and Dr. Micklin, with

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whom Dr. Randall's worked closely on patients over the years, and they're going to be similar to Dr. Schroder. Dr. Crane's testimony, about them referring patients and having good results, that type of thing.

HEARING OFFICER: So you have two character witnesses.

MR. MCKAY: More or less.

HEARING OFFICER: Then Dr. Randall and an expert.

MR. MCKAY: An expert, yes.

HEARING OFFICER: What order do you think you're going to call these in?

MR. MCKAY: I was thinking to call the expert first, but I want to get him back to his family. He's out of Columbia. I can do it either way. Dr. Randall's going to be a little longer than the expert. Maybe, I don't know. Say, we could spend a month here going through these records in detail. It's just impossible. It's just 35-, 40,000 pages of records, just impossible to go through every little nuance, every little shift, left shift, respiratory change, everything else with each of these patients.

HEARING OFFICER: I'll leave it

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completely to your discretion what order to do it in. Just as a neutral observation it may go a little smoother if he did testify first, and that's going to be probably more tedious and more detail. But they're more interested in what he has to say than an expert. He's going to touch on high points, but I'll leave that to you.

MR. MCKAY: I can do it that way. It doesn't matter to me.

HEARING OFFICER: I'll leave that entirely up to you.

And then you think you might have some reply after that?

MS. KREBS-MARKRICH: Yes.

HEARING OFFICER: I think we're doing okay on time.

DR. RICHTER: I looked at different operations, and what they have said here for the criteria was they showed the results of 2008, January and July of 2009, and they said examples of exclusions from the study -- I'd like to have more clarification. He might have had eight patients that came back from reops. But like Dr. Simpson said, seven might be a second look for whatever reasons which we might have the seven right here

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before us and then the eighth one came back 25 times, or however many times it had added up to. I'd put that out there.

HEARING OFFICER: That's good. The lawyers like to have feedback from the jury.

MR. MCKAY: We do not have access to the hospital's data. We don't.

HEARING OFFICER: He can explain his case, I'm sure he will tomorrow.

MR. MCKAY: Sure, sure.

HEARING OFFICER: Anything else we can do while we're still here?

(No response.)

HEARING OFFICER: We'll be here at 5:30 tomorrow night.

(The hearing was adjourned at 10:13 p.m.)

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CERTIFICATE OF REPORTER

I, Joy R. Dick, Court Reporter and Notary Public for the State of South Carolina at Large, do hereby certify that the foregoing transcript is a true, accurate, and complete record.

I further certify that I am neither related to nor counsel for any party to the cause pending or interested in the events thereof.

Witness my hand, I have hereunto affixed my official seal this 21st day of February, 2011 at Rock Hill, York County, South Carolina.

Joy R. Dick, Court Reporter
My Commission expires
June 27, 2018

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BEFORE THE PIEDMONT MEDICAL CENTER
HEARING COMMITTEE

IN THE MATTER OF

ROBERT D. RANDALL, JR., M.D.

CERTIFIED COPY

VOLUME II

DATE: February 17, 2011

TIME: 5:44 p.m.

LOCATION: Piedmont Medical Center
222 South Herlong Avenue
Rock Hill, South Carolina

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ROBERT THOMAS, M.D.

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MR. COOKE: Any special issues that we need to resolve?

MR. McKAY: I don't think so.

MR. COOKE: Okay. Somebody -- a couple people on the panel asked -- there was a reference made yesterday to the second letter that was -- Dr. Randall wrote supplementing the additional cases. Do you remember that?

MS. KREBS: Yes.

MR. COOKE: Is that -- is that an exhibit?

MR. McKAY: I think we -- we put that in. The copy I had didn't have letterhead on it. That is an exhibit. And I've just got a computer-generated copy.

MR. COOKE: Is that one of your exhibits?

MR. McKAY: I think it's December 21st or something like that.

MS. McMILLAN: The third tab maybe.

MR. COOKE: Okay.

MR. McKAY: Yeah, we've got it in there. I just don't have the number in front of me, but --

MR. COOKE: It's attached to your tab

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number three here? Okay.
MR. McKAY: There's some letters in there, and I believe it's the -- I want to say it's December 20th, 21st, in that range.
MR. COOKE: Okay.
All right. Ready to start?
MR. McKAY: I'm ready. Call Dr. --
MR. COOKE: Just state for the record too that the panel did ask to have copies of the policy -- the -- the hearing appellate review procedure, and so those have been distributed.
I thought I was just too tired last night, but it's true. There is no such thing as a Roman numeral VIX, is there?
MS. KREBS: Wrong letters obviously.
MR. COOKE: Okay. Thanks.
MS. HUTTO: That is in fact what it says.
MR. COOKE: Yeah, it is what it says. When I started to read it out loud yesterday, I thought, "I can't translate this. I don't know what's wrong with me," and then I realized it just doesn't exist.
Okay. Is it -- you -- you have no further witnesses at this point?

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MS. KREBS: We have no further witnesses, although we may have a rebuttal.
MR. COOKE: Rebuttal, okay.
Okay.
MR. McKAY: Call Dr. Harry Hicklin.
HARRY EUGENE HICKLIN, III, MD, being first duly sworn, testified as follows:
EXAMINATION
BY MR. McKAY:
Q. Dr. Hicklin, would you state your full name and your medical address, please.
A. Harry Eugene Hicklin, III. Medical address is 430 South Herlong Avenue.
Q. And what type of practice do you have?
A. Cardiology.
Q. And what's the name of your practice?
A. Palmetto Cardiology of York County.
Q. You practice cardiology here in Rock Hill; is that correct?
A. That's correct.
Q. And you have privileges at -- cardiology privileges at Piedmont Medical Center?
A. I do.
Q. Are you -- are you a board certified cardiologist?

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A. Yes, I am.
Q. Now, do you know Dr. Bob Randall?
A. I do.
Q. About how long have you known Dr. Randall?
A. Probably 33 to 35 years.
Q. All right, sir. And you've known him professionally as a colleague for that long?
A. I've known him professionally for 20 years.
Q. You knew him before that?
A. I knew him before.
Q. All right, sir. And do you refer patients who need surgery -- general surgery to Dr. Randall from time to time?
A. I most certainly have.
Q. And in your observing your patients that you referred to Dr. Randall, have you noted they have any particular problems any different than any other surgical referrals?
A. I have not.
Q. Have you had good -- would you -- if Dr. Randall still had privileges here, would you continue to refer him surgical patients?
A. I would.

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Q. Do you know if you -- whether you've had any undue complications from anything Dr. Randall has done with any of your patients?
A. I am not aware of that. I was not aware of that.
Q. Yeah. Would you trust sending a family member to Dr. Randall?
A. I would. He operated on my mother and saved her life after a major motor vehicle accident, multiple internal bleeding. He operated on my mother-in-law, septic with gallbladder problems quite a few years ago. And numerous friends from, you know, younger than me to their 80s, you know, close friends here in Rock Hill, and I know of no problems with any of those cases.
MR. McKAY: Thank you very much. Appreciate it.
Do you have any questions?
MS. KREBS: No.
MR. McKAY: Call Dr. Bill Alleyne.
WILLIAM FRANK ALLEYNE, II, MD, being first duly sworn, testified as follows:
EXAMINATION
BY MS. HUTTO:
Q. All right. Would you state your full

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name and your medical address, please.
A. William Franklin Alleyne, II. Address 124 Glenwood Drive, Rock Hill, South Carolina, 29732.
Q. And what states do you have medical licenses?
A. I'm licensed in North Carolina, South Carolina, and my New York license is on sabbatical.
Q. Okay. All right, sir.
And in what hospital -- and you're a pulmonologist triple care specialist?
A. I am.
Q. And you're board certified?
A. I am.
Q. In what hospitals do you have privileges?
A. I have privileges at Piedmont Medical Center. I also have courtesy privileges at Mercy -- or CMC Pineville -- excuse me -- and CMC main.
Q. All right, sir. And have you worked with Dr. Randall on -- with patients?
A. I have.
Q. And about how long have you known him?
A. Since my arrival in Rock Hill in 1999,

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so a period of about 12 years.
Q. All right, sir. And have you -- and you do pulmonary medicine, critical care medicine; is that correct?
A. That is correct.
Q. So you would see -- some cancer patients or patients that needed lines, that type of thing, you'd send to Dr. Randall; is that correct?
A. I actually do -- or I did most of my lines, but I have consulted Dr. Randall regarding other matters.
Q. Okay. And did you have confidence in his ability as a general surgeon?
A. Yes.
Q. And did you note any undue problems with any of your patients from any of the surgical procedures done by Dr. Randall?
A. I did not.
Q. Would you continue referring patients to Dr. Randall if he still had privileges?
A. I would.
Q. Have you been able to observe his medical judgment?
A. Yes.

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Q. And you believe he has -- exercises sound medical judgment?
A. He has.
Q. Anything you'd like to add?
A. I think Dr. Randall is a fine physician. I think that it's one thing to say that an individual does not have the privilege to operate at a different hospital. I think this institution is going way over the line -- and I emphasize way over the line -- if you say that an individual does not have the right to practice at another facility.
And before this panel or any other panel makes that judgment, I think they need to be darn well sure that they are making the right decision because it's one thing to say that you don't have privileges to work at an institution. It's another whole leap of faith to say that an individual does not have the right to work anywhere else.
MR. McKAY: Thank you. That's all I have.
MR. COOKE: Any questions from the -- cross-exam?
EXAMINATION

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BY MS. KREBS:
Q. Did I hear you say -- you -- you said, if I heard you correctly, a physician -- a physician does not have the -- a right to work anywhere else. What were you referring to?
A. If the subject of this hearing is whether or not to allow Dr. Randall to practice here at Piedmont Medical Center, I think it is certainly within the right of this committee or any other committee. I think if you then extend that to say that an individual, Dr. Randall or anyone else, should not work at another facility, I think that you have frankly gone over the line and exceeded your -- your mandate, if you will. I think that is something for the state board to decide.
Q. Dr. Alleyne, do you have any specific information about any such communication --
A. I'm --
Q. -- that has been made?
A. -- I am -- he asked me did I have anything else to say.
Q. Okay.
A. And I am under oath, and I have said it.

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Q. But you're -- you're not aware of any specific communication that has been made?
A. I am not aware of any other specific information or communication. I am just making my statement for the record.
MS. KREBS: Okay. Thank you, sir.
THE WITNESS: Thank you.
MR. COOKE: Any -- panel have any questions?
THE WITNESS: Thank you for your time.
MR. COOKE: Thanks.
MR. McKAY: Thank you.
THE WITNESS: Am I dismissed?
MR. McKAY: Yes. Appreciate it.
We'd call Dr. Benjamin Tribble.
JAMES BENJAMIN TRIBBLE, M.D., being first duly sworn, testified as follows:
EXAMINATION
BY MR. McKAY:
Q. Would you state your full name and your medical address, please.
A. James Benjamin Tribble, M.D. Medical address, 1850 Laurel Street, Columbia, South Carolina.
Q. And what is your surgical specialty?

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A. General and vascular surgery.
Q. Do you practice both general and vascular surgery?
A. I do.
Q. And where -- where -- where did you go to medical school?
A. Vanderbilt.
Q. And where did you go -- and when did you finish?
A. 1983.
Q. And where did you do your residency and fellowship?
A. I did my residency at Wake Forest University.
Q. Generically called Bowman Gray?
A. It -- it was Bowman Gray at the time, that's right.
Q. And how about your vascular surgery?
A. At that time there was no vascular surgery boards, and so I have no -- no fellowship in that.
Q. All right, sir. You were trained in both at the time?
A. I was.
Q. And you're board certified?

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A. I am board certified in surgery.
Q. Okay. And -- and have you recertified?
A. A couple of times.
Q. All right, sir. And what hospitals do you have privileges in?
A. Palmetto Health Baptist, Palmetto Health Richland, Providence Hospital, and Providence Northeast Hospital.
Q. Those are the four hospitals in the greater Columbia area?
A. They are. Yes, sir.
Q. And how many surgeons are in your group?
A. There are nine.
Q. Nine.
And have you had -- you have been chief of surgery or had positions within various hospital staffs?
A. I have.
Q. And what positions have you held?
A. I've been chief of surgery at Palmetto Baptist and chief of staff at Palmetto Baptist.
Q. So you are familiar with these types of issues, peer review, that type of thing?
A. Yes, I am.

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Q. I assume you had to be a part of these types of hearings before?
A. Yes, sir.
Q. All right, sir. Now, I -- I asked you to review ten cases that have come up for the -- Dr. Randall has been criticized for exercising surgical care that's beneath standards -- the standard of care. Do you understand that?
A. Yes, sir.
Q. And are you familiar with standards of care for surgeons?
A. Yes, I am.
Q. And do you have -- do you work with residents in your practice?
A. I -- I do. Not on a daily basis, but certainly from time to time and I have been recently.
Q. Would that be Palmetto Richland primarily or --
A. Yeah, from -- those from the Palmetto Health Richland and Dorn VA Hospital.
Q. The USC School of Medicine?
A. Yes, that training program.
Q. All right, sir. And what medical societies are you a member of?

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A. American Medical Association, the American College of Surgeons, and the Columbia Medical Society, the South Carolina Medical Society -- Association. I think that's -- American Society for Bariatric and Metabolic Surgery [sic].
Q. All right, sir. And your dad was a surgeon; is that correct?
A. That's correct. Uh-huh.
Q. And your brother -- you have a brother that's a surgeon?
A. Well, two brothers who are surgeons, uh-huh.
Q. All right, sir. Now -- excuse me.
The -- generally -- and you reviewed ten cases; is that correct?
A. Yes.
Q. And it's -- I mean, I'm not going to ask you on page 4,000 of --
A. That -- that might be difficult.
Q. -- read what was said on the seventh line. That would just be impossible to do; is that correct?
A. I -- I think so. That's a lot of cases to look at.
Q. We've got 40,000 pages of records; is

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that correct?
A. Yes, sir.
Q. You primarily reviewed the surgical care, whether there were complications, the surgical techniques, things of that nature?
A. As -- as best I could as represented in the operative note and discharge summary and progress notes.
Q. All right, sir. Do you have an opinion based upon a reasonable degree of medical certainty whether Dr. Randall complied with accepted standards of surgical care with respect to these ten patients? And I'm going to break them down a little bit.
A. Yeah. I -- I think as a general rule, though there were complications, for the most part that the care was -- was meeting the standard of care.
Q. All right, sir. How about general surgery itself? It's a difficult field, is it not?
A. It is. And I'm sure the other fields are difficult as well.
Q. And some patients are much more difficult than others?
A. No question.

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Q. And some of these patients were very complex patients, were they not?
A. Some -- some of them were very complex, yes.
Q. You had a few people who were morbidly obese, a lady who had cerebral palsy and lots of complicated problems?
A. That's true.
Q. The first case I'd like you to talk about is the R[redacted] case. Do you have that one in front of you?
A. Yes, I have that one.
Q. All right, sir.
MR. McKAY: And I hope I'm going in the right order. I know Dr. Hicklin jumped around.
MR. COOKE: Yeah, we'll figure it out.
MR. McKAY: And -- but I think on the letter to Dr. Randall of December 17th I'm going to go in that order if that's okay --
MR. COOKE: Sure.
MR. McKAY: -- the best I can.
MR. COOKE: What exhibit number is that again just in case we want to follow it?
MR. McKAY: Mine does not have a number on it. It's the December 17th letter to

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Dr. Randall. It's in that stack --
MR. COOKE: Yeah.
MR. McKAY: -- from Dr. Edwards.
MS. KREBS: It's Exhibit 4 of the MEC exhibits.
MR. COOKE: Exhibit 4?
MS. KREBS: Yes.
MR. McKAY: Unless the Board wants to go in some other order -- and it's kind of -- yesterday the expert for the hospital jumped around and it wasn't in the order that the doctors got them in. I really don't care which order we go in.
MR. COOKE: Anybody have a preference?
MR. McKAY: Okay.
MR. COOKE: Just do whatever makes more sense for you.
MR. McKAY: All right, sir.
BY MR. McKAY:
Q. Well, the first case is R[redacted] C[redacted]; is that correct?
A. Yes.
Q. Okay. And the initial complaint was that the -- the operative procedure was substandard or shouldn't be done and that it subjected the patient to unnecessary complications.

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A. That's right.
Q. Okay. Now, Mr. [redacted], what were his problems? He had an obstruction and a dilated colon?
A. That's correct, uh-huh.
Q. And there was a criticism that Dr. Randall took him to surgery rather than just observed him. What -- what's your feeling on that?
A. I --
Q. What's your opinion?
A. As I read the criticism, I think the criticism was that the first procedure was maybe not the right procedure, and that is that at least in this document where -- anyway, and according to this document which I think came from the Piedmont Medical Center, I guess the Medical Exec Committee -- I don't know exactly -- maybe the initial procedure was not the right one, but instead it should have been a colostomy.
Q. All right. And what is your opinion on that?
A. I -- I think that's a judgment that really needs to be made by the surgeon at the table. It's a bit hard for me to second guess that.

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But I will say this, that in the end when he took out colon and especially additional colon tissue, there were ischemic and necrotic areas. Not -- not just ischemic, but necrotic skip areas in the colon making me think that -- that his initial thought of taking out at least some of the colon was a better option than doing a colostomy.
Certainly anyone that's -- that's trained in surgery or gastroenterology would know that a full thickness necrotic area in the bowel is -- is not a good thing to leave in somebody because it will ultimately perforate and -- and lead to peritonitis.
And ultimately the pathology report did show skip areas of necrosis which is admittedly difficult sometimes for a surgeon to see grossly at the -- in the operating room, but is not difficult for a pathologist to see. And it is for that reason that sometimes surgeons take people back to the operating room to second look them to look again to see whether something that may have looked suspicious is now frankly necrotic.
And the best I can tell from read -- looking at this record, that's precisely what took place here was second look type procedures to see

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if there were areas of necrosis in the bowel.
Q. And this patient in fact had three planned procedures, did he not?
A. I think that's right.
Q. It was not one procedure, then two additional emergency procedures; it was -- all three of these procedures were planned because of the --
A. That's -- that's my recollection from -- from reading the record.
Q. And the -- the necrotic -- the ischemic necrotic areas, were those most likely caused by this stool that was impacted in there and swelled his bowel up?
A. Yes. The -- the mechanism of that is there -- the bowel will be obstructed and will swell, develop tension on the wall to the point that -- that arterial blood flow can't always get into all parts of it, and some parts may be at more risk than others because of the -- of the distribution of the arterial system, and so you may have skip areas of necrosis.
Now, it's easy for a surgeon when you look in there and you see something that's frankly black and dead and smells bad, we know that has to

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come out, but if -- if the bowel looks kind of normal but there's some areas that look a little suspicious, it's hard to tell, and it's a judgment a surgeon has to make at the operating table about is this best managed by taking this out.
And another issue is, my understanding on Mr. [redacted] was that he had a history of chronic constipation, and that being the case, it's -- it's not a bad move to remove some of the colon at the time of -- of the initial procedure and the initial colostomy.
Q. So --
A. He did get a colostomy at the first operation.
Q. Yes. So talk about short bowel syndrome where you have to go to the bathroom more often, but in his case it would probably be better for his health if he were able to go to the bathroom?
A. Yes. But I -- I would not be thinking in terms of short bowel syndrome because that's something we -- we talk about when we're talking about small intestine issues. But a person who is suffering with -- with chronic constipation not uncommonly will do much better with -- with less

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colon.
Q. Okay. All right, sir. And do you believe the surgical care was appropriate in that case?
A. From my review of the record, yes, I believe it was.
Q. Now, there was a criticism that Dr. Randall mishandled the colon and that caused the vascular problem. Do you see any evidence of that there?
A. I -- I don't. I don't know how I would see evidence of that, though. I don't know how anyone would unless there was somebody there with him in the operating room that -- that knew something about surgery. And I do understand that the colostomy ultimately became necrotic, but based on what I saw in the pathology report, there's a -- there's a ready explanation for that, and that is that this man had skip areas of necrosis, and one of those areas very likely was the colostomy.
Many of you in the panel know that the colostomy is going to be in a little bit of a compromised situation in the best of circumstances because you've already divided the mesentery right there at it to get it to come to the skin. And

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when you do that, that's -- that area is going to be at more risk than others.
So let's say it was a bit compromised to start with, then it's going to be more compromised when a colostomy is created, something any surgeon understands.
Q. All right, sir. And you believe the care was within the accepted standard of care of this patient?
A. From my review of the record. Of course I wasn't there and I have the papers to look at, and it looks like -- looks like good care to me.
Q. Okay. Now, the second patient I wanted to talk about was [redacted]. That was an appendectomy with a bowel injury that was missed; is that correct? No. I'm sorry. I'm sorry.
That was -- that was a laparoscopic cholecystectomy and lysis of adhesions.
A. Yes, sir.
Q. In that case a criticism was made that Dr. Randall should have just done the cholecystectomy and should not have gone to further dissect some areas in the lower bowel. I believe there may have been a suspicion that it could have

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been a tumor or cancer.
A. As best I can tell from the -- from the one paragraph allegation that it is something like that. It says -- addressed to Dr. Randall, "You exercised substandard judgment in further dissecting previously operated upon bowel in the right lower quadrant. Such bowel not apparently contributing to the primary indications for the surgery."
My understanding was that CT scan had -- had suggested there was a cystic mass in the -- in the right lower quadrant that was not -- did not have a clear etiology as to what it was, and certainly in my practice and I think in -- in many surgeons' practice, it's not uncommon when you have laparoscope in somebody to look at that situation to try to determine what is the cause of the cystic mass that has been identified on CT scan.
So based on that, I -- I don't find that alarming that he would choose to look at the right lower quadrant and dissect that bowel.
Q. In retrospect in this case apparently there was an injury to the bowel, was -- was there not, or an injury of some sort?

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A. I -- I think that's right.
Q. And it was not recognized by Dr. Randall at the time; is that correct?
A. It was certainly not recognized at the time of the -- of that operation because I'm sure he would have -- would have addressed it by fixing it.
Q. The patient got sicker and sicker with other people caring for him, and then ultimately he had a second surgery and then -- and dies?
A. Yeah, frankly I can't remember precisely the -- the course of events, but I believe that -- that there was a transfer in -- in call maybe on the weekend or something, and others in the group were -- were involved in -- in making the rounds and assessing his situation and were involved.
But I do -- my understanding is that the peritonitis and sepsis that resulted from the -- the bowel perforation ultimately led to his death.
Q. Thank you, sir.
Now, the next patient, [redacted] --
A. Yes, sir.

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Q. -- you got that one?
Now, this one was a 320-pound man with hernias and bowel obstruction.
A. That's -- that is my understanding.
Q. Okay.
A. I understand he had a CT scan that showed an incarcerated hernia that was causing him pain.
Q. Now, there was a criticism of Dr. Randall even operating on this patient and not just having him observed. Do you have an opinion based upon a reasonable degree of medical certainty whether that's proper to go ahead and do surgery on him?
A. Well, the -- the allegation is that he elected to operate on a man in spite of high risk factors. But the best I can tell from looking at this case, you know, you don't always have a -- have a choice of -- of who your patient is going to be. You have to look at -- at the whole process and make a decision as to whether it's better to -- to leave the -- the hernia as-is, possibly subjecting him to complications of -- of eventual hernia which might be bowel infarction, for example, or -- and/or continued pain and/or

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continued expansion of a hernia.
There's certainly not much you're going to be able to do about the substantial risk factor of a man being -- being 320 pounds. It's -- it's highly unlikely that you're going to be able to change that in preparation for an operation.
So I -- I have not seen, you know, what it is that would cause a surgeon to say that this man doesn't need an operation.
Q. All right. This man had had a bowel obstruction and had had a previous anastomosis at some other surgeon's hands earlier?
A. I -- I do recall that having been the case, and I think he'd had ventral hernia repairs in the past. So it was -- I'm sure Dr. Randall or anyone else going into that case didn't think this was going to be easy.
Q. It wasn't?
A. It obviously was not.
Q. All right, sir. Do you have an opinion based upon a reasonable degree of medical certainty that Dr. Randall most probably complied with the standard of care for surgeons in his treatment of Mr. Erickson?
A. You know what, I mean, this -- this

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case became very complicated as you know. There was a -- a small bowel fistula that -- that occurred and repeat expiration, the bringing out of either ileostomy or jejunostomies to the skin. I mean, that's -- that's a nightmare for a surgeon. It's a very difficult situation for the surgeon and for the patient.
Now, you know, the -- if the question is did he repair the bowel properly or -- or do a proper anastomosis. I mean, clearly I -- I was not there to make a judgment about that. But what I do know is that -- is that all surgeons have that complication from time to time, that is, two things that you've sewn together don't stay together quite right. Something leaks, and once it starts leaking, it often leads to an entire rupture of it.
And I can't know from -- from looking at a record whether it was because of -- of inattention to detail in -- in the course of operating or whether it was a complication of anastomotic breakdown that -- that any surgeon has been around for very long has -- has experienced.
Q. And small bowel fistula -- fistulas, are they rare?
A. No. They're -- I don't have one in the

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hospital right now, but they're not rare.
Q. Is it something you deal with --
A. I deal with --
Q. -- pretty frequently?
A. -- pretty regularly.
Q. Okay. I think there was some testimony that they were extremely rare or something like that?
A. They -- they're -- they're not rare for general surgeons and -- but I'm not saying that -- that they're all caused by a surgeon's anastomosis that failed. I mean, sometimes it's from -- from Crohn's disease. It can be from other -- other things. But small bowel fistula is something that -- that all general surgeons are accustomed to -- to dealing with in trying to -- in trying to manage. And -- and they often have to be managed for a considerable period of time before they can be definitively -- definitively repaired.
Q. And -- and this man had -- is it two surgeries or three surgeries? Three? Three surgeries. I'm sorry.
A. I -- two or three. I can't testify to that exactly right now.
Q. One of the surgery -- later surgeries I

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think Dr. Randall had Dr. Crain also look at it and make sure -- get his input on the repair?

A. I think that's right, as an assistant and maybe an advisor, and I believe the -- the patient was ultimately referred to Duke to -- to remedy the problem.

Q. All right. And you believe that the care of this complicated patient was within the surgical standard of care?

A. You know, again, from -- from looking at the record, I -- unless there's something else that I don't know, I -- I don't see a deviation from the standard of care.

Q. Thank you.

Now, the next patient is a very -- it's a sad case. It's D[redacted] S[redacted]. It's case number five. She's the lady with cerebral palsy.

A. Yes, sir.

Q. That's a very long record. This -- this lady was taken back to surgery maybe 20 times. It's hard to even know how many times. Is that correct?

A. It -- it was a number of times. I -- I don't remember how many either.

Q. These were planned -- most of these

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were planned surgeries for washouts because she's both retarded and schizophrenic and also retorted because of her medical condition of being bedridden her entire life.

So this is not a patient you can clean at the bedside basically, is it?

A. No. No.

Q. Okay. There was some criticism of Dr. Randall --

A. Let me clarify --

Q. I'm sorry.

A. I'd just like to clarify one. My understanding was -- I -- I don't think it was cerebral palsy. I believe she had a posterior fossa tumor.

Q. This was the cerebral palsy --

A. Who are we on?

Q. D[redacted] S[redacted].

A. Oh, okay. I'm sorry.

Q. I'm sorry, we got -- might have got then --

A. I think we skipped over one in this or -- anyway.

Q. Yeah, I'm sorry, J[redacted] P[redacted]. I did. Let's -- let's -- number five. I apologize.

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A. Number four on my list is -- is P[redacted] and number five is S[redacted].

Q. Okay. Well, J[redacted] P[redacted]. I apologize. This is a lady who had the shunt in the -- brain shunt?

DR. RANDALL: Uh-huh.

A. Yeah, she did have a shunt and she had had a posterior fossa tumor. I think -- I think it was resected by a neurosurgeon, if I'm not mistaken, and it's left her with disability, dysarthria, left hemiparesis, permanent -- permanent PEG tube if I'm not mistaken and a -- and a ventriculoperitoneal shunt.

BY MR. McKAY:

Q. And Dr. -- Dr. Randall started with a laparoscopic cholecystectomy on this patient, did he not?

A. That's correct.

Q. And she had -- she had gallbladder disease and needed a -- needed surgery; is that correct?

A. She did. She had a lot of pain, CT scan showing a thickened gallbladder, and a white count of 20,000.

Q. All right, sir. And that -- does that

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indicate surgery?

A. I mean, it -- unless there's something else causing those things, then, yes, I see no -- no criticism of his -- of his indications there.

Q. Okay. How about the decision to do it -- to start laparoscopically as opposed to open procedure?

A. I -- I think that's appropriate.

Q. That's probably more laparoscopic now than maybe --

A. Yeah, I'd say that's actually the standard.

Q. Okay. All right, sir.

And then during the surgery I think there was a -- in opening her up I think the tube with the shunt got some type of injury to it; is that correct?

A. That's correct. What I understand is that the -- the tubing was coming down from the -- from the brain on her left side, but presumably because of a PEG tube in place there, the neurosurgeon tunneled it and diverted it over to the right side. And that was unexpected and the tube was encountered and divided.

And also my understanding is that

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didn't create a big problem in that there was a handy repair kit that the neurosurgeons told Dr. Randall about and allowed him to fix the tubing and proceed on with the operation.

Q. And was the -- now, there was some criticism that he called the -- some of the material necrotic. Is that -- did you ever see that?

A. Yeah, I think there was a question of his calling the gallbladder necrotic and the -- and the colon necrotic by gross examination.

Q. Do you see a problem with that?

A. Well, not -- not particularly. I mean, it's -- you know, I guess we wouldn't need pathologists if -- if we could every time make the call precisely ourselves by grossly looking at things.

There is a notation made in the complaint that in fact turned out the colon was not necrotic, that -- that the gallbladder was but the colon wasn't. But when -- when there's one necrotic organ in proximity to another one that may be inflamed or -- or disturbed in other ways, it can -- it can make other things look necrotic by staining of tissues and so on. It's not a -- it's

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not a leap of faith at all to -- to think that it may have appeared necrotic and appeared possibly unsafe to leave in place.

You know, we actually have been over this on the other case that had skip areas of necrosis. This patient did have a white count of 20,000 which is really a bit higher than you usually see with gallbladder problems. You do see it sometimes.

But, you know, I -- I certainly have found myself in situations where I'm looking at the colon in particular more -- more likely than small intestine and -- and finding that it's hard to tell whether it's viable or not. The colon is -- is a bit different than the small intestine in that it's got a lot of camouflage on top of it, and by that I mean fat. A lot of -- even in normal size people there's a lot of fatty tissue over it making it hard to -- sometimes to make a determination about viability.

Q. And you believe that Dr. Randall complied with accepted standards of care in his care and treatment of J[redacted] P[redacted]?

A. You know, again, from -- from the record I have and comparing the -- the allegations

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to the record, I -- I don't see where these allegations hold water.

Q. Thank you.

Then the next patient, I'm sorry, I skipped was D[redacted] S[redacted] Tell -- tell the panel about D[redacted] S[redacted]

A. My understanding is that she was a -- or is in her 20s, suffers from mental retardation from cerebral palsy and also has schizophrenia. That's the one we were alluding to earlier.

Like a lot of patients with cerebral palsy she had developed a large hiatal hernia even at a young age, a very large paraesophageal hernia. And the problem at her rest home was that she was vomiting everything. And these -- these patients not uncommonly are -- are brought to the operating room for repair of the large hiatal hernia to basically try to remedy the problem.

So she did have that done.

Q. And the criticism --

A. From my --

Q. I'm sorry.

A. From my review of the record I think it was a -- I know it was a laparoscopic operation, but I think largely because of her contractures

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and -- and the limited space in her abdomen because of her contractures and -- and maybe legs being in the way -- I've been there before. I know how that can be. It was converted to an open operation to bring the -- bring the stomach down out of the chest and -- and fix the hiatal hernia.

Q. Is that a complicated surgery on a patient like this?

A. It's a -- it's a pretty big deal, I guess. Yes.

Q. And there was some criticism that he didn't put a PEG tube in. Does that hold any water?

A. Well, I saw the criticism of -- of no gastrostomy tube being placed, and, you know, sometimes a -- it had mentioned that a percutaneous -- it says percutaneous tube gastrostomy which is not really what it is. It would be a surgical gastrostomy.

That can be placed in these situations to anchor the stomach in place, that is, to fixate it to the abdominal wall thus prohibiting it from sliding back up into the chest. And -- and sometimes people do that, and from time to time I have, but it's not a situation where I routinely do

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it -- or I don't think it's the standard of care to routinely do it if the -- if the stomach comes down and can stay in the abdominal cavity without tension and -- and often it does.

Q. And this patient I think after the surgery -- and I don't know if I got my words right -- developed some apnea of her stomach and -- and bowel. Is that -- it just wasn't -- wasn't pumping the food in; is that --

A. Yeah, essentially it was not -- the stomach wouldn't empty basically is --

Q. And that's just a complication that can occur from these types of procedures?

A. It can. I mean, I can -- I can -- I would say that you would expect it to ordinarily resolve its ileus and -- and start emptying, but in this case it did not and -- and certainly that can happen sometimes.

Q. Now, the patient was not eating, and so Dr. Randall had to go back in surgically and put in another feeding tube, did he not?

A. Well, he did. I -- I think he first went back because the stomach was not emptying, and we all know what happens when a stomach won't empty. It dilates and becomes a problem. So he

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decompressed it with a gastrostomy tube.

Q. All right.

A. I think that even with decompression my understanding, the -- the stomach still wouldn't work later on as a -- as an organ to feed into, so he ultimately placed a jejunostomy feeding tube.

Q. And that's sewn in -- or placed in the bowel?

A. It's placed directly into the small intestine and -- and sutured in place. As I recall, he did a so-called Witzel tunnel; that is, he fixated it to the wall of the bowel and fixated it to the abdominal wall, sutured it to the -- to the abdominal wall as well.

And even when the stomach is exhibiting an ileus, that is, it's not working, then the small intestine more commonly will work and then you can feed a person that way.

Q. Now, in this patient apparently she somehow dislodged this tube out of her small intestine. Can you --

A. Yes.

Q. Pulled it out. And there's evidence that she pulled some other tubes out --

A. That's --

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Q. -- is that correct?

A. The record does document that.

Q. So the -- maybe not enough nursing care or something watching her?

A. You know, these -- these things happen in -- in hospitals.

Q. Okay.

A. I think anybody that's -- that's practiced in -- in this hospital or Columbia or any place I've ever been or seen knows that tubes either get pulled out by patients sometimes or by staff that are well meaning but transferring patients and so on. It happens.

Q. Okay. Now -- and this -- after that it was a while before anyone recognized that something was going on with this patient; is that correct?

A. Yes. I -- I think what happened with -- with her jejunostomy tube was it got pulled partially out. And it's unusual for one to get pulled partially out and to remain in the peritoneal cavity but not in the small intestine, and that's what happened in her, and so consequently as the feedings were ongoing tube feeds were going directly into her peritoneal cavity.

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Q. All right, sir. And her inability to communicate, those type of things would affect --

A. No -- no question. Some -- somebody who is more alert, maybe not retarded -- I -- I don't know how she communicated her pain to individuals, but one of the things we're looking for when somebody is having an abdominal problem like peritonitis would be a complaint of pain. And I don't know how she would be able to relate that to the staff.

But I do understand that -- that, you know, tube feedings did go into the abdominal cavity and that will cause peritonitis. It can cause a lot of irritation of all the organs inside.

You know, my -- I -- I have no criticism of Dr. Randall for having that happen. That's -- that's something that -- that can happen. Whenever you do a -- whenever a surgeon is asked to do a procedure on somebody, whether it be a jejunostomy tube, whether it be a central line, there's -- there are potential untoward effects that can happen, complications, and none of those invasive procedures are without potential risks like that.

And so certainly a tube getting pulled

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back like that, that -- that can be a problem. My reading of the operative note and the technique that he describes using and placing the tube is -- is proper. I mean, that's a good way to put in a -- a feeding tube by what I saw in the description of the operative note.

I -- one thing that I think could have been improved upon in that particular case was frankly I think I would have been inclined to operate on her a little sooner than -- than he did when I knew that she had had some tube feedings going into her abdominal cavity. But I think it could be argued -- and he probably will argue that, "Yeah, but she was dehydrated. We needed to resuscitate her some. She -- needs to get some antibiotics on board, IV fluids because of the dehydration."

So that would be I think a legitimate counter to -- to my thought that maybe operating sooner rather than -- than whatever it was, eight hours later, might would have been better.

Q. All right, sir. But as far as you know, the -- the delay in taking her back to surgery, she would have had peritonitis anyway; is that --

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A. She would have had peritonitis anyway, and -- and she ultimately did recover. And it's -- it's not -- I don't see it as being as big a problem as having the usual causes of peritonitis in the peritoneal cavity. The usual causes would be colon perforation or small bowel perforation in which there's a lot of bacteria and sepsis is more likely to intervene in those situations.

You know, this in my mind would be more -- more like something like bile peritonitis where they're --

Q. A chemical type?

A. Chemical peritonitis, yes.

And we -- we certainly do treat bile peritonitis quite a bit differently than we do colon perforation or stomach perforation. It seemed to be more of a chemical peritonitis and -- and the urgency is not the same, and there's some -- some time to -- to prepare the patient is certainly justified.

Q. So it's a judgment call basically of what to do?

A. It -- it is a judgment call.

Q. And either way the injury to the patient was not caused by Dr. Randall's surgery; is

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that correct?

A. No, I don't think the injury was caused by that. I think it was from the -- the tube -- tube being pulled back. It would have been a lot better if it had been pulled all the way out, but -- but it wasn't and so it wasn't recognized.

And, you know, certainly it's -- it's not like I've never seen something like that happen before. As a surgeon who has been around for a few decades, I've seen those kind of things, including tubes that are in somebody's stomach through their nose being pulled back and in feeding too high in the esophagus and leading to aspiration.

In -- in those situations you -- you hope that you're going to get a little help from the nursing staff by recognizing that -- that maybe the tube is further out than it used to be. The -- the doctor can't always be there looking at the patient and seeing the -- the changes, the fact that the tube is now hanging out 12 inches instead of where it was coming out just four inches.

Q. Now, on Ms. S[redacted] she was returned to the OR, and I'm not sure how many times, 15, 16 times.

A. No, I -- I have no criticism of that

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part of it because it was -- it was a necessary -- it became a necessary thing to get her sufficiently debrided and -- and eventually closed up in some way.

Q. And these were things that in some patients some of the procedures could be done at the bedside but not with her because of her mental condition; is that -- some of the cleanings and all?

A. Possibly so, yes.

Q. Okay. All right, sir.

The -- excuse me a moment. I'm sorry.

The next patient I think is number six is -- is S[redacted] W[redacted]. Do you have that one in front of you?

A. I do.

Q. What -- what is -- brief -- briefly describe that patient to the panel.

A. My understanding is he is a man about 42 years old on some steroids for reasons that weren't entirely clear to me, although I think it may have been because of asthma -- the treatment of asthma. He had open gastric bypass sometime in the past and had lost a lot of weight, from about 440 pounds maybe down to 220. And he -- he'd had --

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had had multiple ventral hernias. And then he was taken to the operating room for repair of a ventral hernia or ventral hernias. And that was done laparoscopically.

My understanding is that he had some bleeding postoperatively as evidenced by some tachycardia in the recovery room and drop in hemoglobin that at first was not very impressive, maybe -- I've got in my notes, 10.5 down to 9.2 which as a general surgeon that's -- that's not alarming to me. I mean, that's almost within the lab variation. We see that all the time with -- with the hydration that may go on during surgery and the -- and also the -- the blood loss that might be expected. But the next morning his hemoglobin was down some more to 6.7, so clearly there had been some blood loss, and he's having more tachycardia.

The -- the very unusual thing that occurred here was that I think it may have been somebody, one of the clinicians, a nurse or somebody detected a bad smell from one of his trocar sites. Since his operation was laparoscopic, all he had was -- was the little small incisions, the trocar sites. And one of them

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was -- was draining and smelled bad.

And if I understand correctly, that -- that resulted in a suspicion of -- of infection there and he was taken back to the operating room for laparotomy and debridement of that area. And a very unusual occurrence happened, and that was he had developed a necrotizing infection in one of the trocar sites, and I think in less than 24 hours after the operation necrotizing fasciitis -- I know all the panel knows basically what that is, but it can happen in the first 24 hours after an operation, but that's exceedingly rare.

And I'm not sure, you know, what -- what may have caused that to be the case, but that's -- that -- that was what started this unfortunate man's difficulties, and that was that -- that -- it wasn't the bleeding. He did have some bleeding, but that wasn't the -- the thing that really put him in -- in harm's way and -- and caused him great difficulty. It was the necrotizing fasciitis that started off on one of the trocar sites on his abdominal wall.

Q. Is there any evidence of any surgical misadventure or error causing that necrotizing fasciitis?

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A. Well, nothing that I can tell from the record. I mean, you know, I guess when somebody has a necrotizing fasciitis, within 24 hours you -- you -- as an institution and as a surgeon and as a surgical team, you have to wonder, you know, what is it that contaminated the site because something did. It didn't just happen from -- from, you know, no bacterial involvement. I haven't heard of that.

So somewhere -- it could have been a -- an instrument or a cannula that was thought to be sterile but actually wasn't, some break in technique in the operating room. It could be that it was -- was colonized from -- from his bed from -- after he was out of the operating room. Something got into the incision.

It's just exceedingly rare, but it did result in his having to have a substantial portion of his abdominal wall debrided. I don't remember exactly how big it was. It seems like it was -- from my review is as big around as a grapefruit or a cantaloupe or something like that. When I say abdominal wall, I'm referring to the skin and subcutaneous layer.

So I -- my -- my understanding from reviewing the record is that Dr. -- Dr. Randall

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felt like he better take a look inside because there could be something inside that's leading to a necrotizing fasciitis, that is, something that started from the inside, went to the trocar site, which would be a rational thing to think. So he did a laparotomy on the patient as well.

There was infection in the field, so the mesh was appropriately taken out. You don't want to leave a foreign body in an infected field. And there were -- he -- he needed to close the -- the -- the abdomen back after the mesh was taken out, and he chose to use a Prolene suture.

That's -- for the non-surgeons, it's a -- it's a permanent suture that -- that commonly is used in abdominal wall closures, especially if there's a hernia involved. So there was a hernia here, so I think that's why he chose that. But it's like fishing line. It's kind of a -- it's kind of a monofilament-type suture.

And review of the records suggests that since the man was -- was ill and had a lot of swelling after the surgery, he -- he had swollen enough to press his -- his viscera, colon right up against the -- the fishing line-type suture and it actually cut through the colon, and so later on he

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had a -- a leak from the colon as a result of that.
Now, you know, what -- what I can see not being there but as a surgeon is that Dr. Randall was forced to -- to take care of -- of a hernia in this man's abdominal wall, not with mesh like we usually use because he had to take that out because of necrotizing fasciitis, but instead he was having to pull it together with sutures, and likely there's going to be some tension on it. The concern is that it's going to start pulling apart. Over time that's the reason we tend to use mesh to start with, but mesh was not an option at this point.
And I imagine with -- with the patient's postoperative swelling and so on that it -- it pressed the colon against the suture and -- and basically like a -- like a cheese cutter or something cut into the colon and it started leaking because of that.
I think this man, if I'm not mistaken, was a homeless man, and I don't know if -- if that has anything to do with his -- his tendency to infection or -- or hygiene leading into the -- to the operation and so on.
Later on in -- in its course the

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patient thrombosed. The mesenteric vessel is part of the small intestine. He had to be operated for that. I can't tell from the record why that might have happened in this particular situation, but it was -- it was removed and a small bowel anastomosis was done.
Q. A couple -- a month or more after the initial surgeries he had heparin-induced thrombocytopenia. They were clean -- cleaning him out with heparin. Does that sound --
A. That -- that ER -- you are slurring my memory on this -- on this number six of ten cases. He did have heparin-induced thrombocytopenia, and I think the -- the panel of physicians would know that heparin-induced thrombocytopenia has a second T with that, and that is heparin-induced thrombocytopenia and thrombosis.
And, you know, certainly we -- many of us -- most of us like to use heparin to try to prevent a devastating complication of pulmonary embolus or DVT, but unfortunately from time to time our -- our efforts result in -- in untoward consequences and -- and in this case the HITT was the untoward consequence, and thrombosis in -- in the small bowel vasculature occurred and -- and

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resulted in a substantial problem, that is, small bowel infarction requiring resection.
This man did ultimately wind up with a small bowel fistula which, you know, this -- this would be the kind of case where that might happen. A -- a compromised patient requiring a small bowel resection, that's -- that's high risk for -- for any anastomosis.
Q. And the thrombose-induced cytopenia -- thrombose-induced HITT --
A. Yes.
Q. -- that is just something that for whatever reason, his immune system or whatever, changed him around from heparin working on your clotting factors to doing the opposite and not making him clot?
A. Right, there's an irony involved in that in that heparin is an anticoagulant, but it can in that situation become a procoagulant and -- and result in thrombosis and vessels that ordinarily simply wouldn't thrombose, wouldn't clot.
Q. And that's no one's fault that occurred, is it?
A. I can't say that it is.

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Q. Dr. Randall acted appropriately with this difficult patient?
A. He did.
Q. And this is a -- this is a difficult patient, especially, you know, being a -- he was a homeless man in bad shape?
A. It's -- it's a difficult situation, no -- no question.
Q. Okay. Now, C[redacted] W[redacted], that's the man who came in with the appendicitis; is that correct?
A. That is correct.
Q. And what appeared to be an unconplicated -- fairly uncomplicated appendectomy? Was it uncomplicated or not?
A. Well, I -- I think it was described in the operative note as being difficult -- technically difficult. He was a big man, not -- not huge, I think 220 pounds. Technic -- technically difficult, as I recall, from a long appendix that extended down into the pelvis, and those -- those can be difficult.
Q. All right. And then he had a complication during surgery; is that correct?
A. I think not -- not during surgery. I

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think he -- I think the -- the surgery was technically difficult.

The patient on postoperative day two was able to be up walking about and eating. But late -- later on he started developing abdominal pain again and developed an elevated white count. A CT scan was done. I think it showed some possible evidence of small bowel obstruction and -- and some fluid in the abdominal cavity, free fluid. And this is a case where I think one of his partners, Dr. Schroeder, if I'm saying it right --

Q. Yes, sir.

A. -- was -- I -- I don't know the exact circumstances. Someone else would have to clarify it. But I believe he was on call or maybe it was the weekend or something, and he was covering for this patient and -- and took this information and -- and treated him with IV fluids and antibiotics. I think the white count might have been 9,000. A nasogastric tube was placed I -- I imagine because of the -- the findings of bowel obstruction or -- or findings on CT scan consistent with bowel obstruction.

And I'm pretty sure this was going on over a weekend. Then on a -- on a Tuesday night I

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think the patient took a major turn for the worse and a Dr. Revell was called. I'm -- I'm not sure how it all transpired, but I believe Dr. Revell was the first one made aware, then -- then maybe Dr. Schroeder and -- and -- and eventually as the patient was taking a turn for the worse they called Dr. Randall who even though it was Tuesday my understanding is that -- that Dr. Schroeder was taking care of the patient on Monday because he had I think readmitted him, if I'm not mistaken.

I think he had had readmitted the patient, because he is one -- one that had gone home presumably doing well enough after the appendectomy and had came back. And so my understanding is Dr. Schroeder was continuing the care for him, but then Dr. Revell was on call on Tuesday night when he took a turn for the worse.

But ultimately Dr. Revell being on call at -- at what was the early morning hours, maybe 6:00 a.m., and he called Dr. Randall. Dr. Randall explored him and found that the omentum was dead which is an unusual thing, but, you know, for whatever reason the -- the omentum had -- had infarcted.

And my understanding also is that there

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was a leak at the appendiceal stump that had -- had set up peritonitis that had been presumably the cause of the free fluid in the abdominal cavity, the cause of the -- the apparent bowel obstruction. The obstruction may have been a true obstruction. It may have been ileus. And I -- I would surmise that the -- the affect of the peritonitis probably led to the infarction of the omentum from a low blood pressure.

Q. This is a patient you think probably should have been taken back to surgery on Monday, or do you have any opinion?

A. You know, it's -- in retrospect certainly, yes. I mean, I think that would have been -- would have been the best thing. And it does look like there were indications in the chart where I would say most surgeons would have -- would have taken him back by Monday anyway.

Q. All right. And there are a number of people caring for this particular patient, not just surgeons; is that correct?

A. Yes, there were, and -- and a number of surgeons too. I mean, it sounds like there were three from the group that -- that were involved. And, you know, unfortunately it's -- it's -- you

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know, handoff situations can be dangerous situations, and not just handoff situations from one surgeon to another on a weekend, but from one hospital staff member to another like nursing or -- or with residents.

But this -- this is a situation where I think there -- there sort of was a handoff and -- and it wasn't exactly a handoff. I guess the guy came back in the hospital and Dr. Schroeder admitted him and -- and was managing him.

But, again, I'm not claiming to know the details of -- of the group dynamics and who was in charge exactly on a Saturday night and Sunday night and Monday and so on. I think others may need to clarify that or -- but what I -- what I can tell from the chart is Dr. Randall was -- was not entering orders and progress notes on that patient during that time.

Q. All right, sir. Now, the next patient is a [redacted], number eight.

A. Yes.

Q. And tell the panel about that patient briefly.

A. [redacted], my understanding, is a 65-year-old man with -- I -- I believe he was a

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chronic nursing home patient. I'm not sure why --
Q. That's correct. He was in a --
A. I'm not sure -- I'm not sure I quite have it clear in my mind why -- why he was at 65 having to be in a nursing home full time. But he had a large -- large right inguinal hernia and -- and a history of a hernia repair on that side done laparoscopically I believe by another group or a surgeon in another group.
And Dr. Randall took this man to the operating room for repair of this large symptomatic hernia to -- to fix it, and it turned out that -- that this large hernia that I think was described again as being the size of a large piece of fruit, like a grapefruit or something like that, it turned out that he had the bladder down in his scrotum or down in the hernia sac.
Q. Is that unusual?
A. Very. Extremely unusual.
And I -- I don't know that I've seen a substantial portion of the bladder in a hernia in my career. I mean, if somebody asks me on -- on a board examination what can get into a hernia, I'm going to answer almost anything, but -- including bladder, ovary, appendix, colon. It's all possible

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if it's -- if it's in that part, but bladders don't go into hernias very much. I -- I frankly have never seen that.
But the operative findings suggest that -- that the bulk of this man's bladder had gone down into his hernia and that -- then the -- so it's a difficult situation being a -- a patient that you know that has mesh inside from a previous laparoscopic hernia repair that obviously has failed because the man is presenting with a hernia again. And the allegation is that in -- in the course of performing the first surgery you apparently created a bladder injury that was not properly dealt with until the second operation.
You know, I can -- I can totally understand how -- how a surgeon might not recognize that this is bladder because bladder doesn't have a -- have a real distinctive look to it compared to other organs, and you don't expect to see a bladder mostly outside the abdominal cavity or outside the retroperitoneum but instead down in the hernia sac.
So what I -- what I think happened here is that in the dissection the bladder was -- was opened like a hernia sac might be opened, but it turned out that there was urine inside of it and --

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and it became apparent that, "Hey, this must be the bladder."
And so, again, my understanding from the record is that the bladder was then repaired and the next thing a surgeon's going to do is try to reduce the organ back through the hernia defect, that is, to take the -- the bladder or in other kind of hernias, if it's colon or small intestine, you try to push it back through the hole and get it back inside.
But that wasn't happening. It -- it wasn't going back through the defect and so on. And, again, my understanding from the record is that he decided to not press on with -- with this, realizing that something very odd was going on, and I think he sought the -- the opinion and help of a -- of a urologist. And a Dr. Livingston I think was consulted and the two of them worked on it.
And what I can tell from -- from the operative note was that there was a -- there was a reason why the bladder would not reduce, and that was -- that is, go back into the abdominal cavity, and that was that when the first piece of mesh was -- was placed laparoscopically, it was -- it was placed over a portion of the bladder and in

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such a way that the bladder was not really reduced from the hernia and that the -- again, my understanding is that the patient was saying that his -- his belief was that -- that he had a -- after the laparoscopic repair, he couldn't tell that it had been repaired.
There still was undue swelling down in the groin, and his -- his feeling was that the first operation hadn't really repaired the problem. But then the reason becomes evident in the operation that was done with the urologist, and that is, that the mesh was covering at least a portion of the bladder such that it was keeping it from coming back in as opposed to really fixing the hernia.
Q. The mesh was tacked onto the bladder itself --
A. Yeah. So --
Q. -- or it was tacked onto something?
A. So apparently the -- the first surgeon did not recognize that the bladder was -- was sticking down in this man's hernia. Now, again, I -- I can -- I can in part see where -- where he failed to see that because bladders usually don't go into hernias. That's a -- that's a very unusual

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situation.

Q. The -- one of the allegations is that Dr. Randall caused an injury to the bladder. There's no injury to the bladder, is there?

A. Well, I mean, I guess you could say he did create an injury to the bladder, but the bladder is a -- is a forgiving organ, and, you know, when you -- when things are all stuck to it and so on, from time to time general surgeons will get a hole in the bladder just like we'll get a hole in the small intestine or colon, and fortunately we're trained to fix those holes.

But this situation was a little different in that I think Dr. Randall was expecting to find the usual kind of things down in this hernia, and that might be a peritoneal sac that -- that can become extremely thickened and -- and the other thing is an ordinarily thick-walled bladder can become not so thick walled when it's all distended out.

So it's not hard for me to see how one would think that, "Hey, I'm dealing with a hernia sac." But he did recognize that when he got into it, "This is bladder. It needs to be repaired. We need to have a Foley catheter in place, and we need

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to get a urologist involved here."

So in my mind that's -- that's the appropriate course.

Q. It's not like he cut the bladder and didn't recognize that it was --

A. No, it's not like that and --

Q. It was repaired -- he realized it was a bladder and sewed it up?

A. It's -- it's a very odd situation and a very -- very odd presentation, and I think he handled it appropriately.

Q. The patient apparently did well after the second surgery?

A. That's my understanding.

Q. All right. Oh, there was another criticism that a reviewer made, is that apparently on the left side he had an inflamed scrotum with some pus in it, and that was -- Dr. Randall I think went ahead and drained that. There was a criticism of doing that and not just waiting till they do all the other surgeries. Anything to that at all?

A. I -- I -- I don't have any criticism of that. I think that's a surgeon's judgment about -- about his comfort level with -- with the scrotum and dealing with it, and most general surgeons do

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operate sometimes on the scrotum for various things. So I -- I don't find any criticisms of that.

Q. It didn't cause any problems doing that? It was something that had to be done eventually, anyway?

A. Well, I mean, when there's pus, it's nice to have it drained.

Q. Now, the last patient was J[redacted] P[redacted].

A. No.

Q. Excuse me. J[redacted] R[redacted]. I'm sorry, I'm --

A. Have you done number nine in the sequence?

Q. No, I haven't. I apologize.

A. That would be S[redacted] J[redacted].

Q. S[redacted] J[redacted].

A. Uh-huh.

Q. I apologize.

Well, tell the board about S[redacted] J[redacted]. There's a criticism of a -- what they call sleeve gastrectomy on this patient.

A. Yeah. The -- the allegation is that he -- the allegation is that Dr. Randall performed

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a sleeve gastrectomy, a procedure rarely or never employed for the indication of gastric bleeding. And the first thing I saw was -- was the allegation before I had a chance to read the chart. But many of you know that the term sleeve gastrectomy connotes a bariatric operation, and that's -- that's kind of what -- what the term came from is a weight-loss operation.

And it's true that -- that I never have heard of a sleeve gastrectomy before it became a weight-loss operation. But I -- I don't think that's really what happened here, and instead it was a partial stomach resection trying to remove a bleeding point.

And every other kind of gastrectomy that you ever hear about involves one that -- that's going to require an anastomosis to presumably the small intestine because there are gastrectomies that are -- that are hemigastrectomies where the antrum is taken out or near total gastrectomies where almost all of it is taken out. And then obviously something has to be hooked up to it so the -- whatever food a person eats can drain into the small intestine.

But any -- any surgeon knows that if

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you have a bleeding point on the stomach wall or even a tumor on the stomach wall that -- that you can get out without disturbing the -- the flow of -- of nutrients from -- from the esophagus, food or stomach, right on down to the pylorus, that's better. That is -- we often call that a wedge resection on the stomach. And so that -- that's what he was doing.

I -- at one point in his dictation he does use the word sleeve gastrectony, and I think that may have been the -- the choice of terms that resulted in some -- a reviewer picking on him about that.

Q. Okay.

A. But in other parts he calls it a segmental gastrectomy. But basically it's a situation where portions of the stomach are taken off of the greater curved side, the greater curve of the stomach, and the lesser curve of the stomach is left intact so that you may have a tubular stomach.

But I don't know, you know, how in detail you all have -- have reviewed all of these cases. I know you don't have time to review the details of ten cases, but just to summate what --

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or -- or a summation of what occurred and my understanding is that the man was having gastrointestinal bleeding in -- in a serious way from the stomach and that a gastroenterologist had looked in there and had seen that there was a bleeding ulcer on the stomach wall and that it looked like it wasn't just an ulcer. It was likely a tumor. Not a -- not a large tumor, but a tumor that may have serious ramifications, possibly even being malignant.

So the gastroenterologist tattooed the -- the place on the stomach, something we often ask them to do these days, which means he took some India ink. He squirted it into the wall of the stomach so that the operating surgeon could recognize what part of the stomach had the problem.

And when Dr. Randall went in, he saw the staining on the stomach and -- and chose to segmentally resect that stained or tattooed part of the stomach. So a portion of the -- of the redundant stomach was taken out that way.

Unfortunately the -- when the specimen was examined, the pathologist saw no tumor and saw no ulcer there. Again, my understanding from the record and from the operative note is that

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Dr. Randall was -- was dissatisfied with that, as I would have been, and removed more of the stomach because the -- the India ink tattoo on the stomach wasn't just in a small area like this. It had spread out over a pretty broad area.

So rather than -- than leaving the patient at risk of -- of further bleeding, he took out more of the tattooed area, and at one point he -- he logically opened the stomach, looked inside and tried to identify I'm sure by visualization and by palpation anything that would -- that would represent an ulcer or a tumor and couldn't -- couldn't feel or see anything like that.

But ultimately he removed all of the tattooed area which was a -- a good portion of the greater curvature of the stomach. And that -- the specimen sent to pathology never showed an ulcer and never showed a -- a tumor.

Now, I -- I frankly don't recall whether Dr. Randall was looking through the -- the endoscope himself. I'm sure he can testify to that, but a gastroenterologist was looking through it and probably had pictures of it demonstrating what appeared to be some sort of a tumor.

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So the indications for the surgery seemed to be secure. The approach does not seem to be improper. Again, as a general rule if you can leave the -- the lesser curve of the stomach intact where the vagus nerves run, then you're better off. You have a fairly normally functioning system. And we know that that kind of an operation works reasonably well for people because it's been done thousands of times now in bariatric people leaving sort of a relatively tubular stomach called a sleeve gastrectomy based on the lesser curve.

Unfortunately this man did not empty well. He -- fortunately it did stop the bleeding. The man was not bleeding any more. As to -- as to what the original cause of the bleeding, I -- I think we can -- we can speculate about that. There are -- are types of bleeders in the stomach, something called a Dieulafoy lesion in the stomach that's almost invisible except for the fact that it squirts blood out when you put your endoscope in there sometimes. They can be hard to find. They're very hard for surgeons to find in the operating room. They're very hard for pathologists to find in the pathology lab.

It may have been something like that.

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I can only speculate as to why it looked like a tumor at the time and no tumor had shown up.

Anyway, the -- the man did not empty well and, that is, he wasn't able to maintain nourishment by -- by food going through that tubular shaped stomach. And because of that, it -- I think it's appropriate that he ultimately had to go back to the operating room for another operation.

In that situation the lower part of the stomach was taken out and a -- sort of a Billroth's II reconstruction was done, something that all surgeons are -- are trained on in their residency, where -- where a small portion of the stomach remains in the proximal aspect and a loop of small intestine is brought up and hooked to it.

Q. And it looks like one of the things that they're really critical about -- we had different reviewers saying different things. Apparently he had some kind of bleed or something at the bedside and a little piece of needle broke off in there --

A. Yeah.

Q. -- and Dr. Randall chose to leave it in there.

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A. Yeah. Well, yeah, I -- I -- I was reading through that -- that chart, and I -- and I saw that, and I thought, "Well, that's --" you know, we -- all surgeons really hate that because needles show up so great on x-rays. But a little fragment of a -- of a sewing needle is -- is no different in a human body than these little metal clips we put in all the time to secure blood vessels, hemoclips we call them, and they're often quite a bit smaller. But it's -- you know, plaintiff lawyers love those things, though, because they -- they want to attribute all kinds of ills to them, that is, to the fact that there's a needle -- piece of metal in there.

Now, I honestly will tell you my -- my position would be to, yes, look for it, but I'd look for it for about ten minutes, and if I couldn't find it, I wouldn't be subjecting the patient to a prolonged exploration, and the only reason I'd possibly be thinking about taking the patient back to the operating room at a later time to use fluoroscopy to find this, which would probably be a three-hour operation and very traumatic to the patient would be if somehow I could demonstrate that this thing is actually

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causing a symptom which is highly unlikely.

Q. And that's just a judgment call to leave it alone?

A. That's a good judgment call in my opinion.

Q. Now, the -- the last patient -- where is the last patient -- is -- excuse me -- J[redacted] R[redacted] She's the patient who had a gangrenous gallbladder and had a laparoscopic cholecystectomy.

A. That's right. I do have that one.

Let's see. J[redacted] R[redacted], 68 years old. She had come into the emergency room with abdominal pain. White count 22,000. Gallbladder ultrasound showed some sludge. The next day she underwent a laparoscopic cholecystectomy, was found to have essentially a necrotic or dead gallbladder and some sort of a necrotic mass within the gallbladder. I think it was described as two and a half centimeters.

From -- from my review of the record I -- I can't tell exactly what that was, but maybe because it was necrotic the pathologist couldn't say what it was, but a necrotic mass within the gallbladder. She had stones.

She was sick postoperatively from --

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from having had a septic gallbladder. Again, the white count was 22,000. I think she could be qualified as being essentially septic in a way when she went to PACU.

She had been a very difficult intubation. She -- she had a tough postoperative course, and I think she -- she extubated herself accidentally. And one doctor -- I think maybe it was the intensivist -- tried to reintubate her, could not, managed to -- to use a mask and an Ambu bag to ventilate her until an anesthesiologist could get there. The anesthesia doctor was successful. The -- the thought was in the record that she aspirated at that time when she had extubated herself and -- and during that period of time possibly leading to some -- some pulmonary problems.

But she -- she also after that difficult cholecystectomy was having a gradual drop in hemoglobin, and I think it was over a period of around four days that -- that she would drop her hemoglobin, be transfused, have it come back up some or just respond partially, and then drop back down. And in the end she got 11 units of blood transfused over about four days.

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The -- the rationale, as I understand from -- from the chart, was that, "Yeah, it's bad that she has bled, but it's going to be good if we can avoid reoperating on her. She probably has aspiration pneumonia, and it's looking like this thing is going to stop," but in the end it didn't.

I would -- I would say very likely that -- that if -- if one could know when the bleeding first started that it was going to be 11 units transfused, that he might would have bitten the bullet and gone ahead and reoperated, but, you know, sometimes situations develop where it's a gradual ooze and you -- you hate to be taking somebody back to the operating room when -- when the bleeding has just stopped, and it's because the bleeding is complete and all you're doing is cleaning out a hematoma at that point.

And it's -- sometimes that happens with -- for surgeons. When we go in for bleeding, we find blood, but we don't find a bleeder. And that can be an abdominal surgery and other kinds of surgery as well. But that's -- that's sort of the -- the situation there.

Q. Okay. The -- the first reviewer who didn't testify was critical about using a

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laparoscope instead of doing this open. The man that testified yesterday said he didn't -- he just asserted his choice, basically that either way would be fine.

A. Yeah. Well, I mean, it's a surgeon's choice, and I -- I for one will -- will approach gallbladders like this laparoscopically. And I -- I do recognize that there will be complications of laparoscopic cholecystectomy, but I also recognize that there are complications of open cholecystectomy.

I'm old enough to remember when that was the routine. And it's not like that's -- that's the absolute standby safe procedure. It's a -- it's kind of a big deal when you're dealing with somebody who has a necrotic gallbladder. And I'm of a mind that if you can get it out laparoscopically, do so.

Now, clearly at the conclusion of the operation you have to have hemostasis. He did document hemostasis in his operative note, that -- that bleeding was controlled. Now, hardly any surgeon is -- is going to leave the operating room when somebody is still bleeding without doing something, that is, converting to open or packing

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the patient or something like that.

So, you know, I have no reason to think that the patient was bleeding as he left the operating room. That would be inappropriate if that was the case, but I have no reason to think that was the case.

Q. And this patient -- you said you looked at the lab values. They'd give her blood. Her hemoglobin would go up and then it would go down. You have a cat and mouse game with that.

A. It -- it is. And -- and, again, from the benefit of retrospective vision, I think she would have been better served by a reexploration at some point in that four-day period, but I can -- I can totally understand how one can be at a point where there's been eight or ten units given, but there's a reason to think at that point that -- that, "Gosh, she seems to have stopped and we might can avoid reoperating here," because -- and it did. It stopped at 11 units.

And, again, I'm not -- I'm not arguing that that was the -- the greatest thing, but, you know -- because I'm looking at it from a retrospective view too.

Q. And the patient ended up doing fine?

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A. That's my understanding.

MR. McKAY: Do you want to take a break or keep going?

MR. COOKE: Ready for a break? Yeah. How much more do you have on direct?

MR. McKAY: Oh, maybe 15 minutes or so.

MR. COOKE: Does anybody want to take a break or do you want to wait until after this witness is done?

MR. McKAY: It doesn't matter.

MR. COOKE: Why don't we take a restroom break and then have you finish your direct.

(A recess transpired.)

BY MS. RUTTO:

Q. And, Dr. Tribble, you say you've been chief of staff -- how big of a hospital is Baptist? 400?

A. It -- it's about 400 patients -- 400 beds.

Q. Richland is six -- 600?

A. 500 or 600.

Q. You've been on peer review things many times, I assume chaired and that type of thing?

A. From time to time.

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Q. Okay. All right, sir.
One of the witnesses yesterday was very critical of Dr. Randall about using flawed judgment in his decisions with patients, consistently utilizing flawed judgment in either choice of techniques or decisions involving patient care.
Did you see evidence of that in these massive amount of records that you've seen?
A. I -- I don't.
Q. Okay. And is there -- I know general surgery is a little bit different than some professions. There's -- there are all kind of different approaches that physicians have in handling general surgery; is that correct? I mean, there are different techniques, people are trained differently, there are --
A. Right. There are -- are different -- differing ways to manage the same problem.
Q. And I'm sure that you and your nine partners may disagree or may do things -- approach the same problem in different ways, and that's probably not uncommon, is it?
A. That's right.
Q. And also another allegation is that there were significant technical failures of

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Dr. Randall in performing these surgeries. Do you see a pattern of significant technical failures outside the standard of care that's frequent in these ten patients?
A. You know, I -- I don't, but I -- it's not like I'm in the operating room watching this and -- and making judgments on -- on that part.
An example might be the -- the young man whose appendiceal stump leaked. I mean, I understand that a pursestring was used and a -- and a so-called -- or a so-called Z stitch over it which is a common way to -- to manage that. But certainly having an appendiceal stump blow out or leak is -- is something that happens from time to time. It's not always clear why it does.
So the -- the complications that we've talked about here are things that -- that do happen in the course of a general surgery practice.
Q. Did you see any evidence -- there was one thing that the expert yesterday Dr. Skudder talked about. He talked about there was regular evidence of -- the slightest probable cause by improper or rough handling of a bowel and bowel structures in devascular -- devascularization. Did you see any evidence of that in the records?

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A. I don't. And I would think if that's going to be an allegation you ought to have somebody that's been in the operating room to make that observation, and there are opportunities for that with -- with other surgeons scrubbing in on cases. Surgical nurses can maybe testify to that kind of thing. But other than that, I don't -- I don't know how one can -- can make that allegation.
Q. Just speculation, that type of allegation? You haven't seen it yourself; it's just speculation?
A. Or -- or possibly seeing it on a video. These days sometimes there's videos of operations, and I'm -- I'm not aware of that being documented.
Q. And then there was a -- an allegation that Dr. Randall didn't use good insight into the reality and nature of the patients' problems. Do you see any evidence of that, any significant problems with it?
A. No, I can't come to that conclusion from -- from looking at this. I think he made appropriate decisions about -- about what operations people needed. I mean, it's -- to me it's not like the -- the diagnoses here are -- are difficult. I mean, you have dead gallbladders.

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You have appendicitis. You've got paraesophageal hernia. These are definable diagnoses and the operations were appropriate.
Q. And is it your opinion that Dr. Randall generally complied with accepted standards of surgical care in his care and treatment of these ten patients?
A. The -- yes, except -- with the exception of I think the group dynamics may have been lacking in -- in one patient, number seven, Chris Wilburn. But, again, I'll have to have others to testify about how that works within that group and so on, but, you know, a lot of that -- or most of that is having to do with his partners as I can see it -- as I see it from the chart.
Q. Dr. Randall was notified and he took the patient back to surgery promptly?
A. That's my understanding. I'd have to -- he'll have to testify to how that worked and so on, but I didn't see any evidence in the chart that he was involved in the care of the patient when -- when the -- when the patient had come back with abdominal pain after an appendectomy.
Q. And surgeons -- you have to make judgments and decisions at the time. You're not --

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you as a surgeon would not be expected to be judged in 20/20 hindsight, would you?
A. I would hope not.
You know, I did have a, you know, criticism. I don't know if it's a minor criticism, but I mentioned it earlier, and that was when the tube feedings had gone into the patient, I would have been inclined to operate sooner. But that patient did recover from that. And we talked about how tube feeding in the abdominal cavity is -- is more of a chemical peritonitis like bile as opposed to something that -- that rapidly spirals into sepsis like -- like you see with a perforated colon.
Q. And that's just -- again, that's a judgment? You can't say it's malpractice, it's just basically a judgment on what you would do?
A. Yeah, and I can't -- I can't really say that it changed her course either.
Q. Okay.
A. I don't know that it did.
MR. McKAY: Thank you. Answer any questions that --
THE WITNESS: Thank you.
MR. COOKE: I'll give you the option if

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you want to -- well, why don't you go ahead -- why don't you go ahead and do -- do the cross and we'll -- since we just had a break recently -- unless -- unless you need a break for that.
MS. KREBS: I'm fine.
MR. COOKE: Sometimes people like to have a break before they do cross-exam.
EXAMINATION
BY MS. KREBS:
Q. Hi, Dr. Tribble. My name is Julia Krebs and this is Cynthia Hutto, and we've been asked to present the case on behalf of the Medical Executive Committee here.
You said that you have reviewed materials for this case. What -- what exactly did you review?
A. I have not as many records as I see sitting over there, but I -- I've got records that include discharge summaries, operative notes, some progress notes. So it's -- it's a partial record, and I don't -- I don't have the -- all the vital signs and that sort of thing.
Q. So -- so you didn't -- you didn't get a CD of the record -- of the records for these 11 -- or ten patients?

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A. It was not on a CD.
Q. Okay. So these records were preselected for you, the ones that you did review?
A. Well, they -- they came from the record is my understanding --
Q. Oh, sure. I'm not saying that. But you were presented with excerpts from the record I guess is what I'm asking.
A. But -- yes, the -- but it's the same sort of -- same sort of documents from each case.
Q. And were you also -- what else did you review?
A. That's the only thing I reviewed for this case.
Q. Were you given any -- were you given any reviews that had been conducted by or on behalf of the Medical Executive Committee?
A. Well, the -- the day before I came up here, I went by the office and -- and found a -- I think it was a synopsis of -- of yesterday's proceedings, but I -- I -- I've tried to skim about two pages of it, and it must have been 20 pages and I -- and that was skimming two pages. So since then I -- I didn't get much out of that, but --
Q. So you didn't -- you didn't read any

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reviews from a reviewer on the letterhead of something called AllMed?
A. Called what?
Q. AllMed. You didn't see anything like that?
A. I -- I did not.
Q. And you didn't see any reviews written on the -- on the letterhead of something called AMR, Advanced Medical Review? You didn't see those?
A. I -- I don't think I saw that.
Q. Did you see any correspondence from -- from Dr. Randall?
A. No.
Q. If you -- you were talking -- and I -- I might just go in reverse order.
A. Okay.
Q. Okay. You -- you -- you were talking about a patient by the name of [redacted]. This is the lady who -- who had the 11 units?
A. Right.
Q. Now, some -- something happened in that case to -- to cause a bleeding, did it not?
A. Yes.
Q. And if you would look at the -- at

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the -- hold on just one second.
Did you have the discharge summary?
A. I -- I have --
Q. On pages 37 through 39 of the record.
A. In my box over there I have a discharge summary. I've got a -- sort of a -- a breakdown of it here in front of me as well.
Q. The -- I'll just represent to you that the surgeon writes in the discharge note that the blood loss was secondary for bleeding from the liver bed.
A. Yes.
Q. Did you see anything in the record or excerpts of the record that you have that confirmed that?
A. Yes. That -- that was my -- my impression from the -- from the notes I've had that that's what he said.
Q. So if there's -- was there anything in the -- was there anything in the record to confirm that that was the site of the bleeding?
A. Yes, a CT scan showed a hematoma in that region, so it certainly suggests that at the site of the laparoscopic cholecystectomy that's where the bleeding occurred, but that's -- that

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would be expected. That's where the hematoma was on the CT scan.
Q. So the liver -- the liver bed was one option; there are other possibilities?
A. Yeah, it could be cystic artery. It could be possibly some other vessel in that area, but the common thing being common, it was most like a bleeder in the -- in the bed of the liver.
Q. So if a patient is bleeding out or is bleeding 11 units which is a lot of -- that's a lot of blood loss, right?
A. It is.
Q. The patient is at risk?
A. At -- at risk?
Q. For -- with that volume of blood being lost.
A. At risk for what?
Q. Would you agree that it would be within generally accepted standards of care for a surgeon who does not have a site of the bleeding exact to go in and try and find out what's wrong?
A. Well, it depends on the circumstance and the -- the time frame that the bleeding is ongoing. I mean, we -- we as general surgeons run into those situations sometimes when people aren't

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bleeding very rapidly such as in the gastrointestinal bleeding and your -- you may be thinking that -- that you're going to -- you're not going to let this go beyond a six-unit bleed, that -- that's common for surgeons to say that before they operate to deal with it.
And -- but sometimes when it's reached six, it looks like it's about stopped -- or you think it's about stopped and -- and so some of us have been known to go beyond that.
Q. But you really don't know at -- at six or seven or eight or nine in this case that it would stop; there was no basis in the record to know that it would stop?
A. I -- you don't know it. I mean, the only way you would know is after a couple of days when the hemoglobin has been -- has been steady because it's -- it's quite a bit different than somebody who is bleeding very rapidly.
Q. Other surgeons would stop patients at risk of that blood volume?
A. At risk of what?
Q. At risk of -- of a pretty serious injury or damage or death if the bleeding doesn't stop. Is that a complicated question?

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A. I -- I'm not sure I understand your question, but there's a couple of different ways to look at that. I'm not -- I'm not trying to be evasive, but if what you're getting at is bleeding to death as in -- as in so much blood has gone out that -- that the blood pressure drops and so on, it doesn't appear that that was really an imminent danger here because the bleeding was slow.
Q. Do you agree that most surgeons would have gone in to explore that system before waiting for 11 units of blood?
A. I -- I think likely that the majority of them would have.
Q. You were talking about a -- about the sleeve gastrectomy. Did you ever see a record of a sleeve gastrectomy?
A. The only thing I saw was on this -- I don't know what this document is called, but it has to do with the allegations of his wrongdoing on each of the patients. They use the term sleeve gastrectomy, number nine patient SJ.
Q. But you didn't see the records, so you really don't know what that procedure was about or why it was done?
A. Oh, I did.

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Q. Did you see the record of the gas -- of what -- of the procedure?
A. Oh, yeah. I saw the operative note. Is that what you're referring to?
Q. Yes --
A. I did.
Q. -- of that particular procedure.
A. Yes. I explained -- in fact, I explained to the panel exactly how the operation took place.
Q. On the Ch[redacted] H[redacted] case, it's this gentleman -- a 34-year-old who -- who dies following the appendectomy?
A. Yes, uh-huh.
Q. And I think -- what I heard you to say was that there was some group dynamic, other surgeons were -- other physicians were involved in the care of the patient after -- after the second surgery -- or, excuse me, after the first surgery?
A. That's correct.
Q. Wasn't the ultimate -- the ultimate problem, though, in that case is that indeed the appendectomy -- I think you used the phrase append -- appendiceal --
A. That's my understanding that it had

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leaked or -- or blown out, whatever term you want to use. There was contamination from -- from the site of the surgery, that's right.
Q. So there was some surgical defect at the time of the first surgery?
A. I -- I don't -- I can't say that. I just can say this was a complication of -- of his operation.
Q. Now, what happened in that case, though, was -- was that the -- you said the cecum died; isn't that -- isn't that correct?
A. Yes. And the omentum, and so -- so at the time of the operation not -- not just the omentum was taken out, the -- the right colon, which would essentially mean the cecum, was removed, and I think I had mentioned that the omentum had died probably from a low blood flow state, and I think probably the same -- the same mechanism resulted in the -- in the cecum becoming infarcted.
Q. And if there had been a low blood flow state, wouldn't that have been sort of a generalized problem --
A. No, ma'am.
Q. -- (multiple speakers) and --

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A. Well, except --
Q. -- and that was ultimately found in this case had indeed there been this low flow state?
A. Restate your question, please.
Q. I -- I think you said that you -- only -- only part of the -- of the -- of the -- only the cecum had died in this case?
A. That's correct.
Q. And --
A. And the omentum, by the way.
Q. And presumably as part of that; is that right?
A. Well, it's -- it's nearby, so those -- those two organs were found to be dead. And the cecum which is part of the colon, the omentum which is really a separate organ. It's very unusual for it to infarct or die, but it did.
Q. But if there had been a low flow state, wouldn't there have also been at least patchy neurosis of the small bowel?
A. No. Not necessarily at all because sometimes you have what's called a -- a watershed infarct well known to -- to people that deal with strokes where -- where the more distal parts of the

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circulation are the part -- the parts that die, and the cecum is -- is about the very last thing in the bowel that blood gets to.
It's -- it's the furthest distance by -- by length of vessels from the mesenteric vessels, if you follow what I'm saying. So when somebody has a low flow state, say they've been sick and they've had low blood pressure, maybe they've had clamping down of their blood vessels trying to -- trying to maintain the blood pressure, the cecum is commonly what goes. That -- that's not unusual.
Q. And couldn't you also have had all of that simply as a result or -- or a consequence of the sepsis?
A. Well, sepsis is what leads to the low blood flow state and --
Q. And sepsis is a result of the injury to the stomach?
A. The sepsis is a result of the -- of the leakage at the appendiceal stump, that's correct.
Q. If you could take a -- you talked also about the -- the E[redacted] case, and this is -- this is the -- this is the gentleman who comes in and is a morbidly obese patient, comes in on January 30th

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with abdominal pain after colon surgery, case number seven.

A. Is that C[redacted] E[redacted] we're talking about?

Q. No, we're talking -- it's E[redacted]. I forgot Mr. E[redacted]'s first name.

A. I've got -- I've got a C[redacted] E[redacted] who --

Q. C[redacted] E[redacted].

A. -- who is obese.

Q. It's case number seven.

A. Okay.

Q. Did you -- did you see any evidence in the record as to why this patient could not have been treated conservative -- over a more conservative course given all the --

A. You know, I wasn't examining the patient or -- or hearing about his pain, but I understand that he -- he presented with pain from his ventral hernia, and, you know, if a general surgeon wants to leave himself really culpable, then he just ignores that in a patient and allows it to get larger and entraps a bowel, cause a bowel obstruction and -- and substantial likelihood of problems down the road.

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I think I mentioned that his -- maybe not in this case I didn't, but you can't do anything about his 320 pounds. It's -- that's -- that's impossible to -- to really correct that in a timely fashion to -- to make him a -- a safer candidate. And the very fact that he weighs 320 pounds makes him at high risk of having this thing just really expand more quickly than a hernia that may be involving just omentum or just fatty tissue right now is more likely in somebody like that with his huge abdominal pressure to develop a bowel incarceration in the hernia and complications from that.

So I -- I have no argument with his -- his recommendation to -- to fix the man's hernia.

Q. That wasn't my question. My question -- my question was, Is there anything that you have -- the admission note talks about taking this gentleman immediately to -- to the OR. And I'm asking -- I'm asking whether you see anything in the -- in the records that you reviewed that were given to you to review that shows that there was some emergency that this gentleman could not have been -- been treated or at least an attempt made to treat him conservatively before taking him

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to the OR.

A. Well, what -- what I'm failing to understand is -- is what we would be doing or what he would be doing to him conservatively for those few days or few weeks that you're talking about. I don't understand what -- what we would be managing conservatively given -- given what I've already said.

I mean, a hernia is -- is not going to go away with conservative management. Some things might. Some things might get better with conservative nonoperative management, but hernias don't, but --

Q. He wasn't taken there just for the hernia. Hernia is not emergency. He was taken there also for the potential for obstruction; is that not the case?

A. For small bowel obstruction?

Q. Uh-huh.

A. Yeah, I think that's right, and partial small bowel obstruction and --

Q. And there's a -- do you have the --

MR. McKAY: Will you let -- I'm sorry, you're cutting him off.

A. Yeah, it -- I mean, I see it in the

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records here. There was -- there was a diagnosis of -- of a partial small bowel obstruction which, you know, again, if it's partial small bowel obstruction because of hernia, then in my opinion the thing to do is fix the hernia.

BY MS. KREBS:

Q. And this gentleman -- this gentleman comes in. He's got -- he's got all of his prior history. Do you have the 2/7 op note?

A. Probably it's in here. If it's not, I bet it's in my box.

MS. KREBS: For the panel it's at pages 13 and 14 of the record.

A. I have an operative note here.

BY MS. KREBS:

Q. And do you see that it describes an area of complete obstruction on the 1/30 -- this is -- this is a follow-up surgery?

A. It is, yes.

Q. And it -- and it's -- and it describes an area of complete obstruction.

A. Okay. Read the line to me so I'll be able to follow you.

Q. "It is an area of --" I'm just reading from this particular line. "It's an area of

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complete -- complete obstruction." I'm mostly interested in that phrase. Do you see that?

A. Well, I'll -- I'll try to find it, but if you read -- read me the whole sentence, I might be able to find it.

Q. Just a second.

Okay. It's under patient profile, page one.

A. You know, I'm looking at a different -- different sort of document than you are, so if you'll -- if you'll read it to me, then I'll comment on it.

Q. I'll just read you the -- the start of it -- of the sentence. "50-year-old white male was initially seen me by on referral from the emergency room with small bowel obstruction as well as multiple incarcerated ventral hernias. Patient had history of previous surgery done some years ago in Virginia with a supposed history of diverticulitis, but he appeared to have had a small bowel resection because of the small bowel obstruction with multiple ventral hernias. He went -- he underwent exploratory laparotomy on January 30th, 2009."

A. Yes.

MR. McKAY: You left a word out,

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incarcerated ventral hernias.

MS. KREBS: I'm sorry. Yes.

A. I see that.

BY MS. KREBS:

Q. "As well as multiple dense adhesions in an area of complete obstruction in his previous anastomosis." Do you see that?

A. Yeah. I do see that.

Q. And one infers from that that Dr. Randall was -- was describing a complete obstruction in the earlier surgery?

A. That does sound like that's what he's -- he's alluding to in that operative note of 2/6. So it sounds like -- sounds like he encountered an obstruction at a site that maybe were not even in the ventral hernia, but still it was an obstruction from adhesions or scarring down of a previous anastomosis.

Q. Could you also look at the one -- the original surgery note then.

A. Sure.

Q. And if you would look at the -- at the second page of the -- of the operative report. He describes how -- how a finger could be passed through the anastomosis.

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A. A finger could be passed through the anastomosis, did you say?

Q. Uh-huh. It's sort of -- it's at the last couple of lines left over.

A. Last -- last couple of lines of the operative note?

Q. Of the -- of the op -- of that -- of that page of the op note.

A. Okay.

Q. It's pages three of --

A. Unfortunately I'm -- I'm looking at a -- at a -- one that's arranged a little differently somehow as far as page numbers than yours, but I -- is this after he's already done --

Q. It's the -- it's the surgery on 1/30.

A. I understand that.

Q. And if you -- it's the first -- the second page of the op note is a procedure note and it describes what he's doing. Toward the very end of that page --

A. A finger could --

Q. -- the last several lines --

A. It says, "Finger could be passed through the anastomosis."

Q. Is that -- is that consistent with a --

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with an area of complete obstruction?

A. Well, let me read -- read the part around it then. Let's see.

Well, what he describes is -- is that -- is that there was inspissated material that was -- had accumulated there and had resulted in a complete obstruction at that point. But from cutting the adhesions, freeing it up and so on, he was able to manipulate the -- the material that was in the bowel to a point that he could then put his finger in a -- in such a way as to palpate the anastomosis and demonstrate to his satisfaction that in fact it was patent, but it wasn't patent when the patient presented because it had -- it had an obturator effect. It had stuff stuck in there blocking it off.

Q. Do you see from this -- from this particular record a basis for -- for redoing the anastomosis if -- if it is patent?

A. Well, you know, it -- I suppose if in his judgment that it was the cause of -- of a blockage before, then removing the one that had created the -- the problem that had left the man in this situation is a -- is a reasonable technique.

Q. Now, all the -- all the subsequent

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operations and problems that this gentleman had were at least in part a consequence of the redone anastomosis?

A. Yeah.

Q. Would you agree with that?

A. Yes.

Q. I don't -- I'd like you to look at the case involving S[redacted] W[redacted].

A. Okay.

Q. And that's patient number six.

And this is the gentleman who was morbidly obese. He had diabetes. He had prior gastric bypass, and this was a laparoscopic repair of a ventral hernia?

A. Correct.

Q. And that initial operation resulted in two -- two trocar injuries; is that correct?

A. I guess you'll have to show me where two trocar injuries are documented. That was not exactly my understanding.

Q. Do you see any trocar demonstration?

A. You know, this -- this is the patient that had the necrotizing fasciitis that developed over the trocar site, that is, the severe infection that resulted in a major abdominal wall

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debridement.

Q. So is it your testimony that this necrotizing fasciitis is sort of an independent event?

A. From -- from what I've seen in the record, it's -- it's an independent event because the -- I don't recall his finding anything intraabdominal that -- that resulted in the -- in the -- in the abdominal wall infection. And necrotizing fasciitis of the type he had was involving the -- the fatty layer and the -- and the skin. So he lost a lot of the fatty tissue and skin in that area.

Q. Now, of the records that you were given, were you given any path records from cultures that were taken?

A. I can't remember if I have those or not.

Q. Okay. If I -- if I told you that the cultures showed four distinct fecal organisms --

A. Uh-huh.

Q. -- would that change your view?

A. You know, I -- I'd have to rely on what the -- what the operative note was showing about the -- the findings at the time of laparotomy.

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Q. But if you're the Medical Executive Committee and you have a patient who's treated -- multiple injuries -- excuse me, multiple procedures now and you have a lab report showing cultures of fecal organisms, would -- would it be reasonable to infer that there -- that there had been a fecal contamination and therefore some kind of injury?

A. Well, you know, I think it can happen by other mechanisms where you get fecal contamination in a -- in a trocar site. So I --

Q. Other than perforation and --

A. Other than perforation of -- of one's colon intraabdominal. So -- so I think it can happen other ways, and so -- and my thought is that we'd have to -- have to know what was found at -- at that operation when he went and took the mesh out, because at the time of the debridement of the abdominal wall he took the -- he did a laparotomy on the patient and took the mesh out.

Q. But it's also possible that there was simply a perforation?

A. Well, I guess you're -- I'm not sure what you're getting at, but -- but if I'm -- if I'm reading you right, you're suggesting that his -- his documentation was -- was not forthcoming; is

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that correct?

Q. Well, there's a -- the word necrotizing fasciitis is used descriptively.

A. Yes.

Q. But it's also -- it is also in these cases, the MEC would suggest, a result of -- of fecal contamination arising through the trocar.

A. Well, allow me to look at the -- the first operative note here for a second.

Q. Sure. The first operative note was on pages 58 through 60 of the electronic record. It's carried out on March 16th, and there are lots of references to intraabdominal adhesions requiring significant dissection, and the note goes to some -- some trouble to describe the absence of injury to the bowel.

A. That's what I'm seeing there --

Q. Do you agree with that?

A. -- uh-huh.

Right, it describes an absence of injury to the bowel and -- and consequently he -- he proceeded to put the mesh in place.

Q. And then you go to March -- and then you go to the March 17 note --

A. Right.

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Q. -- which is the following day, and that's on pages 61 through 64 of the electronic record.

A. Okay.

Q. And that March 17 note describes a severely malodorous infection at the site of the lower left quadrant trocar site and talks about necrotizing fasciitis infection.

And I guess my question to you, Is it reasonable to conclude that the immediate development within 24 hours of the malodorous infection after laparoscopic procedure and in the presence of what turns out to be cultures showing klebsiella, enterococcus and E. coli point reasonably convincingly to a bowel injury of the trocar at that site?

A. No. You know, I think that that would be documented in the -- in the next operative note that -- that adjacent to that site that there was a hole in the -- in the bowel. Now --

Q. A --

A. Excuse me.

So, I mean -- I mean, he -- he did a laparotomy after -- at that point and took the mesh out and so on, and, you know, the only way I can

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suppose that is if -- if he's -- if he was lying and didn't -- didn't acknowledge what he saw there. And I'm -- I'm not sure if that's what you're suggesting, but the operative note does not indicate that there was a peritonitis going on, because, you know, where a -- where a trocar is in the abdomen is not -- is not a place where -- where everything is all stuck to it. It's in the free area because you're working through that area.

And if there had been a leakage from the colon as a result of the operation, there should be a peritonitis. There -- there should be not just an abdominal wall infection; there should be fecal contamination in the peritoneal cavity.

Q. All right. Are trocar injuries relatively common?

A. They're fortunately quite uncommon, but in your business they're common.

Q. If you look at P[redacted] which is also a necrotizing fasciitis case -- that's case number four -- at least that's -- that's the phrase that was used.

A. P[redacted], yes, I have her.

Q. And this was -- this was a lady who did suffer trocar injuries to the bowel and -- and to

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the epigastric artery and -- and the procedure was converted to open. This is pages 19 -- the electronic pages 19 through 21 of the Parnell case.

A. I -- I have her record in front of me. Is there --

Q. There was a trocar injury in that case, was there not?

A. Tell -- tell me what trocar injury you're referring to.

Q. The trocar injury to the result -- to the right colon resulting in fecal contamination.

A. Let's see.

MS. KREBS: For the panel it's pages 19 through 20 in Exhibit 22.

A. I'm looking for where that is. I'm not denying it. I just want to --

BY MS. KREBS:

Q. Look at the end of -- look at the end of the second page of the op report. It's a -- the middle -- the middle paragraph which begins with "The patient was returned to the supine position." And if you go to the end of that paragraph, "On inspection it was evident that what had been entered was a portion of the right colon."

A. I -- I remember this now, but I'm not

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seeing it right now in here. But I think what was going on there was that -- not a trocar injury but instead a -- if I'm not mistaken, it was a -- during the dissection of -- of the gallbladder and the inflammatory mass in the right upper quadrant.

Q. But that -- but in any event -- in any event, bowel injury?

A. Yeah, a bowel injury in the course of a dissection of a -- of a necrotic gallbladder.

Q. Lastly, look at the case involving -- unless there's something you wanted to say.

A. No.

Q. I'd like you to look at the case involving D[redacted] S[redacted].

A. Okay.

Q. And that -- that's the lady with the -- the very unfortunately lady with the --

A. Cerebral palsy.

Q. -- cerebral palsy.

A. Yes. Okay.

Q. And I think you said during your -- your -- your testimony that you had no criticism of Dr. Randall, but that you yourself might have been inclined to operate on this patient a little sooner, but am I -- am I saying --

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A. That's -- that's basically what I said.
Q. And I think you said that you thought it was an approximate eight-hour delay and it might not have made that much difference.
A. Yes.
Q. Would your views be -- would your view on that be different -- let me ask you this.
Do -- do you -- were you given any records that you were -- that -- you were provided the -- the CT report that confirms looking at the J tube site -- or whatever, the radiology report -- I'm not sure it was a CT. It's on page 4076 of the electronic record.
A. I -- I've got some copies of some CT scans. Probably -- probably I have seen that, but direct me to the date, and I'll -- I'll answer your question.
Q. Well, it's the -- the -- the leak is confirmed at -- on the report on 4/21; is that correct, April 21st?
A. Yes, I do see an abdominal x-ray that -- that confirms that.
Q. Okay. And then were you -- were you given the -- the informed consent by the parent or the responsible party for this patient also on

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April 21st?
A. I don't know if I have the informed consent form in here. I don't remember looking at it.
Q. Okay. It's -- it's on page 4535 of the record, and it shows that this consent was given and Dr. Randall signed it, but the consent is given -- it's timed April 21st at 4:30 in the afternoon, 1630.
A. I -- I don't have that in front of me, but I'm --
Q. I'll just represent to you it was --
A. Okay.
Q. -- it was provided in the afternoon, and the surgery was not done until -- until sometime in the morning on the following day.
A. The following day.
Q. So we're wait -- we're more than eight hours; isn't that correct?
A. It sounds like it would be.
Q. Had -- had this surgery been performed earlier, isn't there a substantial likelihood that this patient would have suffered a less septic course than she ultimately had went through?
A. That -- that's hard to say given that

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it's not a -- it's more of a chemical peritonitis as I was alluding to. But on -- on the other hand chemical peritonitis does make people sick. It causes scar tissues and so on, and, you know, it just -- from the records I've seen it might would have been better to go sooner.
Q. She was pretty sick.
Do you have any -- were you given any records that suggested that indeed the decision to wait was because this lady could be rehydrated or given antibiotics? Did you get any record of that?
A. I -- I don't recall exactly precisely that, but that was my understanding from my general review. Now, I'll -- I'll be the first to admit to you I haven't read every page of all this, but I'll venture to say you haven't either, nor has any of the panel.
But that was my general understanding that the -- the patient was being prepared, but that's -- again, I'll say it once again. It's not necessarily -- I -- it's not -- it's not true that I necessarily agree that that was the best course.
Q. And would that -- would that understanding come from Dr. Randall? Would that -- where did you -- upon what did you base your

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understanding?
A. My understanding of what?
Q. Of the -- of this possibility of waiting for rehydration or antibiotics.
A. Just -- just picking it up from reviewing the records that that's -- that's what was going on.
Q. And I have truly one last question, and that's with regard to patient C[redacted] who was the first case that you discussed.
A. Uh-huh.
Q. Mr. -- Mr. C[redacted] is a gentleman that presents with a left-sided colon obstruction. It was a sigmoid colectomy. Resection was done in the pelvic part of the dissection. Apparently that was all very complicated and that all turned out pretty well. The rectal stump was closed with a staple, and then the proximal descending colon was brought through the abdominal walls and colostomy.
And my understanding as a layperson is that all the problems occurred with his colostomy which was on the other end of where the real initial problem was; is that -- is that correct?
A. I'm -- I'm not sure I understand what that means.

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Q. Well, that the -- that the problem -- that the problem ultimately occurred at the site of the colostomy is on the other end of where -- where the original inflammation was, using that as a very --

A. I mean, I -- I hear what you're saying as a layperson, and I think I follow you --

Q. Okay.

A. -- but I -- I guess you could say it was separated by some distance from -- from maybe where the inflammatory process was.

Q. Is it -- is it -- there were with this patient in the -- in the end ischemic necrosis of the transverse colon and there was devascularization of the bowel. Can you -- can you state with some certainty that all of that process that occurred with this patient did not have to do with the construction of the colostomy?

Can you exclude the construction of the colostomy as a reason for this patient's problems?

A. No, I think -- I think construction of the colostomy is -- is part of the problem in the sense that as I mentioned earlier, whenever you do create a colostomy the very act of doing so strips some of the blood supply to it.

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And consequently when surgeons do colostomies or ileostomies, one of the things we're looking at on postoperative day one and two and three is the color of it. And we're not just interested in the color just for no reason. The reason is we're trying to see if it's ischemic, if the blood -- if the blood flow is a problem because sometimes it can be.

When you do a colostomy, the colon has to be divided. Mesentery which carries the blood supply has to be divided in part and substantially actually to get it to come to the abdominal wall. And so it -- and so the very end of the colon which is the colostomy is a high risk area.

And so in somebody that already has a -- a problem with a markedly distended colon, maybe distended to the point that -- that blood flow is compromised, then it doesn't surprise me that the colostomy might be a point that -- that ischemic bowel is manifested.

MS. KREBS: I have no further questions.

MR. COOKE: Okay.

MR. McKAY: I don't have many. Just a couple.

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RE-EXAMINATION

BY MR. McKAY:

Q. You were asked about D[redacted] S[redacted]. I don't even know how many thousands of pages her records are, but it looks like Dr. Randall at 6:20 at night is aware of the patient's tachycardia. She's significantly dehydrated, and then he has cardiologists see her later that evening for some consults because of the tachycardia, things like that. So this is a thought process --

A. Right.

Q. -- on getting her into surgery; is that --

A. That's right.

And I have some basic -- basic recollection of that, but because of the volume of these records, I -- I couldn't remember precisely what was going on there. But he was addressing the tachycardia and had a cardiologist involved. It's not like nothing was going on.

Q. Infectious disease people were involved. Yeah, it's not like he went out and played golf. I mean, he's having other subspecialists look at this patient and making evaluations?

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A. Right.

MR. McKAY: Okay. Thank you. That's all I've got.

MR. COOKE: Anything else?

How about the panel? Any questions?

Everybody must be hungry. Can we -- can we let Dr. Tribble eat and go home?

THE WITNESS: Or go home.

(Off-the-record conference.)

MR. COOKE: Let's take a break. Let's try to obviously eat as quickly as we can.

Who is your next witness?

MR. McKAY: Dr. Randall.

(A recess transpired.)

MR. COOKE: Want to go back to work?

MR. McKAY: Yes. Call Dr. Randall.

RONALD DONALD RANDALL, JR., M.D., being first duly sworn, testified as follows:

EXAMINATION

BY MR. McKAY:

Q. Dr. Randall, everybody knows who you are, but give your name and your address for the record, please.

A. It's Robert Donald Randall, Jr. 1964 Rosehaven Lane, Rock Hill. It's 29732.

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Q. And tell the -- give the jury your educational background.
A. Well, I went -- born in Rock Hill. Went to Rock Hill High. Graduated from Davidson College. Went to Bowman Gray for medical school, and like Dr. Tribble was saying, when we trained there, it was North Carolina Baptist Hospital. It's now Wake Forest University, but the residency was all at then Bowman Gray, now Wake Forest University.
Q. All right, sir. And when did you finish medical school?
A. Medical school '76. Residency in '82.
Q. And what was your residency in?
A. General surgery.
Q. Are you board certified in general surgery?
A. Board certified, recertified twice.
Q. When did you last recertify?
A. The last recertification was 2004.
Q. And when did you come to Rock Hill to practice surgery?
A. 1982.
Q. And you practiced surgery here until 2010?

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A. October 15th, 2010.
Q. And what states are you licensed to practice medicine?
A. North Carolina, South Carolina.
Q. And did you practice with a group for a period of time?
A. Yeah, I was with Rock Hill Surgical Associates for 25 years and then Surgical Specialists of the Carolinas for a year and a half. Then I had my own practice of MEC Surgical for a little over a year.
Q. All right, sir. Have you ever had any problems with your credentials in the past?
A. No.
Q. Now, I want to talk about the board action a little bit. All physicians are always subject to peer review, are they not?
A. Yes.
Q. I assume you've been involved in that from time to time?
A. Yes. Usually -- always before on the other side, but --
Q. All right, sir. Have you ever been on the Medical Executive Committee of this hospital?
A. Yes.

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Q. What positions have you had?
A. I was the chief of surgery and as a result of that on the Medical Executive Committee.
Q. All right. Now, you learned on October 15th that your surgical and abdominal privileges have been suspended; is that correct?
A. That's correct.
Q. And did you try to get an expeditious hearing of that?
A. Yes, I tried to get it held as soon as possible, and then I saw on the bylaws it could be between 30 and 90 days and I requested the 30-day hearing time.
Q. All right, sir. One of the reasons for that is because you knew that the method -- if privileges were suspended, that it would be reported to the National Practitioners Data Bank?
A. Reported to the Data Bank, and it's also twofold. With that -- with the suspension of what they limited me from doing, that took 85 percent of my business out. If I could go 30 days or get it reinstated, then I had a chance of maintaining my practice and maintaining the three people I had as employees. But with the time frame that it became, it became financially impossible.

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Q. All right. So you ended up shutting your practice down and terminating your employees?
A. Yes.
Q. Okay. And is -- do you have -- currently have job offers in other hospitals?
A. Yes.
Q. All right. Both in South and North Carolina?
A. Correct.
Q. And you cannot pursue those because of the Data Bank --
A. Bank.
Q. -- for you?
A. They're going to look and see that there's limitations of surgical privileges.
Q. So you would not be able to get privileges at another hospital; is that --
A. No.
Q. And your medical training really doesn't qualify you to work in --
A. No, I --
Q. -- primary care or anything like that?
A. No. I can't be a family doctor. I'm not good -- I'm not a carpenter. I'm not computer literate. I'm not a mechanic. I'm trained as a

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surgeon.
Q. All right, sir. And you need to get your privileges reinstated and reported to the Data Bank so that you can work at this point?
A. Correct.
Q. Do you have -- you still have a child who is in -- in school?
A. My youngest daughter is in physical therapy school.
Q. Now -- and I believe you had a -- a hearing a while back or just more of an informal conference with the Medical Executive Committee, did you not?
A. I was pretty -- I don't have -- informally one, but I did appear before the Medical Executive Committee.
Q. You talked about the cases you had?
A. Correct.
Q. Did anybody ask you any questions?
A. There were no questions. The first questions that was ever asked to me was Tom Simpson yesterday. Nobody has ever asked me about any of these cases, and I welcome anybody -- the chances to talk about them.
Q. Now, one thing that came up yesterday

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is apparently some statistics about multiple returns to the operating room; is that correct?
A. That's correct.
Q. And I believe primarily there were two patients who had multiple returns to the operating room?
A. Right. [redacted] and -- and [redacted] -- well, you know -- you know their names by now.
But both of those had multiple planned returns because in all the years I've been in practice I'd never had patients with open abdomens. I wound up with two of them during this period of time and was treating with an abdominal wound VAC which requires placement of a big piece of plastic and a bunch of mesh and things that you got to go into the abdomen and go around.
And particularly for [redacted], it was impossible. She had to be put to sleep to do it. And earlier the same thing for -- for Steve. So they had repeated planned returns to the operating room.
Q. And [redacted] because of her severe psychiatric problems and retardation and physical problems, she -- you couldn't -- there

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were things you could do at a bedside with a non -- with a more normal patient you could not do with her?
A. Right, you couldn't -- it was hard to do anything to her because of -- not her fault, just her mental status.
Q. Okay. All right, sir.
Now, I'm going to ask you to -- the panel has heard extensively about these patients.
A. Uh-huh.
Q. The first patient I think was [redacted].
A. Uh-huh.
Q. And you were -- you heard the criticisms yesterday. What -- do you recall what Dr. Skudder said you did wrong with Mr. [redacted]?
A. Yeah, that's what I'm saying. I mean, the reviewers came up with one thing I did wrong, and then Dr. Skudder comes up with an entire -- said, "No, this reviewer's wrong and this is a different thing that was -- that was wrong." And the original reviewer stated it should have just been a colostomy, and Dr. Skudder said no, that was all right. But he claimed that the problem was in the mobilization of the splenic fracture causing

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the devascularization.
Q. He said he -- he thought you had some devascularization problems causing on -- I believe on three cases; is that correct?
A. Yes.
Q. No evidence of any devascularization problem?
A. Not from surgical things. There -- there are some devascularizations from the mechanics of the -- of one patient's problem, Carpenter.
Q. All right, sir. Now -- and Mr. [redacted], what -- and I -- I know the panel has heard all this, but what did you do and why did you do it with Mr. [redacted]?
A. Mr. [redacted] didn't like doctors, didn't like coming to doctors, and had been chronically constipated for a long period of time. And was 40s -- he's in his early 50s and sat at home for ten days with no bowel movement and decided he'd still eat while all that was going on. Sat at home for three days before he came in vomiting.
He came in massively distended. Had a CT scan showing complete colonic obstruction all

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the way down to the rectosigmoid, a cecum that was 15 centimeters in size. The emergency room initially called Nirav Patel who appropriately tried to colonoscope him to see if he could decompress him, but could only get very few centimeters into it before he encountered a complete obstruction that he couldn't -- he couldn't pass the scope, so then asked me to -- to see him and we took him to the operating room to surgically decompress him.

Found, as is noted on the CT scan, a massively dilated colon, at least 15 centimeters into the cecum, dilated all the way down to very, very low into the pelvis. Had a big inflammatory hard mass, and it was hard to do, to mobilize it out. It was a -- pretty common as you see with diverticular disease, it's as hard as a rock. It's indurated. It's reactive.

We got it out, got that stapled. Brought up -- or resected that portion of the colon. Tried to decompress his bowel. His bowel because he had been so chronically obstructed was just like it was a toothpaste tube, just packed with -- with just thick mucoid material that's confirmed -- Jim Maynard does the first pathology

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on it and shows a six -- a .6 centimeter lumen which I can document to you is a pretty small lumen for -- for a colon. Also completely filled with mucoid material.

He goes -- he's sick. We put him in the ICU. The next day he's still sick, and that colostomy is looking dusky. So I said -- well, we go back to the operating room and see if we have a problem here. And I go into that -- into his abdomen, and there was some smelly material there. There was still a massively dilated colon.

The colon still at this point is 12 centimeters that you did the pathology on this one, and you measured it 12 centimeters on the cecum. Again, note the colon's completely filled with stool. And so I -- I said I have to take out the rest of this colon. Did that. Brought an ileostomy up. Two days later brought him back again for a planned look and washed him out.

And he stayed very ill for a while, but -- but recovered. And I sent him down to Charleston at some point to get reconstructed because I got no desire to go into his pelvis or go back on that guy to do that. I don't know whether it was done or not.

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Q. All right. So the trips to the OR were --

A. Were planned returns.

Q. -- planned?

A. Yes.

Q. Then H[redacted] C[redacted] that's the patient who you did the --

A. Correct.

Q. -- surgery on and then he went home and came back and was admitted by one of your partners; is that correct?

A. Yeah. Let me get the exact timing of all of this. He -- he never got one.

But, anyway, Mr. C[redacted] was a 72-year-old man who had recurrent abdominal pain. I had seen him back in 2001 or 2002. I don't remember exactly. And at that time he had a ruptured appendix, multiple intraabdominal abscesses, a very sick, prolonged course, but recovered. And I haven't seen him in a year since then.

I saw Larry Pennington who was seeing him for this abdominal pain who colonscoped him and then got a CT scan which showed gallstones but also showed a moderately large cystic appearing mass in

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the right lower quadrant. So did take him to the operating room and performed a -- a laparoscopic cholecystectomy, a laparoscopic lysis of adhesions, removing the -- the adhesions in the right lower quadrant.

The next day -- you know, he was looking all right except his creatinine has gone to 3.2. His white count is still normal at 9,000. Hemoglobin is stable, but he's not looking right. So I've got -- you know, Musialowski was seeing him. One of the neph -- I think -- I'd have to go to the chart. But nephrology was seeing him. We're all trying to straighten all this -- this out.

He did this before when I had done his appendix, so I thought at that point he had some dehydration and fluid loss. We put him in the intensive care unit. Seemed to get a little better during that day. That was a Friday. I turned him over to Corey Crain at five o'clock on Friday.

That weekend was kind of an odd weekend because I have a nephew that was getting married. His father was my brother who died years ago, so I was kind of a semi-father role for the wedding. So normally with sick patients or whatever I least

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come in and check, but I just turned him over to Corey and said, "Call if there's -- there's problems." I said -- I did tell Corey, I was -- you know, "Think about bowel injury if there's problems."

The next day he gets sicker and his white count goes up. He goes on a ventilator. Corey gets a CT scan on him that doesn't leak contrast, and unfortunately Corey believed the CT scan and not the patient and watched him Sun -- Saturday, Sunday while he's getting sicker. I see Corey 7:30 Monday in the operating room. He said, "Mr. C[redacted]s not doing well." I said, "What?" So I go see him and I said, "This guy has got to go to the operating room right now. He's got to have a bowel injury."

I tried to reach his son, and that took three different numbers. They all go to voice mail, different phones, but I don't reach him. But his son shows up then, and his son is angry. He's justifiably angry and says, "Look, I don't want you, I don't want your partners, I don't want anybody from your group touching this patient." I said, "I understand that."

I got Kan Borhanian to come see him and

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took him to the operating room. He spored him. He did have a small bowel injury, peritonitis, and over the course of really the next 24 hours he died.

And this is one that notified the malpractice carrier and things. Like I've told them, this is one that I messed up. I injured the bowel. I missed it. Corey really missed it, and I screwed it up. This is -- I state that unequivocally forward.

Q. C[redacted] E[redacted]n --

MR. McKAY: Do y'all want to ask any questions about each patient while we're talking about it or is that a -- We wait until the end? I don't care.

MR. COOKE: If it doesn't dis -- disrupt you, I'd be glad -- you want to have them chime in any time there's a question?

MR. McKAY: Sure. I think that would -- because --

THE WITNESS: I would prefer that because it kind of keeps flow with the patient.

MR. McKAY: It's impossible to keep them all straight.

BY MR. McKAY:

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Q. All right. So the next one is C[redacted] E[redacted].

A. C[redacted] E[redacted] is a 52-year-old fellow who came in again through the emergency room with severe abdominal pain. Had a CT scan showing multiple incarcerated ventral hernias. A narrowed transition point then in the small bowel suggested at least a partial small bowel obstruction.

I saw him and he gives me a history. He said it was diverticular disease, but that didn't make -- I didn't know what he had. The surgery was done in Virginia. He knew he'd had some kind of bowel resection. He knew that he'd had at least two or three previous ventral hernia repairs all done in Virginia, but this is nighttime. We don't have any records of it.

So, anyway, we hydrated him, took him to the operating room, found four separate ventral hernias, but also multiple, multiple dense adhesions, a lot of adhesions. It's -- none of y'all have really been in the abdomen. But every time you operate, you form adhesions and some people form more than others, and he was one there was more adhesions.

So I'm trying to free up all the

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adhesions and then get back -- posteriorly step back on the retroperitoneum. He's got an obvious dilated small bowel, come to this point, small bowel that's not dilated going -- it's obvious that that's obstructed, and in that area is the old anastomosis.

It's old, convoluted. It's got this inspissated material, thick mucoid material, and big bowel here and small bowel here. Dilated bowel. Point of obstruction. Small bowel. So lysis freed all that the up. Said, "I don't like this, but I got to resect it." So I resected it and did a side-to-side stapled anastomosis.

And I've done literally hundreds of anastomoses in this -- this hospital. In fact, the first two cases done in this hospital were done by me on the day we moved here. So I've been doing these things a long time, and I don't have a -- other bowels that have come apart, but Clair Erickson's did.

He looked fine for a week. A week later he's got enteric material coming out. Take him back to the operating room. As I said, he's already somewhat -- adhesion former. He's got a bunch more adhesions. So I go back in on him.

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Corey Crain is with me that time. Took down a bunch of adhesions, took out small bowel, resected that anastomosis and redid it.

In retrospect I probably shouldn't have reanastomosed him, but you don't -- you try not to leave him with an ostomy. You're trying to leave him -- trying to fix him. I look at the anastomosis. Corey looks at the anastomosis. I said, "This -- we've had problems. Let's look and make sure everything is all right." And we look at it a long time. And it looks fine.

I get a CT scan on him -- two CT scans on him the next week that look fine, but then on Valentine's Day, you know, about ten days later he's got enteric content coming out of his bowel -- I mean, out of his abdominal wound. I took him back to the operating room and, again, same -- he had adhesions.

I call Chris Schroeder in on that one, and we, again, had to resect some bowel. Bring up a jejunostomy and ileostomy. He recovered. He did have to receive some supplemental TPN. I did send him to Duke. I know he delayed a while, but a year ago. The -- well, January 15th of this last year they were supposed to put him back together, but I

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I've lost track of it. I didn't see him in follow-up. So I assume he's -- he was out -- I mean, he was out, back at work functioning and everything, but was planned -- had planned surgery to have it re-anastomosed.

Retrospectively I shouldn't have put him back together the second time, but Corey was there with me. It's decisions. It's always -- hindsight is a lot better than, you know, when you're looking back at it than when you're looking at it.

Q. Okay. These are judgments you have to make at the time?

A. Correct.

Q. How about J[redacted]?

A. [redacted], nice lady, is 57-years-old who some period of time ago, five, six years ago had a posterior fossa tumor. When they resected it, she had severe complications with MRSA infection that just left her with profound severe neurologic deficits.

She had an expressive aphasia. She could speak but, you know, not -- not clear sentences, but could make herself -- we could understand her. Had a dense left hemiparesis -- or

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really a hemiplegia. Had a PEG tube in because she couldn't eat. And that's the main thing. She hated her PEG tube and she also had a ventriculoperitoneal shunt.

In -- comes in through the emergency room with abdominal pain that in retrospect had probably gone on two or three weeks but she really couldn't tell anybody much about it or they really didn't pay much attention to it -- about it. See a CT scan that's got a thick wall gallbladder and she's got a white count of 22,000. I mean, that -- that's a pretty sick gallbladder. Dr. Tribble said earlier you don't normally see those kind of numbers with white counts with just normal gallbladder disease.

Took her to the operating room and began it laparoscopically, and there's this big inflammatory mass of stuff all up in her right upper quadrant. Taking that down. Taking it off the colon. I've got fluid coming out. I know I've got something. As it turned out, it was the bowel. It was leaking out of -- out of a dead gallbladder, but I didn't know that at the time.

So I said, "I got to go open her." So doing it laparoscopically you got then up like

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that. We put them down flat, turn her back. Prep her abdomen -- or just make an incision in her abdomen. Making an incision in the abdomen, I did transect the ventriculoperitoneal shunt. They had brought it down over here and I knew it came in there, but I didn't know it crossed. They crossed it to get away from the PEG tube.

So I cut it and one of these, "oh, crap" moments. "What do I do now?" So I called Mike Cowan. He said, "That's no problem. It happens all the time. There's a shunt repair kit in the back." It has a little silver piece. Put that together, and that functioned fine.

Explored her. Saw a dead gallbladder. Saw again big inflammatory mass in her paracolon.

So they keep talking somehow trocar injuries in this case. There is no trocar injury in this patient whatsoever. None. I don't know where they get that from.

The material I saw leaking was out of the gallbladder. There was a big inflammatory mass in her colon. I did the right colon. Her pathology does not show any perforation. Does show an inflammatory mass in the colon, mucosa intact. They read a questionable perforation. She

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recovered fine. No sequelae other than she was back -- well, back -- she was back to her baseline state of bad health. I mean, I can't get any -- make her any better.

And she had to keep her PEG tube. That's all she wanted out and I wasn't taking that out. So --

MR. McKAY: Any questions about that patient?

DR. SIMPSON: Tell me again, Bob, about the -- the reviewer said they thought there was a bowel perforation.

THE WITNESS: Yeah, well, she -- she keeps bringing up trocar injuries, and I don't know where they're getting that from. She asked Dr. Tribble that, and I don't know where that's coming from.

MS. KREBS: May I?

THE WITNESS: Sure.

MS. KREBS: Page -- this is P[redacted], and it's pages 19 through 22 in the electronic --

THE WITNESS: Tell me -- or give me a note -- operative --

MS. KREBS: It's the --

THE WITNESS: In the operative note

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you're talking about?

MS. KREBS: Yeah, the op note from --

THE WITNESS: Okay.

MS. KREBS: -- from --

THE WITNESS: Okay.

DR. SIMPSON: Page 19?

MS. KREBS: Yeah, page 19. It starts on page 19 on the electronic note.

THE WITNESS: Okay. And what have you got?

MS. KREBS: If you go to page three of the op note --

THE WITNESS: Page what?

MS. KREBS: There are three -- there are three -- three different paragraphs that we're looking at, and I can give you all three of them.

THE WITNESS: Okay.

MS. KREBS: On page two of the op note --

THE WITNESS: Okay.

MS. KREBS: -- starting with this last -- last sentence of the -- of the first -- of the continuation of the former paragraph, "On taking structure adherent -- on taking down structure adherent it became apparent that this was

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either -- that the gallbladder was spilling contaminated bile or possible enteric content was present. Immediately we made the decision to proceed to open cholecystectomy."

THE WITNESS: Okay.

MS. KREBS: Go to the -- the last sentence in the next paragraph. "I write inspection it was evident that what had been entered was a portion of the right colon which was very densely adherent due to the huge necrotic and inflamed gallbladder. A decision was made to proceed with colectomy."

THE WITNESS: Well, that's not gross, but you could look at the pathology report done by Dr. Hart, and there is no mention of any injury to the --

MS. KREBS: You just asked me what we were looking at.

And then -- and then on page three, the first full sentence starting at the top, "A point was selected on the transverse colon to the left side of the perforation and this was cleaned of gastric colon omentum as well as --"

THE WITNESS: Right.

MS. KREBS: "-- mesenteric. These were

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resections --"

THE WITNESS: Oh, but that doesn't mean it's there, but it's something that's -- I've got a big inflammatory mass. I've got this thing --

MS. KREBS: You asked me what Dr. Skudder was relying on.

THE WITNESS: He called it a trocar injury. That's a whole different world.

MS. KREBS: Okay.

THE WITNESS: That's not the same thing. That's a -- that's a major difference.

DR. SIMPSON: Well, let's talk about that, Bob. Explain it to us --

THE WITNESS: Yeah, trocar injury is in entering the abdomen you literally puncture the bowel with the trocar. That's not anywhere stated in that. They made a point of taking this down. It's this big inflammatory mass. And it may have been a bowel, may not, so I took it out.

DR. SIMPSON: So -- but the -- your op note said you were into the bowel, so just explain to us how you got into the bowel. What -- what --

THE WITNESS: Well, I think I was in the bowel. See, you'd have to see one of these

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things to see what it's like. It's this big inflammatory mass. You've got a gallbladder stuck on it. A lot of times -- not a lot of times, but occasionally you even have the gallbladder stone will erode directly into the bowel, and it's adhering up into there.

So I've got this dead gallbladder. I've got this big hard mass stuck on to there. I take this down. I've got this big hard mass. I've got a dead gallbladder, and the safest thing to me is to get it out -- to get it out, which I did.

And it's tough out there in some of these things. I mean, it's just not -- it's not like it's in a book.

DR. SIMPSON: I'm a surgeon. I understand.

THE WITNESS: Yeah. But I'm saying --

DR. SIMPSON: I'm trying to find what they're seeing --

THE WITNESS: It's a very important -- a very important point to me about a trocar injury, a trocar injury, you take -- you're taking a trocar which is -- well, some are six, some are eight inches long. And it -- you're placing it in there, and we always place those -- you're looking

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directly from that -- where that's going in with your camera. You're seeing where it goes in. You're seeing there's no bowel. And I didn't put any trocar into any bowel.

DR. SIMPSON: So you're saying that probably the injury came -- or the injury -- when it was -- when you were dissecting --

THE WITNESS: Dissecting it away --

DR. SIMPSON: -- it away from that --

THE WITNESS: -- it's just -- I saw --

DR. SIMPSON: -- and you treated it?

THE WITNESS: Correct.

DR. SIMPSON: All right. In the -- and if you can show in here where the complaint -- or the reviewer's concerns were. I'd like to sort of match the viewer's concerns with what Bob's response is --

THE WITNESS: Yeah.

DR. SIMPSON: -- and what the thought of the MEC was and seeing this -- let's see. Bob just brought up a point, and one of the things that I've heard was -- we're looking at is recurrent trocar injuries which --

THE WITNESS: Right.

DR. SIMPSON: -- tells of -- you know,

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either sloppy --

THE WITNESS: Correct.

DR. SIMPSON: -- or improper technique, and -- and obviously Bob has got a different view on this.

I want to see if -- if they read -- just like -- just like when you asked Dr. Tribble if he had seen all of these -- you know, the whole chart. He had not. He had only seen parts of it. So I want to get a view if maybe these reviewers only saw parts of this and made that assumption that has got a more -- you know, a reasonable explanation or not. And -- and I'm looking for patterns here and seeing if we get the same patterns that the MEC got --

THE WITNESS: And if there was a trocar injury, you got a big hole in the bowel. That's not in the pathology report, so where -- where did it come from? It's not in the pathology report. There's not even a hole listed in the pathology report.

DR. SIMPSON: And just in the -- the complaint on this one was that the dissection was carried to the -- to the -- I believe to the colon and with the colon resection versus -- versus just

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taking out the gallbladder.

THE WITNESS: Correct. Correct.

DR. SIMPSON: It says in the course of performing the laparoscopic cholecystectomy, you excised -- exercised substandard judgment in further dissecting previously operated upon bowel in the lower -- right lower quadrant?

MR. McKAY: No, that is a different case.

THE WITNESS: No, that -- that's a different case. That's Mr. C[redacted]. That's Mr. C[redacted].

DR. SIMPSON: Okay.

THE WITNESS: This is J[redacted] P[redacted] which --

DR. SIMPSON: Okay, JP. All right.

So in the course of the laparoscopic cholecystectomy encountered inflammatory mass that by your description made identification -- you persisted in lap -- now, it says, "Yet you persisted in laparoscopic dissection converting to open only after observing spillage of either bile or feculent matter."

THE WITNESS: I mean, the -- I -- you can look at the op note. It's maybe 15 minutes, if

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that. I don't know it's persistent. You take the stuff down. You got something. I don't know what that is. Let's go open. That's a real common reason to go open.

DR. SIMPSON: It says you resolved the uncertainty by resecting both the gallbladder and the colon characterizing the latter as necrotic, though the pathologic examination does not support the conclusion.

So tell us exactly again what you saw, Bob, so we know at that point why you resected that --

THE WITNESS: Right, I've got --

DR. SIMPSON: -- part of the colon. That's all I want to know.

THE WITNESS: Right. I've got a dead gallbladdor. I've got a hard inflammatory mass about like my fist up on the -- right at the hepatic flexor just -- just -- just approximately -- which also was seen on the pathology part. There's a large inflameatory mass there.

All right. I've got this large inflammatory mass. Is there a hole in this colon -- if I'd have had a problem in that colon

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and left it behind, that's when you're going to get problems.

DR. SIMPSON: Right.

THE WITNESS: You can take a right colon out of somebody and they continue -- it's not something you're going to be exactly missing. You leave a hole in the colon and you're going to have a big problem. So I felt that was the safest, best thing for this patient who was not a lady you could talk to you, not a lady who could say that -- that she's hurting. That's part of why she's gotten so sick.

DR. SIMPSON: That's all the questions I have on that.

I am certain that -- I don't know if it's going to be any good to let you do this now. I think probably let Bob and his attorney do all her stuff and then if you could make notes and come back and explain, you know, the MEC's position on some of this because we obviously want to get both sides.

MS. KREBS: If I could just make a note for the record just so it doesn't get lost. The -- the first reviewer's report is Exhibit 28. And then -- and then there was Dr. Skudder's testimony

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from --

DR. SIMPSON: Right.

MS. KREBS: -- yesterday.

DR. SIMPSON: Okay.

DR. RICHTER: Can I just ask just one real brief --

THE WITNESS: Sure.

DR. RICHTER: -- question? In here -- in reading your -- your note, you -- I think some -- I can see where there might have been some -- go back to like page 21 I think.

THE WITNESS: You're -- you're in the operative note now?

DR. RICHTER: Yeah, in the operative note --

THE WITNESS: Okay.

DR. RICHTER: -- on the second page. You made note of a perforation.

THE WITNESS: Right. Well, that's -- I called it because I didn't --

DR. RICHTER: Tell me what you meant by that in the operative note.

THE WITNESS: I've got a -- I've got this big inflammatory mass. I don't know whether she's got it -- as I say, you can get the

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gallbladder to erode into the valve. I don't know what it's got on this thing. I've got a big inflammatory mass. I assume it's from a hole in the colon. So I'm guessing that's a perforation, but it's either from a cholecystenteric fistula or just from the thing just eroding into it.

DR. RICHTER: Now, did -- did the pathologist find that perforation or did it not --

THE WITNESS: There's no perforation. There's no per --

DR. RICHTER: There's not -- there's no perforation?

THE WITNESS: There was a big inflammatory mass, no perforation --

DR. RICHTER: On the --

THE WITNESS: -- on the path --

DR. RICHTER: -- on the pathologic specimen there was no perforation --

THE WITNESS: Right. There was a question -- a questionable perforation, but not -- if I can find it here.

MR. McKAY: I think it does say it's questionable.

THE WITNESS: Yeah, it says questionable. Questionable perforation. But

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documents a large inflammatory mass.
DR. RICHTER: And -- and I guess just for clarification for me, knowing what goes on in the OR, a perforation can be from a trocar, but it also can be from the fact that you've got a blowout perforation. A perforation just means that there's a --
THE WITNESS: Right.
DR. RICHTER: -- that the wall of the bowel is -- is open.
THE WITNESS: Well, it --
DR. RICHTER: So it can come open from the inside out or from the outside in. It doesn't necessarily mean that something had caused a perforation from the outside.
MR. McKAY: This area was removed anyway.
THE WITNESS: Correct. That --
MR. McKAY: So it was --
THE WITNESS: -- that was again what -- I viewed this as an abnormal area of the colon. I don't think it's safe to leave, so I took it out.
DR. SIMPSON: Let me read this section out of the reviewer's note, because, again, you know, what I heard yesterday was recurrent trocar

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injuries.
THE WITNESS: Right. And I --
DR. SIMPSON: Okay. And I think that's part of the crux we have to look at.
He says here, "As the surgeon described in his operative note, the peritoneum posterior sheath was then entered through the upper midline trocar site and Balfour retractor placed. At that moment he realized that what had been entered was a portion of the colon, which was densely adherent to this necrotic gallbladder. Because of this injury, he performed a right colectomy."
Is that a true statement?
THE WITNESS: No. I have no idea where that comes from. That's what I said. There's a lot of this stuff from these reviewers I have no idea where they got some of the stuff they got. If they can show that to me in the operative note, I'll be happy to -- to, you know, acquiesce to it. But it's not in my operative note, and my operative note is done right as I finish that case. I mean, I -- and he's seeing this months later or whatever.
DR. THOMAS: Bob, your operative note describes the perforation in the right colon; is that --

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THE WITNESS: Correct.
DR. THOMAS: -- correct?
Is it your contention or thought that that was contiguous with this inflammatory mass --
THE WITNESS: Oh, yeah, yeah. That's --
DR. THOMAS: -- of the gallbladder?
THE WITNESS: -- that's all that this is. This is -- there's -- it's just a -- this is just this big mass. I'm taking this down. When it's real stuck on like that, I may be into the colon. I've got this bowel. It may be a cholecystenteric fistula. I don't know what this thing -- I know I've got a big hard mass. I know I got a dead gallbladder. I think the safest thing to do is get that gallbladder and get that colon.
DR. THOMAS: Is that anatomically in the location where the trocar would have been?
THE WITNESS: There's no trocar injury. The trocar -- the trocar --
DR. THOMAS: It's not where the trocar would have gone in?
THE WITNESS: No.
DR. THOMAS: Okay.
THE WITNESS: No, there's not -- the --

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you tro -- one here, there's one here, there's one here, and there's one here. And there -- that's -- this is up there, where --
DR. POWELL: So the pathology showed what now?
THE WITNESS: The pathology does not show anything consistent with any bowel injury. It says a questionable perforation. It shows a large inflammatory mass. It shows a dead gallbladder, a necrotic gallbladder.
DR. POWELL: So you've kind of got a -- a wad of stuff --
THE WITNESS: Right.
DR. POWELL: -- that you don't -- you don't really know what's --
THE WITNESS: Correct.
DR. POWELL: -- wall and what's --
THE WITNESS: Right.
DR. POWELL: -- peritoneum and what's --
THE WITNESS: What's gallbladder, what's colon, what's --
DR. POWELL: And if you enter on that side of it, you're okay and you come a little --
THE WITNESS: Right.

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DR. POWELL: -- more --
THE WITNESS: I'm -- that's what I'm worried -- I come down. I've gotten in the bowel. Maybe I have. Maybe it's a perforation. I don't know what I've got. I think it's safest to get it out.
DR. POWELL: What did it mean about "He placed the retractor into the bowel"?
THE WITNESS: I don't understand that either.
DR. POWELL: What is that -- where is that -- "Balfour retractor was placed. On inspection it was evident that he then entered a portion of the right colon." That seems like a semantic thing. I mean, once you got retraction you realized, what was wrong --
THE WITNESS: Right. I'm seeing the retractor. I'm seeing a mass. The Balfour has got nothing to do with it.
DR. POWELL: Yeah, "placed the retractor into the bowel," I don't know where that came from. Of course there's no -- Balfour retractor has a -- what, is about this big on the --
THE WITNESS: Well, it depends on

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whether you've got deep ones. Mine is usually -- it's about that wide.
DR. POWELL: So to place on the bowel, you have a clear -- or something larger than a trocar hole, wouldn't you?
THE WITNESS: Oh, yeah.
DR. POWELL: I mean, that's -- I don't know what that --
THE WITNESS: I don't know what -- I never knew what some of these reviewers were coming up with. I -- that's what I -- and I never got a chance to talk to anybody about it.
DR. THOMAS: And, Bob, the trocar -- and what's the diameter roughly of the trocar?
THE WITNESS: Oh, they're -- these are -- well, the one that goes here is ten millimeters, and the ones that are here and here are five millimeters.
DR. THOMAS: You -- you perforated the -- as far as I -- it's possible you may miss a perforation, and sometimes a surgeon will put a suture just -- just as a point to make sure you identify or report a perforation. So it may be possible that that was in fact there but not seen. But if it were a centimeter --

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THE WITNESS: Yeah, if I would have put a centimeter, you would have seen it -- that's the only one that would have gone in. But that's the one they'd have to be talking about, the first trocar which goes up here. The other two were down off to the side. And that -- these are five millimeter ports, so --
DR. SIMPSON: Were there any other specific points that the witness last night brought up about this particular case that you got right there?
MS. KREBS: I have -- I have my written notes which I'm glad to submit --
DR. SIMPSON: Okay.
MS. KREBS: -- to the panel.
DR. SIMPSON: The point --
MS. KREBS: These are from -- from Dr. Skudder.
DR. SIMPSON: Of course I've been on Med Exec too. You know, not being general surgeons we're going by these outside reviewers --
THE WITNESS: Right.
DR. SIMPSON: -- that's what we've got to go with. So, you know, this is your chance to rebut it, and I want to make sure that we see the

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thought process and, you know, I -- the Med Exec has got to go on what these reviewers say too. They got to look at it. I don't know about the rest of the panel, but I certainly want to see what the specifics are.
THE WITNESS: I welcome questions and discussions. I had zero questions, zero discussions when this was brought up before. None. There was never a single question asked of me.
It was real apparent when I went there they made up our minds before I got there. It didn't matter what I said. And they were believing these outside guys, and I don't -- you know, some of these things outside guys say -- looking at some of them, they've got valid points. Like I said, on Clark I messed up. I missed the bowel injury. I don't dispute that.
DR. POWELL: Bob, on -- talking about the right colectomy --
THE WITNESS: Uh-huh.
DR. POWELL: -- if you've got a bad gallbladder and a wadded up colon stuck to it, I mean, is it likely you have to take that out anyway? I mean, I know it was removed, but --
THE WITNESS: Well, I mean, I've done

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probably 2,000 lap gallbladders. This is the one and only one I've had do a right colon in conjunction with -- for nonmalignant disease, but --

DR. POWELL: Well, the reason for the removal was because of the -- it looked -- it was adherent --

THE WITNESS: It's adherent. It's got a big inflammatory mass. She had been sick a couple weeks. That's part of why this goes on for so long because she couldn't tell anybody.

DR. POWELL: You can easily perforate a friable --

THE WITNESS: Oh, yeah, that's what I was concerned about --

DR. POWELL: -- colon.

THE WITNESS: -- that I've taken it down, that I've got into it. That's what I'm talking about the perforation. I may be -- and I may be into it, so --

DR. POWELL: The reviewer says because of this injury you performed a right colectomy?.

THE WITNESS: Again, there was no trocar injury. None.

DR. SIMPSON: Let's --

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BY MR. McKAY:

Q. Bob, I think what -- what --

A. Oh.

Q. -- the reviewer is saying -- listen, to this.

A. Okay.

Q. "It's because you injured it, you had to take the right --"

A. Oh.

Q. "-- bowel out."

DR. POWELL: Right.

BY MR. McKAY:

Q. Is that why you took the bowel out or is it because of these other --

A. Because I had a concern about it being injured. I've got a big inflammatory mass. The worst thing I can do if it does have a hole in it is leave it.

DR. POWELL: Right. Right.

THE WITNESS: That's the worst thing you could do.

DR. POWELL: It doesn't sound like you put the Balfour into the bowel.

THE WITNESS: No, I didn't put a Balfour into the bowel. I didn't put a trocar into

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the bowel.

DR. SIMPSON: I guess on this case again they're saying that --

THE WITNESS: The same -- you're still talking about the same case?

DR. SIMPSON: Yeah, the same case. I'm sorry.

They -- they're saying here that you didn't convert early enough --

THE WITNESS: I mean, if you look --

DR. SIMPSON: -- and -- and that was the reason that -- I'm assuming they're saying, as I read this, that you didn't convert and open early enough and that was the reason the bowel was injured. And that's the -- the whole -- sort of the crux of this. Is that what you --

DR. POWELL: Yeah, that's what it sounds like.

THE WITNESS: Well, I'm not sure because they say I didn't convert to open. I mean, it doesn't take -- it doesn't take long -- you got a pretty good idea whether you can get one of these out laparoscopically or not real fast.

DR. SIMPSON: Okay. But the point is you did convert to an open case?

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THE WITNESS: Correct.

DR. SIMPSON: Okay. Let's go on to the next one.

MR. McKAY: Yeah, D[redacted] S[redacted], y'all have heard a lot about that one.

BY MR. McKAY:

Q. I assume through the --

A. No, she was actually a referral from the gastroenterologist.

Q. Okay. She -- her stomach was all messed up and put up in her chest and --

A. Correct.

Q. -- and had multiple problems, multiple mental problems, physical disabilities.

What happened to D[redacted] S[redacted]?

A. Okay.

Q. I mean, the records are --

A. Yeah, that would be --

Q. -- five, 10,000 pages.

A. It went on forever.

D[redacted] S[redacted], again, a 27-year-old very unfortunate lady. She's a twin and her twin is -- is normal. She had profound birth injuries. Profoundly retarded. Diagnosed with schizophrenia. I don't -- I mean, I -- that preexisted me. I

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don't know whether she is or isn't because I don't know how you can diagnose that in her.

Never ambulatory. It's multiple -- just imagine -- you know, and I mean take care of nursing home or injured -- well, she's got multiple flexion contractures, can't eat, is in a group home and vomits everything she eats. Sees -- is sent to Brett Garretson who can't do much, I mean, can't scope her, can't do much of anything, but gets an upper GI series that shows she's got complete atlantoaxial rotation, which her stomach is flipped upside down and is in her chest. So that's not a good place for it, and she can't eat. So unfortunately she's got to go to the operating room to have that repaired. She's not anything great to operate on, but there's no way I could make her any better.

So I took her to the operating room. Did start it laparoscopically, but didn't think I would be able to do it because doing it laparoscopically you got to get between their legs and get -- you just couldn't do it on her, so I said the heck with this and went open and had a pretty uneventful repair bringing the stomach out of the chest into the abdomen. Did a Nissen which

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is where you wrap a portion of the stomach to stop reflux and to stop it from going back up and close the diaphragmatic defect. Seemed to do well.

The reviewer and Dr. Skudder said that a gastrostomy tube is the standard of care, it should be placed, and it's not. Some people place them. Most people actually don't place them now. It's an older thing. I did not put one in her, though, and wished later that I had because normally in these people you do motility studies, you do a lot of things preoperatively to evaluate them to see how their stomach empties. But we couldn't do that in her because you have to cooperate. You have to have a patient you can -- it was impossible.

So she had no motility studies before. It turned out she had a motility problem in her stomach. So after a period of time being able to feed her, the reviewer asked why didn't she have a PEG tube placed. I asked the gastroenterologist to do it, and they're not -- "We're not touching that lady. We're not going to do it." So I had to take her back surgically and place a gastrostomy tube.

Well, with that we still -- you're hoping her stomach decompresses and gets better and

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empties. It didn't. So we got a period of time we still can't feed her, so placed a jejunostomy tube in her surgically that got along fine, functioning fine and hoping to get her back to her -- her group home.

Well, at some period of time in there she pulls it out but doesn't pull it completely out of that. Now, this thing is sewn to her skin. It's sewn to the abdominal wall inside. It's sewn to her bowel, and her bowel is sewn up to the abdominal wall which she pulls it. We know she does. Later on she -- she's found later with a gastrostomy tube in her hand. Later -- I mean, she -- she would pull every tube and line out that -- it was pulled out partially but not completely. And we missed.

It went on for some period of days. Chris had her over the weekend and didn't catch it. And I had her like a Monday and didn't catch there was a problem with it. And we get to like Tuesday and I said, "This isn't right." So I get the study that -- we inject contrast through it and it shows it's not -- it's not out of her abdomen. It's not her bowel, though. And the contrast pools. There's a pocket that's sort of like walled off and

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collecting stuff.

So this is about six o'clock when I get this report called to me. I go up and I've got progress notes and things. We see her about 6:20. She's tachycardic. We've been presuming she's been getting fluid in there for the last several days, but she's not, because it's been going into her abdomen. I know it's not -- I mean, this is not a new problem. It's been going on a couple days. She's tachycardic.

So I got the cardiologist -- I have to go back in my notes. One of the cardiologists sees her that evening, rehydrate her. There's also a problem in trying to find her father, her family -- separated mother and father and there's a real problem trying to find somebody with her. We finally get permission, rehydrate her and took her back the next day to the operating room where we find the tube is displaced.

And we placed it into the -- I put it back in the same place. One of the reviewers says I shouldn't have done that, and I'm not sure why. You know, I put it back -- rather than make another hole, I put it back the same place it was. That tube forever after that functioned fine. It still

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functions to this day.
She did have a bunch of abscesses. Because of that, there was planned multiple operation -- we took -- she's the one that I probably took her back ten, 15 times at least to the operating room to wash her out, to -- again, she had a wound VAC. We have a big plastic sheet you're putting all around the open abdomen.
Again, I've had two open abdomens in the 28 years I'm here and they were all -- both in this same period of time.
So she had multiple planned returns to the operating room to wash it out and treat that, and ultimately it granulated in and ultimately got a skin graft and ultimately she got back to the group care, group home. Still fed by a feeding tube, a jejunostomy tube.
I don't know what I could have done to keep her from pulling the tube. We could have recognized it was out earlier. I -- Chris missed it. I missed it.
Yeah, we maybe could have taken her to the operating room a little earlier, but she was dehydrated. She was behind. She was tachycardic. We did -- she saw Patel. So, anyway, we spent a

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period of time rehydrating her and returned her the next day.
DR. SIMPSON: This case was a lawsuit. What was the complaint on that? Why did they sue you on that one? Do you remember the complaint?
MR. McKAY: The S[redacted] lawsuit?
DR. SIMPSON: Yeah.
MR. McKAY: Well, they've sued the hospital for the nurses not properly watching after the patient and notifying people. They've sued -- they've sued a batch of people. They sued Dr. Randall --
THE WITNESS: Yeah.
MR. McKAY: -- and sued his practice. It's the McGowan, Hood firm. I'm sure y'all are familiar with them.
DR. SIMPSON: Oh, yeah.
MR. McKAY: They'll get the business.
THE WITNESS: And the suit is in -- for lack -- I guess the lack of attention to the tube being dislodged and lack of timeliness in repair for my part of it.
DR. SIMPSON: Let me go through this one a little bit. And, again, I think it's going to be important for us to go through these peer

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reviewer outside reviews because this is what the Med Exec Committee had to use --
THE WITNESS: Uh-huh.
DR. SIMPSON: -- had to go on. And so I think we need to give adequate, you know, time to you to rebut these, and also I want to look and see what Dr. Skudder said again on some of these.
And the first thing on this one, you know, one of the major I guess processes that could have been -- I guess it could have been looked at -- or you should have taken her to surgery sooner because of the paraesophageal hernia.
THE WITNESS: That was interesting too. He says one thing. Skudder says something else.
DR. SIMPSON: Yeah, I want to make that point. Skudder said that he -- he disagreed with that --
THE WITNESS: Yeah.
DR. SIMPSON: -- so -- and as we go through these reviewers, let's look at the points that have good points on it and the bad points.
MR. McKAY: They disagreed on that position.
DR. SIMPSON: Right. The J tube placement again, to the extent -- so tell us -- you

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said that's really standard of care, but that's --
THE WITNESS: Gastrostomy tube.
DR. SIMPSON: Yeah, the gastrostomy tube.
THE WITNESS: No, that's not standard of care to place -- to do a Nissen or a paraesophageal repair and -- I mean, that's surgeon preference. Some people do. Most people don't. Particularly laparoscopically you're not putting them in now. So most people do not have one now.
Yeah, in retrospect I wish I'd have put one in. I have great retrospect, but not --
DR. SIMPSON: Why do you say that in retrospect --
THE WITNESS: Because I had to go put one in surgically later.
DR. SIMPSON: I guess I thought that it would -- you know, going back to what Dr. Skudder said, the thought behind it putting that in to hold it down, would that really -- he said that wouldn't have made any difference --
THE WITNESS: That stomach --
DR. SIMPSON: -- didn't make any difference in this case and --
THE WITNESS: Her stomach -- no, her

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stomach is where it's supposed to be. That's never been an issue. Her stomach is repaired properly and function -- it's where God put it.

DR. SIMPSON: So you're saying that there is not really a standard of care to --

THE WITNESS: No.

DR. SIMPSON: -- place it --

THE WITNESS: That's right.

DR. SIMPSON: -- a procedure -- (multiple speakers) --

THE WITNESS: That's not and most people do not put one.

DR. SIMPSON: Okay. So I would -- it seems to me that the major point that came about on this was the J tube coming out and getting the peritoneal infection --

THE WITNESS: And I agree. She --

DR. SIMPSON: -- (multiple speakers).

THE WITNESS: And I agree that's --

COURT REPORTER: I can only get one of you guys at a time. I'm sorry.

THE WITNESS: I'm sorry. Okay. I'm sorry. I shouldn't have jumped in on him.

I agree we should have caught it earlier, plus or minus about operating. I think

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the question -- we should have caught it earlier than what we did because the period of time -- I think it's out 36 -- I think it's out some period of time before we figure it out. But unfortunately it didn't come out of the abdomen -- totally out. It came out of her bowel.

DR. SIMPSON: But the main point that everybody's making, even Dr. Tribble, was that she should have been operated on in probably eight hours?

THE WITNESS: Yeah, I mean, I -- I can -- I can -- granted should have operated sooner, but it's 6:20 when I'm seeing her. We're getting her hydrated, and we're trying to find the family. By that time it's 2:00 in the morning kind of thing, and, yeah, I guess I should have gone at 2:00 in -- 2:00 in the morning.

But, you know, I could agree that that probably should have happened.

DR. SIMPSON: Okay.

THE WITNESS: Like I say, there -- there are things I've screwed up in this thing. I don't say everything is perfect here by any means.

BY MR. McKAY:

Q. You make a judgment call --

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A. Right.

Q. -- you know, about two o'clock in the morning here --

A. I mean, that made no -- I guarantee that made no difference in her outcome.

DR. SIMPSON: That's all I've got on that case.

MR. McKAY: Let's see what's the next one --

DR. THOMAS: One question. Bob, as far as the delay perhaps in recognizing, can you go through some of the signs that you normally recognize peritonitis as a complication --

THE WITNESS: Well, they don't get any peritonitis -- you don't have any signs with her because normally people will tell you, "That hurts," or, "I'm having pain," or something. You've got nothing with her. She -- she's nonverbal -- well, she can say a few words. She can say eat. Her -- I mean, but she couldn't tell you that she hurts. The thing that you normally get is "I hurt. That hurts me. This is hurting. I'm sore."

Her white count was up and down a little bit. But -- well, that was what finally did

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it. Her white count went up. She got febrile. He didn't get that till -- till that day when we do the study. We didn't have either of those.

The first thing we get is, "It hurts." But unfortunately with this patient she couldn't tell else us that. She just can't talk, or not -- not meaningful. I mean, she makes a few words.

DR. RICHTER: Could this have been -- could this have been picked up by an actual examination of the -- of the abdomen during the weekend?

THE WITNESS: Well, we were -- I -- I -- Chris --

DR. RICHTER: Is it still bandaged up --

THE WITNESS: No, you could push on her abdomen, but she wouldn't respond. I mean, she doesn't -- if you push on it, they have to grimace or say it hurt.

DR. RICHTER: So she didn't have any -- any peritoneal signs that you --

THE WITNESS: Not that she elicited. I mean, she's sitting there, oh -- even at the time the tube's out, I mean, she's -- at that point she's got it when she's got febrile and white count

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is up. That's what -- you know, unfortunately you have to see her to see just how profoundly retarded or whatever -- whatever term you want to use she is.

MR. McKAY: I think in the D[redacted] S[redacted] case it's really important to keep in mind that this is a patient who has got contractures, has never moved, has always been bedridden, profound -- can't communicate, and pulled -- apparently pulled -- well, we don't know how the tube got out.

THE WITNESS: Right.

MR. McKAY: The tube was properly placed. Was it -- was it moved by a nurse or someone tran -- transferring her? Did she pull it out herself? We -- we know she pulled other tubes out. We don't know. This is not a physician-caused injury.

The question is, Could the repair have been done earlier on that, and that's purely judgment. And it depends on the size of your hospital. You know, some of the hospitals I work for they got hot and cold water all the time, any type of specialist 24-7, I mean, like Carolina, or, you know, MUSC.

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But here you got to pull teams in. It's going to be a complicated surgery. You know, what -- I don't see what the -- that's a question you got to figure out. Does it make a difference to take her in at two o'clock in the morning instead of bring -- and bringing a group in or waiting till the next morning when all the surgical teams are there and the specialists were in the hospital.

And she was unstable. You're an anesthesiologist. Do you want to take a patient in surgery who is tachycardic, very dehydrated? You might want her a little more stable. I mean, these are all things that you look at the patient at the time, you know. These are decisions. It's a judgment call.

Sorry.

BY MR. McKAY:

Q. The next one is the W[redacted] case.

A. Okay.

Q. Is it S[redacted] W[redacted] or S[redacted] W[redacted], the homeless man?

A. That's W[redacted].

Q. I'm sorry, it's patient six.

A. Okay. S[redacted] -- all right. You're on

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S[redacted] W[redacted]?

Q. Yes.

A. Okay. Okay. Yeah.

All right. Well, he is a 45 -- yeah, 45 -- 45-year-old man who came in -- actually came in with the cardiology service complaining of severe upper mid to chest pain, but ultimately had a negative cardiac workup and they started really looking at him and his -- his pain was really more abdominal pain. So they got Steve Bott to see him who then gets a CT scan and shows multiple incarcerated ventral hernias.

His past history was pertinent that about two and a half years before this Corey had done an open gastric bypass on him that had had several subsequent ventral hernia repairs all done -- done open. He at that time apparently weighed like 440 pounds and was down to about 220 pounds.

He was on 20 milligrams of Prednisone daily for some side -- fibromyalgia, some -- it was never really clear to me why he was on it, but he was on 20 milligrams of Prednisone a day.

I note about a year -- a year before this he had had an abdominoplasty by Chris Crawford

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and following the abdominoplasty had severe abdominal wall infection that he almost died from but had recovered and now is back in, severe abdominal pain, obvious incarcerated ventral hernias.

Took him to the operating room and did a laparoscopic repair of multiple ventral hernias with -- you know, with incarcerated bowel and omentum that was reduced seemingly uneventful. He was, however, tachycardic in the recovery room, and his heart rate, 110, 115 without any real good reason why. So we put him in the intensive care unit just to kind of monitor him.

Checked the hemoglobin on him that night which is like 9.2 and it was 10.5 or something before. So that's not a significant change. That's pretty much what we see lots of times. However, the next morning his hemoglobin was 6.2. I said, "Well, he's got to be bleeding intraabdominally, and we got to the operating room to see if we can get some blood in him." So we urgently transfused him and took him directly to the operating room.

While they were prepping him, a nurse noticed on his trocar site in his left lower

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abdomen and said, "This stinks. This just smells like dead fish." I mean, it did. I looked at it, and he's got this big bluish discoloration all around the trocar site. So I start debriding it and he's got necrotizing fasciitis at the trocar site. It's confirmed later on pathology it -- fascial necrosis and pathology consistent with -- with necrotizing fasciitis.

What you wind up doing is cutting out everything. So he's got a big defect about, I don't know, 15 by 20 centimeters in his left lower abdomen debrided. All right. Well, that's got to have some explanation for it. It's got to be intraabdominal. So then I made a midline incision and explored his abdomen. He had no bowel injury. There was no -- there was a little bit of blood in his pelvis. There was no significant bleeding. There was no bowel injury at all. I said, "This doesn't make sense. There's got to be something going on."

So I extended the incision up superiorly. In extending it superiorly, his transverse colon was plastered up to the interior abdominal wall and he had a bunch of adhesions. So I'm having -- oh, I better take that down. I'm

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trying to take that down, and I made a -- about a end of your little finger hole in the transverse colon that I sewed up and closed.

DR. SIMPSON: That -- that was -- you did that while you were trying to dissect --

THE WITNESS: I did that in taking the bowel off --

DR. SIMPSON: And that's up in the transverse colon?

THE WITNESS: That's up here. That's up here.

DR. SIMPSON: Not down on the --

THE WITNESS: Not -- way away from the trocar site --

COURT REPORTER: You guys are doing it again.

THE WITNESS: I'm sorry.

COURT REPORTER: I can't get --

THE WITNESS: Okay. I'm sorry. Let him go and then I'll go.

DR. SIMPSON: Okay. Ask the question, so that -- the small hole was made in the transverse colon which was well above the site where the trocar --

THE WITNESS: That --

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DR. SIMPSON: -- infection in the fasciitis was made?

THE WITNESS: Correct. That hole was made by me with Metzenbaum scissors taking it off the anterior abdominal wall using sharp dissection, because you've got -- you got to do that. You got to cut and cut and you got into it. And I noticed when I got into it and I closed -- otherwise no injury was -- was noted.

Closed his abdomen with multiple interrupted Prolene sutures, and we got along all right until -- I don't remember the exact timing of it. A week later, some period of time later he's getting fascial necrosis which happens sometimes when you pull all these -- because he's a big fat guy still and you pull him together with tension.

If those stitches start pulling out -- I got Prolene stitches bridging across, and I got -- now, do I take those out? Because if I take it out, he's going to pop open and I got an open abdomen or delete them. I left them which turned out to be a bad thing to do because as his colon distended up, it just -- the Prolene cut right around the area -- pretty close to where the repair was but just cut his colon.

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So then I took him back to the operating room and resected that and brought out a colostomy and a mucous fistula. One reviewer said I shouldn't have taken him to the operating room. I don't know how you can just leave an open colon sitting in a middle of a wound pouring out stool. That's -- that's generally not -- not the preferred thing to do.

So, anyway, that got along. He had a -- now an open abdomen that was debrided. He was the one we were taking back regularly to the operating and debriding. And I actually closed him using a material called Stretta. And he's closed, but he's got a wound VAC over where we've got him closed. And he can go home except he's homeless. He lives out of the back of his car. He's got nowhere to go.

This surgery is March. He's -- this is now two months later, two months where we've done nothing to him other than wound VAC changes which are now up on the floor. He's feeding. He's walking around. He's eating regular food. But he's getting heparin flushes because he's got to keep an IV. This was the unit he's on. With the heparin flushes he got heparin-induced

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thrombocytopenia. His platelet count got down as low as 6,000. Got -- I forgot.

One of your associates -- you didn't see him, but one of your associates sees him and documents what we've got. And also documents starting to look septic. So I start looking, take down part of the Stretta. I said at that point a piece of bowel comes up that's necrotic and it's dead because he's thrombosed a portion of his small bowel mesentery from the heparin-induced thrombocytopenia.

So we -- we're two months after I've touched him surgically. Took him back to the operating room and now it's a real mess and resected it. Got all right from that. Then ultimately he got fistulas. He went down to Charleston where they resected the fistulas. He then got other fistulas, and the last I knew they'd sent him to some group home or something with one or two fistulas out. He's alive and healthy but -- well, he's eating, but he's got a fistula.

Again, there was accusation of a trocar injury here. I don't know possibly where that comes from. There was no -- unless she's going to declare I was lying in that operative note, there

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was no injury to the bowel, but culture -- I don't know where -- I'd have to -- again, these volumes of records.

I don't know whether his cultures were that operation or the operation where his colon was injured. If the colon is injured, I know there were enteric organs and stuff.

For necrotizing fasciitis Dr. Skudder said there's Gram-positive organisms. That's incorrect. They're usually the fact that it's anaerobes. Now, anaerobe organisms will let all kinds of things come in. So that's typical of -- of necrotizing fasciitis is that you get multiple varied organisms. So it's consistent with that too.

No idea why he got it. And I think what happened, when I put this trocar in because of the way his abdominoplasty had been done, I think I might have hit his inferior upper gastric, made part of the muscle necrotic in that flap and it died. He had still bacteria -- I don't know. I don't know why he got it.

It is documented that it happens in people. I don't know why he got it. I don't know what I could have done about it. I don't know what

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I did to do it. He did get it and it was, you know, a series of events thereafter. But there was no trocar injury in this patient whatsoever.

DR. RICHTER: The only -- one of the questions I have is Dr. Tribble had mentioned that you can get trocar infections --

THE WITNESS: Uh-huh.

DR. RICHTER: -- that for -- or site infections that are not necessarily due to colonic perforation.

THE WITNESS: Correct. It's documented that you get necrotizing fasciitis out of all kinds of clean surgeries. And there's -- I could show you hundreds of cases of it. I mean, it's rare, but it happens. And --

DR. RICHTER: What could be the etiology of that?

THE WITNESS: Well, again, I think with him -- as I said, he had had abdominoplasty before and had a massive in -- he apparently died -- nearly died -- Chris -- Chris Crawford was telling me about that later, but he nearly died of this infection after his abdominoplasty.

I think what happened was -- in doing an abdominoplasty they move everything basically,

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and I think I hit his inferior upper gastric making that part of what's basically a flap necrotic. I'm guessing. That's the only thing I could ever put that together out of that because where he was infected was down here, down in -- right where the abdominoplasty is, right where the inferior upper gastric is if you move it after an abdominoplasty.

And he had known colonization from the surgery before and he's immunosuppressed on 20 milligrams of Prednisone per day. And he also was a diabetic, but --

DR. SIMPSON: The point of the Medical Exec Committee and Dr. Skudder made, Rob, was that the culture from that trocar wound was -- initially before you did any dissection or after your initial operation had fecal strains in it.

THE WITNESS: Well, I'm saying I don't know. As I say, there's so man -- I'd have to -- I'm not denying it. I don't know where -- whether that culture is that one or whether he's looking at a culture when I took him back for his colon injury which would -- would make sense. I don't know. I -- I have no evident bowel injury at that surgery.

DR. SIMPSON: If that was the culture,

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is there some other explanation other than a bowel injury during -- during the trocar that could have put --

THE WITNESS: We have some --

DR. SIMPSON: -- fecal material in there?

THE WITNESS: Sure. We have some reusable trocars. I don't know whether that was one that had been re -- you know, they were sending them off to be reprocessed and re-sterilized. I don't know whether that was one or not. I don't know. They quit -- I quit letting them give me reusable trocars after -- I mean, the re-sterilized trocars after that.

DR. SIMPSON: Is there any way you could think of that there could have been, you know, fecal bacteria that would have contaminated that particular site? I mean, we can probably check and see --

THE WITNESS: Well, I mean, he could get it from stool in his bed. He could -- you know, there's him touching stuff. I mean, there's all kinds of ways it could have happened. There's no way to say how it happened.

All I can say, there was no bowel

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injury. I did not see any injury to his bowel, and it doesn't show up any time -- the next injury we have to all his bowel is in his transverse colon from where it's cut down. If he had a bowel injury, I never repaired it. It never fistulized. If there's a trocar injury, where is the -- where is the evidence of it? Where is -- where is the fistula? Where is -- he's going to be -- he's going to show me something and that never happened.

DR. SIMPSON: That's a good point. Let me ask you a little bit about that.

So where that trocar -- where the fasciitis was, is that section of bowel still present?

THE WITNESS: Yeah. Yeah. He's never lost any bowel, at this time. He did later. At that time he had no bowel resected.

DR. SIMPSON: But when was that part of the bowel resected? How long --

THE WITNESS: That never was.

DR. SIMPSON: Never was?

THE WITNESS: Never was.

DR. SIMPSON: Okay.

THE WITNESS: That never -- he's still got it today.

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DR. SIMPSON: That's the point I was looking for.

THE WITNESS: Okay.

DR. SIMPSON: That was the key again, a trocar injury.

THE WITNESS: I wish they would --

DR. SIMPSON: What do you think on -- on --

DR. THOMAS: Is there any way to verify that culture that MEC counsel brought up last night to see where that source was taken from?

THE WITNESS: Where it was and when it was, I don't know. I mean, there -- so --

DR. THOMAS: That seems to be pretty important.

DR. RICHTER: Is it in part of the medical records that would --

MS. KREBS: I'm sorry, I don't have a patient. I'll provide it.

THE WITNESS: As I say, there's cultures I took then, cultures I took when I got his colon done later. I don't know what -- when that culture is.

But there's lots of ways you get wound -- or get fecal contamination. If he's got a

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trocar injury, when did -- how -- it never manifested itself. I don't -- it's never there.

DR. SIMPSON: That -- that's a key point. Particularly now. If that -- if there's a trocar injury at that site, it would have --

THE WITNESS: Oh, yeah.

DR. SIMPSON: -- somewhere that would have showed up.

THE WITNESS: Something somewhere.

DR. SIMPSON: I'm not a general surgeon. I know that.

THE WITNESS: I guarantee that would have been a hole -- that part is colon, and if you're going to say fecal material, that would have to be hole in his colon. You're not going to have somebody have a hole in their colon from a trocar that never shows clinical signs of that. It shows some wound drainage, something. And he's got none of that.

And if the culture comes out a second time, that's because they've got his colon transected.

DR. POWELL: Why are they talking about the blood clot from the pelvis and then over there they were talking about the first surgery describes

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it uneventful, nevertheless there was some kind of reason for hemorrhage?

THE WITNESS: Well --

DR. POWELL: Was that -- I mean --

THE WITNESS: -- the hemorrhage -- the blood loss comes from necrotizing fasciitis. That's -- that's where the -- as a sum -- that's why I say I explored him thinking that -- I thought he was going to have something bleeding in his abdomen. He had a clot, but it was this big. I mean, it was nothing -- it wasn't enough to explain going from a nine and a half -- 9.5 to six -- 6.7.

I mean, it -- it was not two liters of blood in his pelvis at all. It was just a small clot I kind of scooped up with one hand, because a lot of times you get a little blood from the trocar sites, some dissections or in this case taking down adhesions.

DR. POWELL: I got lost in the comment "It is not mentioned -- it is not mentioned that any needles were left behind." What --

THE WITNESS: I have no idea what they were talking about.

DR. POWELL: What was --

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THE WITNESS: I have no idea what that reviewer was talking about.

DR. POWELL: He's talking about routine practice in surgery, but I don't know what he's getting -- I don't understand --

THE WITNESS: I think they're just trying to -- I think they're trying to find some way to justify what they're saying. I have no idea what he's meaning.

DR. POWELL: I think they're talking about the Prolene suture.

So that's -- is that like a retention suture in the -- in the --

THE WITNESS: Well, those are -- those are actual fascial sutures. They're figure eights in -- in his fascia, and later on -- this happens when you're pulling big fat guys together in an area -- it's got the tension on it and necrosed and the sutures pulled apart -- well, they pull out -- the fascia pulls apart. The sutures are still there and still tight.

DR. POWELL: So cuts if as it --

THE WITNESS: As the bowel --

DR. POWELL: -- as it herniates through --

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THE WITNESS: Through -- the bowel pushed up against it.

I mean, I should have -- one of the things you're looking at and debating, do I cut those sutures and leave him with open abdomen or -- you know, and I didn't and one of them cut into his bowel. That's a week later or so. That's later. That's -- that's a surgery when his colon gets injured.

DR. SIMPSON: Is this the patient that had subsequent necrosis from his colostomy?

THE WITNESS: No.

DR. SIMPSON: Okay.

THE WITNESS: No. This was the guy I was talking about two months later he did thrombocytopenia with -- or heparin-induced thrombocytopenia. But these operations are March. That operation is in May.

DR. SIMPSON: Okay. Yeah, I see now.

DR. POWELL: This is the same guy that's on 20 of Prednisone a day --

THE WITNESS: Correct.

DR. POWELL: -- is that right?

THE WITNESS: Correct. All along he's on Solu-Cortef. There's -- he was kept on -- on

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steroid supplementation because he had chronically been on it so long. So he's on steroids all through this period of time.

DR. SIMPSON: Would it have been appropriate to stop the steroids or do anything different from that standpoint?

THE WITNESS: Well, I think -- I don't remember exactly whether we stopped it at some point. I mean, you know, we may have at some point. I don't recall exactly how they were -- I mean, he was on steroids -- you always have to -- you know about covering them when they go to the operating room, we always cover them and leave them on them because they've been on -- he'd been on it a long time.

DR. SIMPSON: I don't have any further questions on this particular case at this point.

THE WITNESS: Okay.

BY MR. McKAY:

Q. I guess -- [redacted] is the next one. That's the 31-year-old man.

A. Yeah.

DR. SIMPSON: Find that case.

THE WITNESS: Yeah, Mr. Milburn is a 34-year-old fellow who had had abdominal pains off

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and on for several months and got increasing pain, came to the emergency room I believe in early December of 2008 with fairly marked abdominal pain, white count of 20,000, right lower quadrant tenderness.

And I saw him and said he's got appendicitis. So we took him to the operating room and did an open appendectomy. He was a little harder than the average one because he was -- he was six-two, 230, and his appendix was about 13 centimeters long going -- which is a lot long -- it's probably twice the length of an average one, going down in the pelvis and stuck. So I had to make the incision a little bigger and that kind of thing and mobilize it up.

I did have -- pulling up a bleeder in the mesentery. And I put one stitch 3-0 silk suture in. And he had a gangrenous appendix that we took out. Inverted the stump with a pursestring suture and in typical fashion what's called a Z stitch which is another stitch over the top of it.

Kept him in the hospital a couple days afterwards, but the second day he's around walking, eating, wants to go home. Okay. He doesn't have any insurance, so he's wanting to get out of the

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hospital. So he goes home. That's Tuesday. He comes back to the hospital Friday evening saying he's having abdominal pain and vomiting.

At this time he's got a white count of like 20 -- I don't know exactly, 20,000 thereabouts. They get a CT scan on him that shows some questionable fluid, questionable blood in the pelvis. Chris Schroeder is on call for us and admits him. Sees him, admits him. Oh; also on the CT scan showed a transition point possible bowel obstruction. They put him in the hospital, put him on nasogastric suction. Gave him IV fluids and antibiotics. Per Chris's report he started to get better and he starts feeding him.

Well, Chris didn't tell me he was in the hospital. I didn't know this guy was back in the hospital because Chris does that sometimes. He just kind of takes over patients, and I guess he thought the guy was all right. And he -- he just didn't tell me. I did not know he was in the hospital. So he's now in the hospital.

Monday he's doing all right. Chris is feeding him. Tuesday he's up and around feeding him. He's got another x-ray that shows the bowel contrast has -- has progressed and there's no sign

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of obstruction. So he's eating, supposedly talking about letting him go home.

Well, that night this guy starts getting sick. Walter Revell's on call and they called Walter three times during the night, and Walter gives him orders by telephone -- he's getting sicker. About 4:30, 5:00 in the morning Walter told them to transfer him to the intensive care unit. They transfer him to the intensive care unit, and then on his arrival or transport -- I don't know because I'm just finding this out afterwards -- he arrested.

They put an endotracheal tube in him, get a postintubation film. He's got free air. So they call Dr. Revell. He's got free air. He says, "Well, call Schroeder." This is now about 6:00. So Chris hadn't cut his beeper on yet. So they call Revell back, and he says all right, comes and sees him and sees I operated on the guy and calls me.

So I come up to see him and I said, "Well, he's got to go to the operating room." This is the first time I've seen this guy -- well, this is now Wednesday -- from the Tuesday before, for eight days. First time I've laid on eyes on him.

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He's arrested. He's on a ventilator and he's in septic shock on Levophed and dopamine. As I say, he's got to go to the operating room.

So I took him to the operating room and opened his abdomen and it's just a foul smelling ness, multiple organs. He's got a dead omentum. His entire omentum is dead. His right colon in the area of the appendix has got an air leakage around his stump where -- which was the etiology of where this all began.

And I took out the omentum. I took out his right colon. And that went along uneventfully, but he goes in the intensive care unit. So all through this period of time he's been on Levophed and dopamine. He goes through a septic period of time and in the next -- the next -- well, within 24 hours he dies.

Now, at autopsy -- actually Rob Thomas did his autopsy. He was found to have severe coronary artery disease. He has got 90, 95 percent occlusion of all three vessels with the primary cause of death being sepsis and -- and myocardial ischemia.

In this patient I think he did have a appendiceal stump leak. It is something that --

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that happens. Normally you don't get these kind of events. I think it -- you know, I can't talk much about what went on during the -- the time when he comes back in the hospital because I never saw him. I didn't know he was in the hospital.

Dr. Skudder somehow thinks that I could have ligated the right colon or right colonic artery and ligation of an area around the appendix, and that's -- that's a bunch of vessels. To do a right colon you've got to be way down at the root of the mesentery and take a bunch of vessels to take. Even if I did that, there's no way that makes the -- the omentum ischemic. That's -- that's two separate entirely different blood supplies. That's not off the right colon.

And I think he -- I think he did have appendiceal stump leak and sepsis that unfortunately he was doing relatively healthy until he got real sick and septic and went into septic shock and low flow state and had ischemia and then dies of it.

His pathology does not show necrotic cecum. It shows necrosis in the area of the appendix with a small appendiceal -- or a periappendiceal perforation, and it shows a dead

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necrotic omentum.

I did have, you know, a technical problem here of appendiceal stump leak. That's not an unheard of event to have all these other cascading factors is -- and I don't know why all that progressed along at the time or how -- because all I've got is how Chris was telling me and what they were telling me, he was doing fine and -- and all right.

Again, more aggressive intervention could have been done. I probably would have drained him. I probably could have -- I probably could have considered lots of things, but I never -- never saw him, never was involved in his care until he was -- other than taking his appendix out and seeing him when he was arrested and virtually dead on Levophed, ventilator and got to go to the operating room.

DR. SIMPSON: Let me ask you a question about this reviewer's append here. The initial appendectomy was done laparoscopically?

THE WITNESS: No, it was an open appendectomy.

DR. SIMPSON: Open appendectomy?

THE WITNESS: Uh-huh.

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DR. SIMPSON: Okay. It says here that there was evidence of -- this is at the reoperation. "There's -- evidence of perforation was identified with multiple abscesses and a perforation in the distal small bowel near the area of the appendectomy." So not a stump leak.

THE WITNESS: No, it's not -- it's not -- that's not a documented pathology report. There's not -- there's no perforation of the small bowel. There's the perforation -- well, I could read you the -- the pathology report.

DR. SIMPSON: Let's find that because that's the reviewer -- and that's a significant finding, and I think part of what Dr. Skudder's commentary on this review was was that again it was a poor handling of the area of surgery.

THE WITNESS: No, he had -- he had a three centimeter -- oh. There -- there it is. After the second surgery, there's a five centimeter segment of distal ileum and 35 centimeter sub -- transmural necrosis with perforation of the cecum six millimeter perforated area in the cecum at the base of the appendix. Six millimeter hole at the base of the appendix. There's five centimeters of mucosal necrosis extensive inflamnation in the

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pericecal area. But there's -- the perforation is a six millimeter hole at the base of the appendiceal bed.

So, I mean, that happened. That part of it -- and he had the leak, but it's a -- there's no way that I ligated the right colon suturing one -- and putting one -- when you go to do a right colon, you've got to take a bunch of vessels down and there's a whole arcade that comes around. There's a bunch of stuff you have to -- and he doesn't have a dead right colon. He's got an area at the base of the appendix that leaked. Now, why he got into all this extensive infection I don't know.

DR. SIMPSON: Are you saying, Bob, you think that the -- the infection is secondary to the leak of the stump, caused the gangrene of the cecum and the --

THE WITNESS: Well, yeah, I think that -- see, he didn't -- he doesn't --

COURT REPORTER: You guys are doing it again.

THE WITNESS: I'm sorry.

COURT REPORTER: It's getting late and --

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THE WITNESS: Okay. If you can give me your question.
DR. SIMPSON: Specifically I want to try to find out why the -- the cecum and the omentum and the distal part of the colon became gangrenous. Probably from loss of blood flow?
THE WITNESS: Well, that's -- that's the point. I don't know why the omentum -- I mean, that's not a mechanical problem. That's a flow state from being in shock and on Levophed and all this other stuff or getting septic and going into shock. But he arrested and, you know, he was not in the peak of health when he arrested obviously. That's what caused that.
He didn't have a necrotic right colon. He's got a six millimeter perforated area of the cecum at the base of the appendiceal bed. He does have a five centimeter area of mucosal necrosis, but that's not the whole -- that's a five centimeter area inside. That's, again, a flow state. He's got no atypia present.
I mean, it says, "Mucosal and transmural necrosis with six millimeter open perforated area. This is at or near the appendiceal bed. Suture material appeared --"

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yeah, he perforated at the appendiceal stump closure.
Now, why he got into this -- he got into a shock state. Now, why this guy who is otherwise healthy did this, I'm -- I mean, because according to [redacted], as I say, he's walking around and he -- and doing fine. And that's all I got to go on. His white count had gone down. I don't know why he had such severe coronary artery disease at 34 but he did. He's a two pack a day smoker. He's a lot of things he shouldn't have been, but I -- I don't have total explanation.
I know there was not a mechanical ligation that could possibly have caused the whole omentum to be dead. It's just -- you can't do that, not putting -- I put one stitch in the -- well, it had to be appendiceal artery.
DR. SIMPSON: Have you ever had a stump leakage before?
THE WITNESS: One. I had a --
DR. SIMPSON: How many appendectomies have you done?
THE WITNESS: Appendectonies? 1,200, I don't know, out of the years.
I've had one. And that one was, you

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know, a young guy that -- as most of them do, they kind of get an abscess. You open it and it heals. I don't know why this guy got into all this degree. I mean, I -- doing this looking at him I think I would have been more aggressive about maybe getting a CT drain, run fluid or trying something, but I wasn't involved in his care at that point at all.
DR. POWELL: If you have atherosclerosis that bad in the coronaries, the more distal you go -- and Rob can tell us more about this --
THE WITNESS: Right, I said he was -- he --
DR. SIMPSON: Is mesenteric vasculature affected similarly?
DR. THOMAS: In -- in a lot of cases yes, but not always. It's not always predictable whether you -- because sometimes it can be pretty severe coronary disease in the aorta, renal arteries, mesenteric arteries are not as bad. Usually there is a correlation, but not in all cases.
DR. POWELL: I don't know who this reviewer was on page five. You know, he -- he goes through and says everything is appropriate and he

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says, "May be due -- may be secondary to the perforation of type O profusion that was seen in this case."
THE WITNESS: Well, again, I think that's -- I think that's the etiology. He gets a perforation. He gets septic. He gets a low flow shock state. And that's what caused all this necrosis. Again, I've never seen a completely dead omentum, but that's what he had. I mean, his whole omentum was dead and it's documented in the path report.
DR. POWELL: Was this a separate reviewer? I mean, this AllMed reviewer -- it says, "Reviewed by board certified general surgeon," and he found everything here was appropriate, and he's talking about a low flow state which the guy last night said that would be more of a generalized, not a focal sort of thing.
THE WITNESS: This -- this is funny through this process. Sometimes they'll have -- they have one set of reviews and they -- I answered one set. They came back later. It was a different set of questions, a different set of reviewers, and Dr. Skudder has got a different set of reviews, different set of questions. It's not been one,

two, three all along in this process whatsoever.
DR. POWELL: It just seems odd to me that you got two opinions almost divergent from two -- two reviewers.
THE WITNESS: Right.
Next patient or --
BY MR. McKAY:
Q. Yes, next patient is --
MR. COOKE: Can we take about a five-minute break?
MR. McKAY: Yeah, absolutely.
MR. COOKE: Some of us need to call home.
(A recess transpired.)
MR. COOKE: Ready to go back?
MR. McKAY: Yes.
BY MR. McKAY:
Q. The next patient is [redacted]. He's the man in the nursing home with the hernia that turned out to be his bladder down in --
A. Yeah, [redacted] is a 65-year-old fellow who two years ago had a laparoscopic inguinal hernia repair by another surgeon in this ins -- well, I can't remember if it was done here or not, but it was done by another surgeon who operates in this

institution.
And both he and his wife stated that his swelling was still present in the recovery room, but -- it wasn't fixed and they were not happy about it and through the year it had gotten bigger and they wouldn't go back to who had done him before. I saw him in the nursing home when he's got about a volleyball-sized huge, not reducible right inguinal hernia, complaining of it hurting.
Took him to the operating room knowing it was a complex hernia, but you figure it's a bowel in it. And when -- I get into it and there's this big sac and I've got a big hernia sac and I got this other big sac that I think is a hernia sac and I open and it's bladder. I mean, it's got urine in it. I assume it's a bladder. But virtually -- I'm looking -- as big as this is this is virtually this whole guy's bladder all down in there -- in there.
Q. Did you repair that?
A. I took out -- and I got pathology -- sent in about 11 by ten centimeter hernia sac and took out -- I repaired the bladder, tried to put the bladder back to reduce it back up into that. I

mean, I could get it so far and it just -- I couldn't push it any further. I couldn't get it to go.
So I said, well, I can stop that. I can hold in place. I put mesh plugs there, put a drain, put a Foley in knowing I was going to have to do something else at that point. My option at that point would be to explore his abdomen which I've not discussed with his family and hadn't done any workup, not at all figuring I was going to have virtually the guy's entire bladder in this hernia site.
So that's a Friday.
Q. Didn't -- didn't you also have some --
A. Oh, yeah, well, that's the same -- same time -- he had a left scrotal mass that turned out to be a big abscess.
Q. Drained that?
A. Drained that. We put a drain there and that was sort of incidental to everything.
I don't know why he had a big -- he had a large left scrotal abscess. And I have no idea why he had it, but he did.
Q. That's something that needs draining?
A. Yeah, he had -- yes. It was the

size -- orange-size abscess and we drained that.
Got, well, Woody Livingston to see him and we got a CT scan because you don't -- I didn't know where his ureters were and where his trigone or where any of that was with his bladder down that far. We got an idea where that was and documented he's got bladder towards there, that the anatomy is otherwise all right.
We took him back on a Monday with Woody and Al Leroy exploring through the abdomen and me going back through the -- through the groin. And repaired the hernia. Woody repaired the bladder, and he did fine. I mean, this guy's -- his wife loves me because he got his hernia fixed and it not been fixed from the previous time.
The reason we couldn't get it back in the abdomen was I found -- in the abdomen you place a big -- when you're doing a laparoscopic, you got about this size piece of mesh that you tack with metal tacks. Supposed to be along the inguinal ligament and up over the vessels. Well, it had been tacked partially in the inguinal ligament, but most of it was onto the bladder stuck onto the side.
So that's why it was anchored to the

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inguinal ligament and anchored to the bladder and that's why I couldn't push it back. I had to cut -- we had to -- I had to resect part of his bladder to get the mesh off the bladder. But we repaired all that. And he did fine and recovered well with no problems.

Q. One of the people I think criticized you for draining the abscess.

A. Right. We were --

Q. Did it have anything to do with --

A. No, it -- we were there to repair this big, painful, large hernia. He repaired that. He had a scrotal mass that I actually -- I presumed was going to be a hydrocele. I knew it was a fluid sac. You think it's just a hydrocele which is just a water sac. Well, it was an abscess. I have no idea to this day why he's got a large left scrotal abscess, but he did. And drained it and nothing of any consequence or problems to it.

Q. So you could have drained it later on in a second surgery or drained it then?

A. Yeah, I mean, it was purely -- I mean, again, I thought I was going to be finding a hydrocele because I knew he had a fluid sac in there. But why he had an abscess, I don't know,

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but that's what it was. He just drained it, I mean. Like I say, he's -- he's happy as a clam and they all love me because his -- because his hernia got fixed.

Q. And he's done well?

A. Yeah, he's back -- I mean, he's back in the nursing home where he didn't want to be. He never wanted to go to the nursing home and doesn't like that, but he -- he's fine, at least the last I saw him which was November I guess.

Q. All right. And I can't remember what the -- oh:

The paper reviewer said that you had confusion about the anatomic defects.

A. Well, I did at various part of this thing because I've not seen a whole bladder down in the inguinal hernia. So, yeah, I didn't know what I had until I'm opening what I think's a hernia sac and I got urine and I got bladder.

And I was convinced -- Bob Thomas did the pathology in this and I was sure I was sending him stuff that was going to come back as bladder. I was amazed it didn't. It just came back hernia sac. I thought I was even sending him part of the bladder then.

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So, yeah, this was not exactly textbook anatomy by any means, and I was -- I'm opening what I presume -- which is what you do. You open a hernia sac and you take and see bowel and push it back in. Open the hernia sac, said, "Oh, crap, that's urine and this is -- that looks like bladder mucosa." But I repaired it and put --

Q. It's kind of like -- like it was inferred that you had an injury to the bladder and you didn't --

A. No.

Q. -- fix it or didn't see --

A. I knew -- I knew all along it was the bladder and thought I was going -- in fact, I said I thought I was going to get the bladder back on the pathology report and didn't.

Q. And then there was some question I think about a peer reviewer -- about your judgment in trying to repair these things?

A. Well, I didn't understand that. He said that I shouldn't have tried to repair it. What are you going to do? Are you going to leave him with this huge incarcerated inguinal hernia? And pain is an absolute indication for repair, particularly when it turns out his bladder is down

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in the thing.

Now, draining the abscess at the same time, yeah, once I put a mesh in, that may be not the best idea, but I didn't know it was going to be an abscess. You presume a fluid filled scrotal mass is a hydrocele. It was an abscess, but it had no effect on anything. I mean, it got drained and --

Q. I think Dr. Skudder said that he thought you should have drained the scrotum and then put the remainder of the operation on hold to get the infection cleared up, and he said that's a judgment issue and had no consequences --

A. Yeah, I --

Q. -- or effecting the outcome?

A. Again, I was there primarily to address what really was hurting him, giving him troubles, what his complaint was which was this huge volleyball size inguinal hernia.

Q. And this was a surgery that you in fact -- when you found it was bladder and you saw the anatomy was all screwed up, you did -- you stabilized the area, you backed off and you called in a urologist?

A. Well, the next -- Woody sees him the

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next day. It wasn't -- it wasn't -- nothing was, you know, urgent about any of this stuff. We took him back Monday. This is Friday, took him back Monday. It was an elective procedure.

MR. McKAY: That's -- any questions by the panel on that one?

DR. POWELL: So what happened with the bladder, Bob? You -- this guy says excision of the bladder because we're not really -- it's not a standard -- you didn't excise the bladder --

THE WITNESS: I didn't excise the bladder.

DR. POWELL: -- did you? I mean --

THE WITNESS: No, I -- there's no bladder in the pathology -- I actually thought I was going to be sending -- I thought there would be some bladder in the pathology report. That's what --

DR. POWELL: So you kind of get into the bladder -- bladder wall because it's down in there --

THE WITNESS: I'm getting in -- I've got this big sac. Normally that big sac when you're in the inguinal area is an inguinal hernia sac, you know, the -- the peritoneal being pushed

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down and you open it and there's a bunch of small bowel or even colon stuck down there. I open it and there's urine and I know then what I've got.

One of them said I should have put a Foley in pre-op. Okay. I mean, it wouldn't have altered anything. I still would have had bladder, and when I saw it was bladder, I put a Foley in right there on the table.

DR. POWELL: Do you normally put a Foley in a hernia --

THE WITNESS: No, I don't know normally put Foleys in hernias.

DR. POWELL: So I understand, so, I mean, you got into the bladder wall knowing once you got in there what that was.

THE WITNESS: Correct. I didn't excise any --

DR. POWELL: You didn't excise the bladder?

THE WITNESS: No. The bladder's still -- he's still got a bladder. He's got a functioning bladder. There's no bladder on his pathology from that, and I sent -- I mean, there's not tissue I hid from him. I gave you all that I took out.

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DR. THOMAS: Bob, I'm looking at two reports. It looks like the first surgery was on the 11th. That's when we received the tissue. That's the one --

THE WITNESS: Yeah, there -- there's a Friday and a Monday, and I'd -- I'd have to look back at the dates. But there's a Friday, his inguinal hernia -- or initial attempted inguinal hernia, and, secondly, the Monday when we go back with Woody and Al Leroy and work on the bladder, take the old mesh out, repair the hernia definitively.

DR. THOMAS: It looks like on that procedure we just had the hernia sac, and that's most likely what it proved to be, and then on the opposite side we have testicle with abscess --

THE WITNESS: Yeah. Yeah, we took out the testicle. Woody said, you know, when I was talking to him, "This guy's not going to need his testicle. Make the repair." Easier to take his testicle out. He's 65 and sort of semi-demented in the nursing home, so we took his testicle out.

DR. THOMAS: And that looks like on the following -- I guess several days later, Monday or whatever is when we have the -- the opposite test

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score --

THE WITNESS: Right.

DR. THOMAS: -- and then there's a bladder in that procedure --

THE WITNESS: Right.

DR. THOMAS: -- but not the first one?

THE WITNESS: Right. Correct. That's the bladders. We deliberately resected some of the bladder as -- and Woody said, "There's too much bladder. It's redundant. We can take -- you know, he's got plenty of bladder. He's too -- and he --" that was then taken out. We had to take out part of it to get the mesh off of it. The mesh I had -- I had -- it wasn't my mesh.

DR. THOMAS: Right.

MR. McKAY: The next -- any more questions about this patient?

BY MR. McKAY:

Q. I think the next patient is Ms. -- is it S[redacted] J[redacted] or S[redacted] J[redacted]?

A. S[redacted] J[redacted].

Q. S[redacted] J[redacted].

A. Yeah, Mr. J[redacted] is about a 52-year-old fellow who -- seemingly in good health. He's a smoker, but not having problems till he suddenly

started vomiting blood -- blood in massive amounts. Came to the ER hypertensive, massive hematomas. Admitted to the intensive care unit. Ultimately received 11 units of blood over about the next couple days.

Had an upper endoscopy, Brett Garretson, but I was not present at the endoscopy, but Brett shows me the Polaroid picture from it and it looks for all the world like a probable gas tumor -- gastrointestinal mucosa tumor. It's -- it's a little tumor that sits in -- it's commonly -- anyway, it looks like a tumor. It doesn't look like an ulcer. There's something that's there.

And he's got also a visible vessel. You see visible vessels in -- in and around these areas. They tend to re-bleed. I've got an 11 unit blood bleed. I've got a tumor as it looks like on the path report. So I take him to the operating room with the intent of just wedging this thing out presuming it's probably a gas tumor.

Well, I get in there and I can't find it. I can't feel it. I don't know where it is. So I start going off -- they had tattooed it. When they tattoo it when they're looking at it, they put

a needle into the wall and literally inject India ink which is supposed to be kind of a small area. But when they get going, they -- they can kind of blast it so it's a -- can be a big area.

So I resect where I think -- off where -- where he's described it and on the greater curvature and where it should be. Resect that. Send it to pathology. Nothing -- Bob -- Bob appears a lot. You -- you were the one looking at it saying, "There's no tumor here. There's no nothing here." I said, "Okay. I got to take more of this thing." So I take out more and send it over. "No, there's nothing here." So I said, "Crap."

I open his bowel -- I mean, open his stomach and I can't -- I don't see anything there. So I'm left do I do nothing else or do I -- so I took out everything that was tattooed, and they tattooed it. When they tattooed it, that was -- that was pretty much a good portion of the greater curvature. So I put a stapler down along and -- and took that out.

And I -- you have to call it something for coding and -- and the placing. That's where the -- the --

Q. Sleeve.

A. -- sleeve gastrectomy term came from because you have to code it as something. It's not -- you know, you can't code multiple wedges. You can't -- so I just -- that was the closest thing to it, and I called it a sleeve for coding purposes. But what it was was wedging out a portion of the greater curvature.

He got along great, eating, goes home and does fine for a week, I don't know, then comes back to the office and he doesn't look too good. He's dehydrated and put him into -- to the hospital and he's got a outlet obstruction. In doing it you wound up taking a portion of his stomach and you narrow the stomach down.

And he turns out also to have gastric stony, which we didn't know at the time. His stomach wouldn't empty. So I've got this narrowed area in the stomach that's not emptying. He's dehydrated. So, anyway, we rehydrate him. I took him to the operating room and did a vagotomy, an antrectomy and a Billroth II. And he got along fine except again his stomach wouldn't empty. It wouldn't empty for a while.

So we were sitting and sitting and

trying to feed him and trying to endoscope him and there's no ulcer. There's no tumor. We know that whatever it was there is not there anymore. Nirav Patel can pass the scope through the anastomosis. It's patent, but his stomach doesn't empty.

So, all right, I took him back to the operating room to surgically place a jejunostomy tube in him which we put in there. Fed him through that for a while. He goes home with that. I sent him down with Karl Byrne who's a guy down -- I know down at MUSC who does a lot of gastric surgery, gastric stuff, and he said, "Yeah, everything is fine. You've done all right. You've just got to sit and wait on him. And he'll open up." He said, "He may need revision for acid reflux later. If it would, I'd do it in March or April. You can do it or I can do it." I said, "Well, we'll sit and wait."

Anyway, we waited him out and he got fine. He's -- by the end of November -- he works as a mechanic. He was back working as a mechanic eating anything and everything. I took his gas -- I mean, his jejunostomy tube out and he's -- he's fine. He's back at work and no problems.

The term sleeve gastrectomy, again,

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that's -- I mean, that's the closest thing I can come up to describe what I wound up having to do -- having to do because I couldn't find -- never did find what was seen -- I got a picture of it. But I never found it -- a path -- and it's gone, whatever it was, because he never bled again and he never had any -- any problems out of his -- out of the bleeding out of his stomach. He did have the prolonged period of time where he had to have jejunal feedings till his stomach finally emptied.

Q. It looks like what they were harping on -- on this case reviewers got -- he got a little piece of needle in his --

A. Yeah, he got -- in the jejunostomy tube, he started bleeding out of it one night when he was up in the ICU and I explored him. I thought it was just going to be a wound bleeder, and I got in there and found it was deeper, so I had to put a stitch kind of -- you know, he -- at that, you know, he was still a pretty big guy, like 190 pounds or so.

I had to get way down in there, and a piece of -- it was the 3-0 silk broke off. A needle broke. I knew the needle broke. But I'm up there in the ICU and, you know, there's no light,

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no nothing, and it's -- you're not going to find that thing up there, so I just closed it. I told him, told his wife about it, said, "It's not any problem. If it gets to be a problem, we can take you -- but you have to go to the operating room. I have to use fluoroscopy. If it was me, I wouldn't do it."

And they're fine -- they were fine with it. He still got the needle, but -- because to get that needle out, it's in -- it's in the subcutaneous tissue of the muscle. It's outside his abdomen. It's a portion of 3-0 silk. He and the family, the wife and patient are well aware of it, and would not anticipate it doing anything problematic to him at all.

Q. I believe this is the case that Dr. Skudder said he really didn't have enough records to analyze the case. He didn't have much of an issue with it. Oh, yes.

When -- Skudder said that the reviewer we've got in writing made a big deal out of some bleeding at the gastric tube site.

A. Well, he made a big deal about the needle and me being --

Q. The needle and all that --

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A. Right.

Q. -- that Skudder didn't have an issue with it, so --

A. Yeah.

Q. Then the last one and apparently this is the --

DR. RICHTER: One question.

MR. McKAY: Yeah. Sorry.

DR. RICHTER: Bob, is there any -- with this guy's -- if one of the deals that this reviewer -- reviewer on paper makes is he -- he sort of says that if we just let things go and just sort of giving him time to get his gastric rest, would he have come back from that rather than requiring a second operation. I was just wondering what your thought was.

THE WITNESS: Yeah, that's one of those things. Again, you're making a call. It's possible, but -- but you wait on these people, you wait a long, long time. And I have to come up with some way to feed him and I couldn't get a tube through him. That would have put him on intravenous hyperalimentation, because there's no -- there would be no way to interim feed him --

DR. RICHTER: Which is the --

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THE WITNESS: -- which has got complications and a lot of problems in and of itself. I thought I could repair it. And as it did turn out, I repaired it. It's one of these things you're judging, "Yeah, you can do that, but you got this risk." And sitting out -- you still may still op -- or I can operate on him.

DR. RICHTER: I just thought --

THE WITNESS: Yeah, I mean, again, that's -- there's times you make choices and things and that is a choice. I don't -- I don't think it would have been the best for him. Particularly as long a period of time as he had gastric atony afterwards. I -- I still think he would have come back to an operation.

And, again, Karl Byrne, that's all he ever said was fine, everything was supportive. No problem.

DR. RICHTER: Okay.

BY MR. McKAY:

Q. And the last one I guess is J[redacted] R[redacted], and I believe that --

A. Yeah.

Q. -- we found out that that's the one that kicked over --

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A. Yeah, that's the one that everybody keeps coming back to apparently.
Q. -- and summarily suspended your privileges.
A. Right.
Q. That's the lady that had the gangrenous gallbladder that you did laparoscopically.
A. Correct.
Q. One person said you shouldn't. One said it was fine. And she had the bleeding over four days --
A. Right.
Q. -- 11 units of blood and that -- there was criticism you should have gone back in?
A. Right.
Q. Is that just purely a judgment call?
A. Well, I think retrospectively if I'd -- again, if I'd have known it was going to be 11 units of blood, yeah, I would have operated on her, but you don't -- I didn't know that at the time going forward. I can document -- I got multiple progress notes. Hemoglobin is up to the -- you know, 11.5. "If decreases to this, we'll go to the OR. If this happens, we'll go," but none of those things happened.

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Q. So her blood is coming up -- or the hemoglobin and HS --
A. She went out -- she went the first day down to 7.3 which that's not that unusual for somebody who is only starting out -- she started ten and a half or 11 or something.
Q. Was she an older lady?
A. She was 67.
Q. A lot of them are a lot older --
A. Yeah, she's older. She was, you know -- and she was sick. I mean, this -- this was not in any way an elective gallbladder. This lady's sick, septic. This is a dead necrotic gallbladder with a two and a half -- this was Maynard. It wasn't you this time -- two and a half centimeter necrotic mass in the gallbladder that who knows what the hell that was.
She only had one little stone, but it was one little stone impacted in her cystic duct which caused all this. I mean, she came with a white count of 20,000 and sick. So we hydrated her overnight. Took her to the operating room. It was a difficult laparoscopic cholecystectomy. I've done probably 2,000 laparoscopic cholecystectomies. Prior to her I've had three people I had to give

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blood to, and they were -- all of them were older gentlemen on blood thinners which she doesn't fit.
She's by far the one I've given the most blood to, and it -- it happened. We were watching her. She's drifting down and coming back up.
The problem also got added in the interim she was a very difficult intubation. Bob Stark was her surgeon at the -- at the laparoscopic cholecystectomy and had to use a GlideScope. I mean, Dr. Richter knows all this kind of stuff. And she got later difficult intubate -- he had a very hard time intubating her but did get her intubated and because of all that and the sepsis and some concern about whether to extubate her or not.
Anyway, she's up in the ICU on a ventilator and pulled her endotracheal tube out because she's, you know, sick and septic, and Sally Wooten was the intensivist and couldn't intubate her. She could not do it. She could bag her. So she's bagging her blowing up her stomach, gets ahold of Mark Wooten who comes up and is able to intubate her because she vomits in the interim, and he sees vomitus at the cords.

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You presume -- she aspirates. She immediately gets chest x-ray changes. She's got a CT scan later showing changes consistent with -- with aspiration pneumonia. So I've got this lady. She's not in shock. The pressure is all right. She's running, you know -- but, I mean, her heart rate is up to hundred, you know, which is not -- but she's septic and she's sick and she's got aspiration pneumonia.
And, yeah, she's bleeding, but she looks like, you know, it's going to stop. It's not like this lady is about to bleed to death or something. And so we transfuse her. It dropped to 7.2. We transfuse her and went up to ten something. "Okay. That looks all right." Then it dropped to 8.2. So we transfuse her up again, and, you know, it dropped like to nine. Then it went back up and it went to 11 something and it stayed -- and stayed up there, because this is over four days.
This is four days I'm sweating on this thing, do I operate on her or do I not operate on her. And it's not -- these are things you're looking at going forward. If I had known in -- you know, you tell me this is going to be 11 units of

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blood, yeah, I'd go take her to the operating room. I didn't know that going forward. And in the end she recovered.

Now, she -- she was sick, but she was sick from sepsis. She was sick from bleeding. She was sick from aspiration pneumonia. She was sick from being 67 years old and she recovered. She went to rehab. Didn't like that. She came back with colitis, and then -- you know, she had -- that was from all the antibiotics and stuff. Recovered from that and recovered.

So, yeah, I don't think -- I don't think I had a major vascular injury. I think it was bleeding out of the liver bed. They bleed big time. You get these big liver sinusoids particularly in a necrotic gallbladder. You don't -- in -- in an uninflamed gallbladder, you can get a nice wall. You kind of shell it out. There's -- there's nice plains. That's not the case when you get a dead necrotic gallbladder. You're -- you're really working to get that out.

And there's some liver sinusoids that can bleed pretty good, and it won't bleed sometimes when you're sitting there looking at them. If I would have gone back on her, there's no way I could

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have done it laparoscopically. If somebody talks about doing it laparoscopic -- you can't go back on somebody that's got, you know, as it turns out, 11 units of blood laparoscopically. That would have taken a big incision.

I've scooped out a lot of blood. A few times I've helped people or been involved with that. You get in there and you don't really find the bleeding, or it's a liver bed and you just pack it and you get out.

So I don't -- I don't know what was the answer. I don't know what was the best thing to do at the time. I know I was debating all along about what's right, what's not to do. I know it turned out good, and that's all I can go by.

I think -- I think she bled out of the liver bed. She may have bled out in a cystic artery because when you get necrotic like that, the vessel is necrotic too and you clip it. But they usually -- they usually thrombose that vessel, so that doesn't usually bleed. I don't think -- I don't -- had an injury in the hepatic artery or portal vein or something, I mean, that's -- she doesn't bleed over three days and stop with that. I mean, she's bleeding right there at surgery.

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So I think it's liver bed, possibly could be cystic artery, but that's less likely because that -- that's thrombosis when it gets necrotic like this.

So this is one of those that you're looking at I don't know what's the right thing to do and I -- you know, and I'm -- I've got plenty of notes that you can see in the chart. Yeah, if she -- hemoglobin stays up -- you know, I'm talking primarily with Dr. Kan who was the intensivist most of the time taking care of her. "How is she doing?"

"She's doing this."

I mean, it wasn't like I was just ignoring the lady. And she did recover.

DR. SIMPSON: Bob, let me ask you, what was the complaint by the family? That's what triggered this to risk management.

THE WITNESS: I don't know. I don't know what the -- I never received that. I didn't -- you know, I didn't know till this hearing that there had been a complaint from the family.

DR. SIMPSON: Okay.

THE WITNESS: I figured something had triggered it, but I don't know what the family's

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complaint was.

The -- the husband had a hard time understanding that this was -- I mean, I think he's comparing her to routine gallbladders. Gallbladders come in and I've got hundreds of them come in and really fine and go home the same day. I think he thought this was -- and I had a hard time convincing her -- she was sick to begin all this stuff.

And he -- he's a funny -- he's a nice guy, but he just dotes on her at any -- and she's one of these -- southern porcelain princess. Anything she said or any complaint he jumps all over it and tries to fix or whatever. And I think he -- I don't know. I think he thinks that I messed up somehow because she just didn't bounce in and go home in -- in a day or that day or something, but that -- that's not how she started.

DR. SIMPSON: How many laparoscopic cholecystectomies have you done?

THE WITNESS: 2,000.

DR. SIMPSON: And how many years have you been doing them?

THE WITNESS: '89 was the first I guess.

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DR. SIMPSON: Okay.
BY MR. McKAY:
Q. That's about when they started, wasn't it?
A. Yeah, we started probably -- the first ones were really '84, '5. They really come out in '87, '88. We started -- late '88, early '89 is when we started doing them. And I say I -- that's by far my most common. There are days that I've done five lap gallbladders in a day. I did three the day that -- that they came -- that they said I had to stop operating, so...
Q. Dr. Randall, is -- the patients you've talked about some of whom were very complicated patients, were they not?
A. Correct.
Q. And some of the patients had a high rate of return to surgery because of the complicated nature of the patients themselves; is that correct?
A. Yes.
Q. Especially D[redacted] S[redacted] who you couldn't -- everything virtually had to be done with -- under anesthesia, didn't it?
A. That's correct.

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Q. And the other one was the other gentleman with the necrosis in the wound VAC?
A. That's -- yeah.
Q. A lot of care on one of those?
A. Right.
Q. Do you believe that you complied with the standard of care of surgeons?
A. Except for W[redacted] C[redacted]. As I said, Mr. C[redacted] yeah.
Q. He was --
A. I acknowledge -- yeah.
Q. -- a system problem?
A. Right.
Q. What do you want this committee to do?
A. Well, the whole series -- they reported this thing to the Data Bank, and that's a big deal. I've already had to write to the North Carolina board to explain that, and I hadn't heard back from them. I'm sure South Carolina is going to follow.
First, this -- this -- this threatens my license, my basic license. And, secondly, I worked -- before I had -- a period of time I worked locum tenens. I worked as a trauma surgeon up in Asheville. I got great reviews. They love me. They want me to go back. I've got a job in

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Asheville, but I can't -- I'm having to delay them and hold off this -- this process because as soon as they look and see I got a report in the Data Bank saying I can't do abdominal surgery, that's going to end it.
And, as I say, I just -- I need to go to work. Because of the timing of this thing, I had to close the practice, and that left me with a lot of debt. And I got a daughter that's getting married and a daughter -- I need a way to pay debts. I can't work. The only way I can work effectively is as a surgeon. And I've got people willing to hire me.
And I've been doing this since -- as I say, since 1982 here, and I've got a track record of hundreds of thousands -- if not thousands of cases in this place, and I had a run of bad cases. I agree -- but a big part of this is you'll look -- there -- a lot of them are emergency room. A lot of them -- this -- you're going to find particularly for general surgeons in this institution, people don't like this hospital.
So the elective nice little gallbladders with, you know, a 28-year-old that works down at the bank, they don't come here now.

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You get the J[redacted] P[redacted] that they got strokes and hemiplegias or are big fat people coming in the emergency room just because they're sick and acute. And I'm sure Dr. Richter probably know -- you know, pathology probably knows about the instance of, you know, acute gallbladders versus -- you know, those change.
It's just sicker patients. It's just a different change in the quality of the patient that comes into this institution. And it's tough. Like Chris Schroeder saying, this is a tough place to be a general surgeon.
Q. The patients you -- a lot of these patients had altered anatomies from numerous previous surgeries, gastric by -- gastric bypasses?
A. Yeah.
Q. I mean, these are not just clean --
A. No.
Q. You can't pick your patients?
A. No. You have --
MR. McKAY: Any questions the board has in general? I know he's tired.
DR. POWELL: Bob, when the surgery department was smaller, we -- we always used to hear all these cases that were selected out --

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THE WITNESS: Right.
DR. POWELL: -- and somebody would flag it and the guy --
THE WITNESS: Right.
DR. POWELL: -- was in it and then the surgeon would give an explanation. Was any of that -- and I don't know how the peer review --
THE WITNESS: We don't have that. There's none of that. The first time I ever heard of this -- the first was that -- the privilege committee which is Earl Jenkins and Norman Taylor, went before them and they approved it. Then it -- that got to the MEC and they did not approve it and I appeared before them. And I said that one -- that one was a done deal when I walked in there.
That's the one -- nobody asked me a question. Nobody -- this is the first time I've got to discuss these cases. The very first time. I gave them written --
DR. POWELL: Do we have any process in peer review, I mean, to do that? Somebody else may have to answer that question, but when somebody is brought up with a bad review, I mean, is there a way to explain it other than this forum? I know there isn't.

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THE WITNESS: I don't know. That's -- that's a hospital answer I guess because -- yeah, we use -- you remember the days. We would talk about cases and review them and discuss them. And I miss those. We don't have them.
MR. COOKE: I think that -- I think the whole process is described in the bylaws. I'll have to check and see if it was in the part that was given to you today. Probably not. And I think this picks up with the hearing and appellate review procedure.
THE WITNESS: Anyway, I just, as I say, appreciate the chance. As I say, this is the first time I've had any questions or any discussion about these cases. The very first time. I sent my written things in, but nobody asked any questions. Nobody ever discussed any of these cases with me till tonight -- or as I say, his question last night is the first question I've had about these cases.
DR. POWELL: When -- in general surgery when -- when you -- you said you recertified 2000 --
THE WITNESS: It's every ten years.
DR. POWELL: Ten years.

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THE WITNESS: Yeah.
DR. POWELL: Are you required to submit cases for review --
THE WITNESS: Yes.
DR. POWELL: -- before the board?
THE WITNESS: Well, a certain number -- you have to list the cases you've done. To tell the truth, I'm not sure how it is right now because I'm not -- I'm up two years from now. If I can start renewing -- the last time I had -- you had to produce the numbers of cases you've done in the previous years and some of the outcomes and that sort of stuff, what you've done and all that -- I don't know what it is right now, because I just hadn't dealt with it.
DR. POWELL: We had to select cases and ask you to submit records. Do you have to do that at all?
THE WITNESS: I don't -- as I say, I don't know now because it's been a while since I've done it and I've got a couple years till I have to do it again. So I don't know what the current process is. The last time I had to submit the cases I've done in the previous years, the numbers and then they -- I don't remember -- I don't

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remember whether they had outcomes or -- or what was -- what was the exact part of what they -- what you had to produce.
You had to produce, you know, your CMEs. There was a bunch of stuff you turned in, but I don't know -- I know there was, you know, a breakdown of you did these kind of cases and these number of gallbladders. You had to turn that in.
MR. McKAY: I'm done if there are no more questions.
DR. THOMAS: Just one question. I -- I think we're all still learning what exactly our role is -- how broad -- I guess this is what Tom has handed me right here.
But, Bob, you kind of just mentioned that your goal is to be able to work again.
THE WITNESS: Uh-huh.
DR. THOMAS: Talk a little bit more about that. Are you asking for your privilege to be reinstated or are you asking --
THE WITNESS: Well, what happened out of this thing, you know, economically -- again, they could have given me a hearing at 30 days or 90 days. I asked for a hearing at 30 days. They put it at 90 days. That was in the first of January.

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They had a witness that was supposed to be there their expert witness that then says can't come, be there a week -- so it was delayed a week. Then their expert witness can't come and now we're here a month later. So I'm almost -- it was 120 days out.

So in that period of time I had to close my practice here. I'm not going to restart and come back into this -- this hospital. I want the report removed from the National Data Bank. That's killing me right now. It's going to conceivably cost me my license. It's going to conceivably -- I know it's going to cost me being able to work.

So if they would have done it in a timely fashion, I would have stayed and tried to keep going here, but I -- I've had to close everything here because of this -- money, the economics of it. So right now I want that Data Bank report removed.

MR. McKAY: I think they'll have to reinstate your privileges or make you eligible for reinstatement --

THE WITNESS: Eligible for -- okay.

MR. McKAY: -- and send that to the

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Data Bank --

THE WITNESS: Okay. Whatever -- whatever the process is.

MR. McKAY: -- and resign in good standing or whatever --

THE WITNESS: Yeah, whatever -- whatever the mechanism of it is. I'm not trying to work here because I'm not going to reestablish an office. I've got right now Myrtle Beach or possibly back to Asheville to go to work, but as soon as they look and you've had your privileges restricted for abdominal surgery, that -- that -- that's going to end that. So I've been kind of delaying them and telling them I'll get this to them and trying to delay till -- till I can try to get this process reversed.

DR. RICHTER: Bob, I know this has been a long, difficult, arduous process for you. Is there anything you can take away from this going -- going forward in your practice --

THE WITNESS: Yeah, I have --

DR. RICHTER: -- before you go someplace else?

THE WITNESS: Yeah, I mean, I had a run of bad cases. I had some errors in -- in judgment.

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I'm a happier person now. This -- this period of time a lot of stuff was going on. I was also going through a divorce. So it was just a lot of personal kind of stuff going on through that -- that -- that period of time that's not in place now.

And I -- you know, I have a pretty good -- I'm happiest right now that I finally got heard by somebody. That's the biggest thing I'm happy about right now. And I think I can operate. I think I've proven I can operate. I'd like the chance to just go do what -- I like fixing people. That's the whole point of an operation. I can go in and fix somebody. That's why I like surgery. I want to go back to fixing people.

And it was never about the money or economics of it. I just want to go work.

MR. McKAY: That's our reply unless we've got some documents we filed that I've looked at or not looked at. I think one of the cases may have a letter from Dr. Byrne at MUSC that everything was fine. But We've got some affidavits.

MR. COOKE: We might have some cross-examination.

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MR. McKAY: Oh, I'm sorry.

MS. KREBS: It's -- it's -- it's 11:10, and I'm assuming that most of you have to go to work tomorrow. I defer to the committee. I have a few questions for -- for Dr. Randall. They would relate to the filing of the Data Bank, and they would be -- and they would also relate to his assertions that he hasn't had an opportunity to be heard. And I think it would be valuable to put those on the record, and I would -- if I talk really fast, I can be done by -- by 11:15.

Dr. Edwards has been sitting here all this evening. I have some questions that the committee had last night, and so we asked him to come back. It is very late. We could convene or we could try. What's your pleasure?

DR. SIMPSON: I prefer you go ahead and ask your questions.

MR. COOKE: We've come this far. Let's go ahead.

MS. KREBS: Okay. Thank you.

RE-EXAMINATION

BY MS. KREBS:

Q. Dr. Randall, you've made a few references to the Data Bank. Are you aware that

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federal law requires the hospital to report any suspension that was --

A. Oh, I'm not denying that. The -- the timing of it -- again, if they could have given me a more timely hearing, we wouldn't have had to report. I understand. I'm not denying that they had to make the report. I wanted it reported ideally that there was a review and subsequent overturn of the suspension. I'm not -- the hospital did what they had to do.

Q. Okay.

A. They could have given me a more timely hearing.

Q. And you're aware that -- and are you also aware that to get rid of the report or whatever the expression was that you used, to actually remove the report the hospital under federal law would have to void that report and effectively the -- all of the charges of the Medical Executive Committee would have to be dismissed? Are you aware of that?

A. I don't see a problem with doing that then. That sounds like a good thing to do.

Q. I'm sure.

Are you also aware that if there's any

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modification of that report -- if any -- if any -- if the sanction --

A. I have no idea of the federal laws of that Data Bank report.

Q. All right. But you're -- because you're satisfied that the hospital is doing what it has been required to do?

A. Correct. I understand they had to make the report and they reported factually what they -- what they sent to me.

Q. You -- you stated now several times that you were not given an opportunity to be heard by -- until tonight?

A. That I had no questions until tonight.

Q. So you are -- you are acknowledging that you appeared before the committee and had an opportunity to express your views to the committee --

A. I've come out --

Q. -- more than once; is that --

A. I talked. I don't think I was heard.

Q. But you had an opportunity to appear and speak to them?

A. Yes.

Q. And to submit letters to them --

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A. Correct.

Q. -- or documents to them?

On more than one occasion; is that correct?

A. Yes.

Q. I'd like you to -- and I'm not -- I'm not going to repeat all of that, but, you know, I'd like you to look at what is our Exhibit 16, and I think it is -- I think it is -- Mr. McKay's Exhibit 1 or 2. It -- it's a letter that you wrote.

A. Okay. Where am I going to find that here?

Q. Exhibit 16. It's your Exhibit --

A. Exhibit -- okay. Hang on a second.

Okay. My letter, yes.

Q. This was your -- your response to the Medical Executive Committee following the -- it's dated September 16th.

A. Yes.

Q. And it -- and it follows appearances before the various peer review committees where you were -- where you were -- where you were invited to attend.

MS. KREBS: And for the committee's edification, those minutes start at Exhibit 35.

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BY MS. KREBS:

Q. But this is -- this is a letter that you wrote, and this is just your position --

A. This is my letter, correct.

Q. I'd like -- I'd like you to turn to your -- your -- your description of the -- of the Parnell case. And it's on -- the pages are not numbered, but it is --

A. I got it. I found it. Okay. I found it, yeah.

Q. And we've talked about the -- the P[redacted] case at length, and I'm not going to repeat that. But start with the reviewer. Could you just read that last sentence.

A. I'm sorry, I'm lost.

Q. "The reviewer makes note of some colonic injury leading to the colon resection."

A. Okay. "The reviewer makes note of some colonic injury leading to the colon resection but there's no colonic injury noted in my operative note or an injury or entry into the mucosa of the colon noted on the pathology report."

Q. Now, you -- you repeat that statement in the -- in the December 21 letter that you submitted.

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A. Uh-huh.
Q. Is that actually correct that there's no -- based on what we talked about earlier, that there's no evidence of colonic injury regardless of whether that came to --
A. Again, I state there's no injury noted on the pathology report which is true.
Q. And all -- you also state that "no colic injury noted in my operative note."
A. I state in the operative note that I've got a mass. I don't know whether or not there's an injury or not. I do state that.
Q. So you're saying that when you write -- we looked at a couple of sentences in that report earlier.
A. What I write there -- what counts is what's on the pathology report. That's what the guy is looking at and sees whether there's a hole or injury to that bowel and there is none.
Q. But it would have been reasonable based on your operative note for the Medical Executive Committee to find there wasn't an injury and just -- I'm just -- I'm just asking.
A. Well, that's -- I don't know what the Medical Executive Committee could find, but, again,

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the point that y'all are making is a trocar injury, as I -- as I understood, and there's definitely no trocar injury.
Q. But there was injury -- colonic injury?
A. There was a mass in it, and, no, not by the pathology report. There's an inflammatory mass.
Q. At point -- I'm looking at page three of the operative report for Ms. Randall -- [redacted] I'm sorry.
A. While I'm turning ask me -- okay.
Q. I'm just looking at this one sentence. "A point was selected on the transverse colon to allow the site of the perforation and this was clean of gastric -- gastrocolic omentum as well as mesentery."
Is that the same as no injury?
A. Well, again, I thought at the time it was perforated. You don't know -- you're looking at a big inflammatory mass of stuff. I'm thinking, yeah, it must be an injury. There might be an injury. But on the pathology report there's no injury. It's immaterial if it was an injury or not because an injury happened in taking it down and I view the colon as something that's got to come out.

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Q. You said that you had done 2,000 --
A. Probably in that range, yeah. Laparoscopic cholecystectomies.
Q. Between the period of, say, 2008 to 2009, do you know how many patients you operated on roughly?
A. No, I don't know those numbers.
Q. Have you -- have you looked at those numbers at all?
A. No, I've not looked at the numbers of cases I did.
Q. So the 2,000 is career. It's not within the last -- within the period of time that we're looking at?
A. I haven't done 2,000 in the last two years, no.
Q. No. I'm asking you --
A. No, I did less in the last -- in the last few years, yeah, and I certainly did less during the period of time all this stuff's going on, because there was a period of time I was out of the hospital. I was not -- I was working in Asheville for six -- you know, six-month period of time, so I was not here. Obviously it was reduced for that period of time.

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MS. KREBS: I have no more questions.
MR. COOKE: Any redirect?
MR. McKAY: No.
MR. COOKE: Any more questions from the panel?
THE WITNESS: Thank you.
MR. COOKE: Then that concludes your case.
MR. McKAY: That concludes my case.
MR. COOKE: Reply?
MS. HUYTO: We have a rebuttal witness, Dr. Edwards.
Anybody need to take a break?
NATHANIEL EDWARDS, M.D., being first duly sworn, testified as follows:
EXAMINATION
BY MS. HUYTO:
Q. Good evening, Dr. Edwards. You've been here a while, so I appreciate your patience.
There have been some questions I guess, and we asked you to come back tonight. If you could maybe address one -- one question that the panel had as far as the processing -- or the question about the process of cases coming to -- to peer review. Could you address that for the panel?

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A. Sure. I think we touched on it last night when I spoke. But I said there's not any ongoing -- certainly not that I know of. We've confirmed there's no morbidity and mortality conference like you used to have in the old days. There's no ongoing prospective collection of cases as they're -- in surgery that I know of like there is, I said, in cardiology.

And the way that things come to peer review, as I said last night, is that they come through complaints or reports from either staff members of the hospital, physicians or patients and patient family members.

Q. And do you have any additional information --

A. So, well --

Q. -- specific information?

A. -- so after that question last night, Dianne West looked back and saw how these particular cases came to light, and there is I think two or -- two or three were physician-initiated complaints, and then a few more event reports which are staff-initiated, and I think one was a malpractice claim that came in that way, came in through the -- I forget what they call

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it -- risk management department.

Q. And were there certain patterns as far as within the surgeons that came to light?

A. So, as I said, these cases all came in in 2009 when I was not on peer review, so I don't know what happened in 2009. But in 2010, as I recall, there were no cases that came in that were of any concern on the surgical -- from general surgeons. We get most of the cases from the emergency department, a lot of internal medicine.

I don't recall any other cases involving general surgeons except for the three more that we got with Dr. Randall in 2010.

Q. And did you find that the -- the other surgeons in -- in reviewing that peer review process, that other surgeons had the same mix that Dr. Randall had as far as --

A. His mix or a case -- I mean, we don't really look in that period -- in terms of case vol -- I mean, my assumption is we have several surgeons here who are busy. I don't know people's case volumes, but I assume that -- and I know -- I know personally that they're busy surgeons.

I don't remember seeing any general surgery peer review cases coming for -- only ones

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besides Dr. Randall. That doesn't mean they didn't happen, but certainly nothing that comes to memory.

There's -- there's a dramatic difference between Dr. Randall's cases coming before peer review in 2009, and even 2010 it was just those three, but I don't remember any others on anybody else.

And that was a concern of the MEC. We look through things -- I don't think the MEC looked at the outside reviews and, you know, took them as -- at face value. I mean, they understood they were reviewers and that there are errors in those. Like excising the bladder, I think we read as incising the bladder. You know, I think there were typos and there were errors in judgment.

I don't think we -- the Balfour retractor and the trocar injuries were not such a focus for us. I think that's been brought out in this hearing. It was more just inadvertent bowel injuries and an anastomotic breakdown that was a concern for us.

And the two -- and I think one of the drive -- one of the driving factors at the MEC level was just the volume of cases. Looking at it -- you know, we get into the details of the

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cases and -- and different reviewers having different reads on it, but it was more the volume of cases coming through peer review through the process that we have, which really for a case to get reported it has to be -- has to get to a certain level such that a physician is going to report another physician or a staff member is going to forward a report or family complaint.

So it's a pretty high standard to get into the peer review process. So that was concerning that it was such a volume with that high threshold to even get there. It wasn't like we were prospectively looking through every case and looking for every complication.

That was a concern -- I'm sorry. And also on the peer -- on the external reviews as far as I know there were just -- there was just one external review that we looked at for each case. AllMed did some. AHR did some, but there was not -- they weren't multiple reviewers until Dr. Skudder came that I know of in terms of external review.

I don't think that we -- you know, we understood that they're not perfect in their problems. We did read in detail Dr. Randall's

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written response and listened to his verbal response at the ad hoc committee and the MEC. And there were not questions I think because -- I don't know. I can suppose. I don't know why.

But I think we had had the opportunity, unlike you, to have read all of those things beforehand and we had been through -- I mean, you've been through this for two days. We went through this for -- there's multiple meetings over and over and a lot of hours put in. So that may be why there are less questions. I don't know. The --

Q. You -- you mentioned AllMed and -- and Advanced Medical Review, but did you know at the time who the particular reviewers were at that point?

A. No. Those were anonymous.

Q. And would you expect just based on your experience in the hospital that Dr. -- have any reason to expect that Dr. Randall's experience in his patients would be any different; he would have sicker patients or more difficult patients than any other surgeon --

A. No, no reason to believe that. No specific knowledge of it.

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Q. Okay. And the court reporter has what's been marked as the MEC's Exhibit 62. If you could take a look at that real quick. Again, our discussion with the -- discussions of the matters that were brought to the peer review and the general summary of that. Can you just confirm that that's --

A. Yes.

Q. -- what we were talking about?

A. Yes.

Q. Okay. Thank you.

And could you address the -- I think we had talked about and questions did come up from the panel last night on the earlier review, that it originally had been done on -- on the --

A. So those two -- I think those cases were from 2006. And the only knowledge I have directly of those were from minutes from a meeting that referenced them.

And that was a series of cases that had come up where -- in 2006 referring to Dr. Randall's outcomes, particularly I think with abdominal surgery -- I'm sorry, inguinal hernia repairs. I should say hernia, not inguinal necessarily, and carotid -- carotid surgeries.

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And at that point a -- as I think a one-year review was done -- open review of his hernia -- hernia repairs and carotid endarterectonies. During that time there was -- but it wasn't all abdominal cases. There was one carotid surgery performed.

So essentially he stopped at that point, and that may have been when Dr. Kan Borhanian came and started doing carotids. There had been I guess problems enough that they wanted to look at the carotids. And at the point they started being reviewed there was only one done.

And then the inguinal hernia repairs were sent -- I think all the studies were sent for outside review. Reviewers found some minor problems. Again, on our rating scale of one, two, three and four they were twos, and a couple -- but the peer review committee itself downgraded those to ones and -- on their -- on their review of the cases.

MS. HUTTO: And I guess for the panel it's those minutes -- I think y'all have looked at some of those, but those were reflected in Exhibits 49 through 59 and -- those reviews.

BY MS. HUTTO:

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Q. And did that represent all hernia repairs? Were they looking at those?

A. I think that they looked at all hernia repair -- I don't necessarily -- I don't know if it was inguinal or all hernia repairs. I think it was a one-year time frame.

Q. Look at Exhibit 49. All types of hernia repairs? I'm not sure I'm saying that right. It probably starts at 59 but goes --

A. I think that this -- open hernia repair. That's right. So it was open hernia repair I guess is what is listed.

Q. So the review was limited?

A. To open hernia repair and carotids.

Q. Okay. And if you could look at Exhibit 57.

A. Okay.

Q. And what were the concerns that were reflected there by the committee?

A. This is the -- so this is the -- the credentials committee has requested the peer reviews committee consideration of the results of an outside review of Dr. Randall -- practitioner 4018 is how it's referred to -- following identification of trends at his reappointment.

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cases that were reviewed by this committee within the past two years were reexamined by an outside reviewer. The findings were as follows.

Do you want me to read that paragraph?

Q. What were the -- in the paragraph starting -- what -- what were the overall concerns?

A. So errors in judgment in technique, a lack of appreciation for the morbidity and mortality of large abdominal hernia repairs in the elderly, lack of surgical experience in handling difficult dissections around the portal structures which were -- and ret -- and pelvic retroperitoneum.

"The access to critical care and medical specialist seems adequate; however, no detection and involvement by the surgeon after procedures. There does not seem to be tightly defined 'return to OR' criteria for re-explorations based on physiologic parameters."

And they also reference the use of anticoagulations and all of its indications should be reviewed formally with the surgeons, colleagues as the appropriate use is often overlooked.

Q. Could you provide any additional information to the committee about any insights

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that Dr. Randall provided to you when he spoke to you in the meetings where he met with you about what -- what he saw as any issues in the cases?

A. I mean, it was essentially what we talked about tonight. I'm not sure exactly what you're asking.

Q. Did he show any insight into the cases or any concerns related to the cases?

A. Well, he -- in two cases -- and this one I think was Mr. -- it was a W, and it's not [redacted] or [redacted]. The one who had the cholecystectomy and had the cystic mass. I think he's the one that started to decompensate on Friday, and then Dr. Crain took care of him over the weekend and he ultimately expired. He did indicate then that he -- you know, that he did not manage the patient properly that first day he started to go bad and transferred to the ICU.

And I think he has said that time as well as this time that in Ms. S[redacted] he wished he had gone ahead and put the G tube in initially.

But then as I said yesterday, he did also when we -- and, again, he didn't have the chance to prepare a written statement, but when we did discuss Mrs. R[redacted], he did mention that it

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was a little bit of bleeding there. There was a little bit of bleeding, and that was a concern to the committee.

Q. Okay.

MS. HUTTO: Okay. Thank you. The panel may have some additional questions.

DR. SIMPSON: How, do you know over this period of time how many patients expired?

THE WITNESS: So of these patients that was a concern of -- of the seven original cases, two were deaths and the one was the young man C[redacted] W[redacted] who died with the appendiceal rupture -- or that repair. And then the other was -- the other W, not W[redacted].

DR. RICHTER: W[redacted] C[redacted]

THE WITNESS: W[redacted] C[redacted] Who had the -- that perc -- the fecal problem.

DR. THOMAS: What about prior to that? When this -- the peer review was going on for 2006, you may not know who that -- this is probably before your time. You weren't probably on Med Exec then, but --

THE WITNESS: So you -- you mean the -- the cases way back that's referred to from 2006?

DR. THOMAS: Yes. The --

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THE WITNESS: I don't know -- yeah, I don't know the details of any that led to this -- that 2006 -- I don't know what happened in that period.

DR. THOMAS: Okay. Do you think there's any bias in the Medical Executive Committee maybe based on some of these previous peer reviews or anything?

THE WITNESS: 2006 cases?

DR. THOMAS: Yeah. Or anything leading --

THE WITNESS: I don't --

DR. THOMAS: -- in any way that led to revoking Dr. Randall's privileges?

THE WITNESS: No, I think that -- I mean, they were certainly taken into consideration, and the -- the patterns that we seen to be concerned about -- or were concerned about in 2008-9 were similar to these.

The -- the operating under portal structures was an issue that seemed to be again in these recurrent cases, and then returned to OR based on physiologic parameters, you know, how much bleeding was enough to go back to the OR, how sick do you have to be in the case of the man who died,

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you know, Friday and got taken care of by Chris over the weekend. You know, when he starts getting sick and going to the unit, is it time to go then.

So it was the same -- I guess it was -- it was a reference point, but I wouldn't say a bias -- you know, source of bias. And I do think -- you know, and I think I said it last night, the Medical Executive Committee was largely involved, but then we expanded to the ad hoc committee. So we had the credential physicians as well as the peer review physicians, and it really is a good group of people who -- I don't think there was any sense of -- you know, it's peers and I think everybody knows that, you know, next time it could be me who is being evaluated.

So it was taken very seriously, and I think everyone fully understood how things could end. So, you know, I think it was taken very thoughtfully and, you know, there was a lot of consideration, a lot of time put into it. Cases were reviewed and we had Dr. Maynard with us on the extended ad hoc committee looking up pathology for us. We had the charts available to reference.

So I didn't get any kind of any sense of any mal-intent or anybody was unhappy or

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anything like that.

DR. THOMAS: Do you think that the whole process -- this whole thing was reasonable? Anything that could have been done better or more completely?

THE WITNESS: Well, I think that one thing that -- as I'm thinking tonight that could be is to go back through -- you know, take -- and we brought it up at the Med Exec, actually was to go through and look at -- which would be a lot of work, take this period of time, look at all the cases done by all the surgeons and see what happened.

And I think you could -- there's certain things you can look for easily. We did look at that return to OR data which is pretty quantifiable and comparable. And the point has been brought up that Mrs. S[redacted] and one other person, Mr. W[redacted] had several returns to the OR, but when -- when we looked at the data, we looked at only unplanned returns to the OR. So all the subsequent washouts weren't counted as unplanned returns in that 26 returns. They -- they were counted as planned returns.

And even if you take out those two

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patients which account for several returns, that still leaves six patients who had -- not counting returns, but there were patients -- there were six patients who returned to the OR for Dr. Randall and there were zero or one or two for the other doctors.

So that -- that's one thing that we could do. I think in looking forward and even potentially could be done to look back during this time period every complication we could pick up, which we -- you know, I've done that for my pacemakers. I can look at every pacemaker I do, look back and see the post pacemaker chest x-ray, what's the pneumothorax. We did that in our group.

So there's some things you can catch. I think some things you won't if somebody goes home and has a complication at home, but that should be equally not caught for all the physicians.

DR. RICHTER: One -- one of the concerns that I have with the process as far as external review is when I look back at the external reviews, it looked like there were maybe three surgeons at the most that looked at all ten charts. If you go back and look at the identifiers of the external reviews, five of the cases were reviewed

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by the same surgeon.

THE WITNESS: Uh-huh.

DR. RICHTER: So it wasn't like -- and in fact the surgeon even noted that I think in one of his reviews said, "Once again we have an apparent pattern here."

THE WITNESS: Uh-huh.

DR. RICHTER: I was just wondering if when you do the external review processes if you shouldn't -- because earlier the testimony was -- was characterizing it as, you know, ten different surgeons looking at ten different cases, and that really is not the fact.

THE WITNESS: Uh-huh.

DR. RICHTER: And I'm wondering if going forward when we have external reviews if we can assure that there's more than three surgeons looking at it, three anesthesiologists or three cardiologists.

THE WITNESS: Uh-huh. I think that sounds reasonable.

DR. RICHTER: And I think -- and I personally can appreciate how difficult it would be to get a general surgeon from this immediate area to sit on -- on this panel or even -- even try to

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render -- render judgment because the previous avenue that we had to discuss cases has been taken away from us. And I'm talking about the medical -- medical profession as a whole, not just this hospital.

THE WITNESS: Uh-huh. Well, it would be -- and we did in building this panel try to put together like we did on the ad hoc -- the ad hoc committee is pretty much defined by the existing doctors, but it fell out with that many doctors that we had a good representation, but we tried to get anesthesia, pathology, you know, people surgery -- sub-surgical specialists and oncologists who at least have some working knowledge of the matter without having a general surgeon.

And we thought about -- we discussed hiring a surgeon to be on this panel, but then I guess you'd have to have it be half paid by each party, you know, to keep it objective -- keep it objective.

DR. RICHTER: And it --

THE WITNESS: It's a challenge.

DR. RICHTER: Yeah, and I commend you for the -- personally commend you for that because I think you're right. We have to -- what we have

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here, but I can understand the difficulty it would be to get a general surgeon from this area to come and sit on this committee.

THE WITNESS: And I also want to say that through the whole process -- it certainly isn't perfect, and if I were designing the process, it wouldn't be like this at all, but this is what we have partially because of a legal environment we work in and other things.

But, you know, I think that at least it's working -- although it's working slowly, it's working and we've gotten -- or we've been able to assemble a panel that's going to be objective and, you know -- so I think the process although it's imperfect, you know, it's -- at least we're, you know -- we're following our bylaws. I don't think we deviated from the standards that are set out in the bylaws. I mean, we're kind of hemmed in by the bylaws in a way in terms of what we can do.

DR. SIMPSON: I just want -- one more thing and then I'm going to quit.

The final concern when Dr. Randall's privileges was suspended was two patients out of his group had died and then the last patient was a significant --

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THE WITNESS: Believe it or not, we were concerned that it could reach --

DR. SIMPSON: -- (multiple speakers) which is questionable or that could have been another disaster?

THE WITNESS: Yes. And that was --

DR. SIMPSON: The thought process?

THE WITNESS: Yes.

And like I said, at the meeting at which we decided to recommend to the board the revocation, before the summary suspension there was a very strong discussion of "If we feel this strongly about this, why are we waiting for an appeals process that may take 90 days? Plus there's 90 days for this hearing to occur and then there's a potential appeal to the board after this. You know, should we not act sooner?"

So that was very much on the -- on the minds of the committee even prior to the J[redacted] R[redacted] case -- or -- yeah, it was J[redacted] R[redacted] -- Mrs. R[redacted].

DR. SIMPSON: Was that -- was that case reviewed before y'all made the decision by a --

THE WITNESS: R[redacted]'s case was not. Mr. H[redacted] and the one right before him were made

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aware to the MEC.

DR. SIMPSON: Okay.

THE WITNESS: But she was the one that was only seen by the MEC when they -- when they met to uphold or revoke the summary suspension.

DR. SIMPSON: And was Dr. Randall given a chance to present that case to y'all prior to suspension by the MEC?

THE WITNESS: He -- so what happened was -- and I -- he came to the -- initially to the -- I'm just going to say this to get -- keep my mind straight -- initially to the credentials committee, then to the ad hoc committee, and then to the MEC, and I think it was after the summary suspension that he came to the MEC -- oh, it was before. So it was before but he addressed the case. And I'm try (multiple speakers) --

DR. RANDALL: And then you asked me about it --

THE WITNESS: Right.

DR. RANDALL: -- and I know it was going to be -- kind of speaking off my head about it at the time, but that was --

THE WITNESS: I can look at the minutes. And I've just lost that. There were --

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there were so many minutes --
DR. RANDALL: We had the written presentation. Then, "But what about J[redacted] R[redacted]?" And I didn't know that she was going to be involved in this, and I talked from memory about it.
DR. RICHTER: This is --
THE WITNESS: October 25th was the meeting I think.
DR. RANDALL: I don't know what the date of that is, but the meeting where we had the written presentation and then you asked me, "What about J[redacted] R[redacted]?" I didn't know -- she was not on the list and I spoke off memory.
MS. HUTTO: If -- if you'll look at October -- Exhibit 35 is the minutes of the October 25th meeting.
THE WITNESS: That's the meeting after -- this would have been the meeting --
DR. RANDALL: Suspension.
THE WITNESS: Summary suspension, yeah. That's right.
So the summary suspension was issued on October 15th. So Dr. Randall came on the 25th, ten days later, to speak to the committee, MEC, regarding summary suspension. And at that point

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the J[redacted] R[redacted] case is what had tripped the summary suspension on the 15th. So he did have that but not a written, you know, time to prepare, I don't -- I don't think, for that one. It was just a verbal communication.
BY MS. HUTTO:
Q. But, Dr. Edwards, the purpose of the meeting, was it not, when the MEC met, that was to determine -- you imposed the suspension but the MEC had to meet to decide --
A. Right.
Q. -- whether to uphold the suspension --
A. Correct.
Q. -- or not?
A. Right.
Q. So Dr. -- Dr. Randall had the opportunity to meet and present at that meeting --
A. Yes.
Q. -- prior to the MEC making a decision of whether to uphold the suspension?
A. Correct.
DR. SIMPSON: So prior to the final decision for the suspension, the peer review, ad hoc committee and the MEC had reviewed all of these cases and had heard from Dr. Randall his chance to

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discuss them?
THE WITNESS: Except for J[redacted] R[redacted], the last one, and that was only presented by him to the MEC.
DR. SIMPSON: To the MEC?
THE WITNESS: That's what I can remember, yeah.
DR. RICHTER: One of the -- this is to Ms. Krebs and Ms. Hutto.
I noticed that all the other peer review reports, at least the ones that are 26 through 35 -- or 34 -- 26 through 34. The others have some supporting documents as to why they were referred to the committee except for Ms. [redacted], and this is one where there's a complaint by a family to a physician.
And so I was wondering if there was some more -- what was the complaint? Was there a complaint about not going back to the OR quickly? Was the complaint about the anesthesia care? Was the complaint about nursing care? I don't know what the complaint was that brought this to the attention of the Medical Executive Committee.
THE WITNESS: I don't know that y'all know. It came as a patient complaint, and, yeah,

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those go to the medical staff office. And then -- and then I heard about it from them.
DR. RICHTER: Okay.
THE WITNESS: But Dr. Ran -- I mean, Dr. Patterson, you know, heard it first being in the office, and he -- I don't know if he can speak here, but he may know the exact nature of the complaint.
DR. PATTERSON: I guess not.
THE WITNESS: Okay. But -- so the bottom line, all I know is it was a complaint lodged by the husband.
DR. RICHTER: Okay.
THE WITNESS: And that -- you know, those come in to MEC --
DR. RICHTER: I just was curious as to what the complaint was. That's all.
THE WITNESS: Yeah.
DR. RICHTER: And that's -- I guess that's neither here nor there.
THE WITNESS: I don't -- I don't know.
DR. RICHTER: Thanks.
MR. COOKE: Did you have cross-examination?
MR. McKAY: I just have -- I did have a

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few questions.

RE-EXAMINATION

BY MR. McKAY:

Q. You -- you've been sitting in -- through this hearing both nights, haven't you?

A. No, I was only -- I gave testimony and then left last night. I was the first witness. So I missed the rest of last night, but all -- all of tonight.

Q. You would agree that the two company -- these independent reviewers for these two companies, there are some errors in their reviews?

A. Yes.

Q. Fair enough.

And you didn't hear Dr. Skudder, I don't believe, where --

A. No.

Q. -- he disagreed with some of the things in their reviews too --

A. I did not.

Q. -- is that right?

Did you hear Dr. Tribble?

A. I did.

Q. He disagreed with some of their conclusions, so --

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A. Yeah.

Q. -- it's just --

A. And I made that statement earlier that we certainly -- the MEC saw that there are errors or certain things that, you know, how can you know if you weren't in the OR. But despite that, the overall pattern is what was concerning to us, and there were things in there that we were concerned about that our panel said, "Yeah, that was a problem." So, yeah.

Q. And y'all initially had a Dr. Barone I think from Alabama or Virginia somewhere who was going to come and testify; is that correct?

A. And I -- I don't know details on that because that was arranged by the medical staff office.

Q. Okay. And he ultimately refused to come?

A. Correct.

Q. And got Dr. Skudder I guess on short notice and he came. He --

A. Yeah, I guess. I wouldn't have had any involvement in that. That was primarily arranged by the medical staff office.

Q. And y'all didn't know -- you didn't

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know Dr. Skudder was a well-known plaintiff's expert witness with lots of cases against doctors?

A. I was not aware of that.

MS. KREBS: I have -- I have not raised an objection. I'm going to object here.

MR. COOKE: Dr. Skudder --

MS. KREBS: Mischaracterization.

MR. COOKE: Challenge that characterization.

MR. McKAY: No more testimony from us.

MR. COOKE: Anything on redirect?

MS. KREBS: No, sir.

MR. COOKE: Questions from anybody else?

DR. RICHTER: The only thing -- a couple of things.

What again is our charge? What is the panel's charge? I want that to be one of the last things we --

MR. COOKE: That's probably worth covering once again. Then we'll talk about what we're going to do from here.

The -- the panel has the ability to close the hearing now if everybody is finished --

THE WITNESS: Should I be -- I'm -- can

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I should be excused or --

MS. HUTTO: Dr. Edwards has some rounds. Is that --

THE WITNESS: I'm going to go do some -- I'm going to go do my morning rounds.

MR. COOKE: Please.

THE WITNESS: Okay.

MS. HUTTO: Thank you.

MR. COOKE: It's almost morning.

MS. KREBS: Thank you.

MR. COOKE: And let me -- I think just for the record I'll say them one more time, and then we'll be in communication with each other anyway, and so I can clarify things as we go.

I'm just going to read you bits and pieces out of article VIX, which is really IX. It says that the -- "If requested by the judicial review committee, the hearing officer may participate in the deliberations of such committee and be a legal advisor to it, but the hearing officer shall not be entitled to vote.

"In this -- this type of a case which involves revocation of privileges, the body or committee whose adverse action occasioned the hearing, which the MEC shall have the initial

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burden to present evidence in support thereof, thereafter the burden shall shift to the practitioner to support his or her challenge to the adverse action by a preponderance of the evidence that the grounds therefore lack any substantial facts or basis or the conclusion drawn therefrom are either arbitrary, unreasonable or capricious.

"In all cases the hearing committee shall rule against the practitioner unless the hearing committee determines that the practitioner has met his or her burden of proof."

Then it goes on to talk about procedures for the hearing. And then under section J it says, "Upon conclusion of the presentation of oral and written evidence, the hearing may be closed. Each party shall have the right to submit a written statement within ten days of the close of the hearing providing arguments and authorities in support of its position. The hearing committee may thereupon within 30 days after receiving post hearing written submissions of the parties render a written decision in the matter which shall include a written statement of the basis of the decision.

"The hearing committee may forward a written decision together with the hearing record

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and all other documentation considered to the chief executive officer. The hearing committee's decision shall contain findings and facts which shall be in sufficient detail to enable the parties, the board or any other appellant review body to determine the basis for the hearing committee's decision on each matter contained in the notice of charges. The decision shall be supported by reference to the hearing record and all other documentation considered by the hearing committee."

I'm just asking, which exhibit is the -- is the statement of charges? Notice of charges?

MS. KREBS: It's I believe Number 4.

MR. COOKE: So that will be the template that the -- that the committee will follow because you're going to have to make -- you're going to have to reveal the basis for your decision on each matter contained in those charges.

Now, basis of decision, "The decision of the hearing committee shall be based on the evidence produced at the hearing. This evidence may include, but shall not be limited to, oral testimony of witnesses, briefs or memoranda of the

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points and authorities presented in connection with the hearing, any material contained in the medical staff's credential files regarding the person who requested the hearing, any and all applications, references and accompanying documents, all officially noticed matters, and any other relevant evidence considered by the hearing committee.

"The hearing committee shall also be entitled to consider all other information that may be considered pursuant to the medical staff bylaws in connection with applications for membership to the staff, medical staff and for clinical purposes."

Now, I don't read that as necessarily saying that this committee has to go out and research all those things itself. Presumably one party or the other would have brought those things forward if they were -- if they deemed them relevant. But that doesn't exclude the possibility if the committee wants to look in the credentialing file or applications or anything like that, that they would have the ability to do that.

One thing that the committee has asked for and that is in connection with your submissions we would like to have a proposed order finding in

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your respective favors, the meeting or requirements of the bylaws with the proper references to the record and references to each of the items in the notice of charge.

Is that -- that what we decided it was?

And we'd like it in Word format so they can make changes to it. And for convenience sake, I'm going -- I could be the point of contact. I'm going to get all these guys to e-mail me their contact information. So if you want to send them to me, I'll make sure they get to the members of the committee.

And then I will also be in touch with members of the committee so we can find the time sometime after ten days but before 30 days after that which you can meet to deliberate.

MR. McKAY: One question I had. Ten days, when will that be, because it would be nice to have a copy of the transcript. There's no way she can do that within ten days. So I'm just thinking logistics.

MR. COOKE: Well, I guess the parties could probably agree to an extension. Sort of under the impression that you would like to move this on, so --

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MR. McKAY: Well, I would. I have a big trial coming up the 7th of March. So I need to do it sooner than later.
MR. COOKE: Well, I mean --
MR. McKAY: I'll knock it out.
MR. COOKE: We can --
MR. McKAY: Ms. McMillan can knock it out.
MR. COOKE: You know, I don't mean to put words in these guy's mouths, but they start at 30 days. It probably wouldn't --
MR. McKAY: Sure.
MR. COOKE: -- wouldn't kill them if you wanted to take a few more days. We'll -- in the meantime we'll go ahead and try to find some dates that they could meet within the next 40 days.
So if the parties wanted to agree to more time, like I said, we're okay.
MR. McKAY: We may be okay on time. I'm just trying to --
MR. COOKE: So we would -- we would try not to -- we would try not to move that out --
MR. McKAY: Sure.
MR. COOKE: -- that outer limit of -- it's a total of 40 days for which there's a

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decision.
MS. KREBS: Give us dates and we'll do our best to accommodate.
MR. McKAY: Sure, I'm not -- just --
MR. COOKE: Why don't you let me know, and if you need more time, I will ask the committee if they're agreeable to that.
MS. KREBS: Just to be -- if I could just say in my words, what I'm hearing the committee wants is -- is proposed -- proposed findings, proposed conclusions, proposed -- proposed final order with the case support for the various propositions that we're submitting. Is that --
MR. COOKE: Well, such that it complies with what they're supposed to do under the bylaws. So if they agree with everything you said, they can sign it and send it to the CEO and be done.
Was there anything else?
DR. RICHTER: No.
DR. SIMPSON: No.
MR. McKAY: We usually have a closing statement, but I think it's pretty late, so --
MR. COOKE: Well, like I said, we've been here this long. If you want to say something,

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go ahead.
MR. McKAY: Well, it's awfully late and I'm awfully tired.
But it's just -- first I appreciate all your attention. I know no one wants to be here. And this -- these cases are a little bit out of most of y'all's field, but I can't tell you how -- well, you know how important this is to Dr. Randall. I mean, this is a career-ending thing for him. He's worked hard. He's well-trained. He's maintained his certifications.
And we just appreciate you giving a fair hearing. Thank you.
MR. COOKE: Anything?
MS. KREBS: I have no -- nothing to say other than that the Medical Executive Committee throughout this is more than aware of the investment that Dr. Randall has made in his training, his education and the time. It knows because it could be any one of these gentlemen and ladies, but of every decision they've made here, they made -- they made solely on the basis of trying to establish what was in the best interest of patient care for the purpose of patient safety.
They've tried to get the facts of the

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matter as best they could. They tried to extend the rights that are required under the bylaws, and more to the extent that is feasible and in the end to come to a conclusion by the facts that they determined. So thank you.
MR. COOKE: Also I think I made a partial misstatement yesterday when I was describing the procedure. As I read it again, either side has the opportunity to appeal if they get an adverse ruling from -- from the board.
MR. McKAY: Who is the appeal to?
MS. HUTTO: To the board.
MR. COOKE: To the full board.
DR. SIMPSON: Board of directors.
MR. COOKE: Now, let -- let me ask clarification from -- from these two sides.
In other bylaws that I've seen, the appellate -- appellate committee has the right to affirm, reverse or modify the recommendation of the MEC, but I don't see that here. I just see it as it's either up or down. Is that the way you read it?
MS. KREBS: I have to look actually.
MR. COOKE: What I was referring to, I've seen other cases where the board might say,

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you know, "Well, we don't think he should be terminated, but we think he should be, you know, peer-reviewed for a period," and go through a proctor and that kind of thing, but I don't really see that in here. I just --

MR. McKAY: That's just -- it's a little --

MR. COOKE: Yeah.

MS. KREBS: "If the appellate review committee conducts the appellate review," blah, blah, blah, "to afford its proposed position before the board in rendering its final decision as to removal, the board shall either adopt the appellate review committee's decision or modify that decision. In no case shall the board's modification result in the imposition of a greater penalty or restriction."

MR. COOKE: Okay. So it looks like the board has -- not us, but the board has the authority to modify whereas we're just either going to accept or reject the decision of the MEC.

MS. KREBS: Three minutes to 12:00 that's how I read it.

MR. COOKE: Well, if you --

MS. KREBS: Don't hold us to --

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MR. COOKE: If you think differently between now and ten days from now, include -- include that in your submission.

DR. RICHTER: The appellate review committee or whatever has the ability to just put comments attached to their decision?

MR. COOKE: I think you can do that, yeah. It --

DR. RICHTER: So the board makes a decision?

MR. COOKE: Yeah, he asked whether they have authority to put comments associated with their decision, and I -- I interpret this as yes, because they're supposed to give reasons as to each finding in the MEC's charges.

DR. POWELL: When you say each charge, are you talking about each individual case --

MR. COOKE: Well --

DR. POWELL: -- or each -- or each of the ones to the board and while this thing's --

MR. COOKE: I guess I read it -- if you read it literally, you -- you take that notice of charge and each of the charges in there you have to comment on.

All right? All right. We'll adjourn.

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Thank you very much. Everybody.

(The hearing was concluded at 12:02 a.m.)

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CERTIFICATE OF REPORTER

I, Yvonne R. Bohannon, Registered Merit Reporter, Certified Realtime Reporter, and Notary Public for the State of South Carolina at Large, do hereby certify:

That the foregoing transcript was taken before me on the date and at the time and location stated on page 1 of this transcript; that all statements made on the record at the time of the proceeding were recorded stenographically by me and were thereafter transcribed; that the foregoing proceeding as typed is a true, accurate and complete record of the proceeding to the best of my ability.

I further certify that I am neither related to nor counsel for any party to the cause pending or interested in the events thereof.

Witness my hand, I have hereunto affixed my official seal this 21st day of February, at Columbia, Richland County, South Carolina.

Yvonne R. Bohannon
Registered Merit
Reporter, CRR
My Commission expires
April 11, 2015

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Confidential: Not subject to disclosure pursuant to S.C. Code Ann. §40-71-20 and other applicable legal privileges

BEFORE THE PIEDMONT MEDICAL CENTER HEARING COMMITTEE

In the matter of
Robert D. Randall, Jr., M.D.

DECISION
FINDINGS OF FACT AND CONCLUSIONS

This matter is before the Undersigned Hearing Committee pursuant to the provisions of Article VIX (sic) of the Piedmont Medical Center Bylaws. An evidentiary hearing was held on February 15, 2011. The parties submitted post-hearing proposed findings on or before March 3, 2011. The members of the Hearing Committee reviewed and considered these submissions, as well as the hearing transcript and pertinent sections of the Bylaws.

The Hearing Committee has fully deliberated and has reached its decision, and it submits this Decision in accordance with the requirements of Article VIX, Section 4.J. and K. of the Medical Staff Bylaws. The Committee understands that under Article VIX, Section 4.G. of the Bylaws, the Practitioner, Dr. Randall, bears the burden "to support his challenge to the adverse action by a preponderance of the evidence that the grounds therefore lack any substantial factual basis or the conclusion drawn there from are either arbitrary, unreasonable or capricious."

Every member of the Hearing Committee independently reviewed the evidence concerning each case that formed a basis for the MEC decisions under review as well as the overall circumstances concerning Dr. Randall. The members of the Committee also discussed and debated each case, and other relevant matters referenced in Article VIX, Section 4.K. at length.

The Committee notes that Dr. Randall has had a long and distinguished career as a surgeon and has been a respected member of the Piedmont Medical Center Medical Staff and of the community. The Committee fully recognizes the gravity of the consequences to Dr. Randall of the actions that the Medical Executive Committee ("MEC") has taken against his surgical privileges. The Committee further notes that throughout these proceedings Dr. Randall has vigorously and earnestly defended his conduct as a physician. Equally, the Committee finds that the MEC has diligently carried out its duties under the Bylaws to protect the patients of Piedmont Medical Center by extending privileges of membership on the Medical Staff "only to professionally competent Licensed Independent Practitioners who continuously meet the qualification, standards, and requirements" set out in the Bylaws. (Article II, Section 1).

In its deliberations the Committee noted discrepancies in some cases between the MEC findings based on external reviews and the testimony of the MEC expert, Dr. Skudder. The Committee also fully considered the testimony of all witnesses, including Dr. Randall and his expert, Dr. Tribble. Nevertheless, the Committee unanimously finds

that the actions of the MEC were in no way arbitrary or capricious, but rather were carefully considered and carried out in accordance with the Bylaws. For the reasons discussed in more detail below, the Committee unanimously further concludes that Dr. Randall has not demonstrated by a preponderance of the evidence that the MEC's decisions to summarily suspend his privileges or to recommend revocation of his clinical privileges lack any substantial factual basis or that the conclusions drawn therefrom were arbitrary, unreasonable or capricious.

Findings of Fact

Procedural History

1. Robert D. Randall, M.D. is a board certified general surgeon who came to Rock Hill, South Carolina to practice surgery in 1982. T. 308.

2. In 2006 the Peer Review Committee of Piedmont Medical Center notified Dr. Randall that it had recommended that 100% of his open hernia repairs and carotid surgical procedures be subjected to retrospective review. The Committee based its recommendation on a review of 21 cases that had suggested various errors in judgment and technique, including a lack of appreciation of the morbidity and mortality of large abdominal hernia repairs in the elderly and a lack of surgical experience in handling difficult dissections around the portal structures and pelvic retroperitoneum. MEC Ex. 55-57.

3. The 100% review was conducted during 2007. The cases reviewed received acceptable scores in the review process and the Committee terminated the focused review. MEC Ex. 19-22, 49-54.

4. In 2009 Dr. Randall came again to the attention of the Peer Review Committee when several new cases suggested a pattern of issues similar to those that had been identified in 2006. These included inadequate preoperative assessment, rough handling of the bowel and post-operatively a concern that there was not enough active involvement by the surgeon or early recognition of signs and symptoms in the patient that should prompt a return to the operating room. T. 15-16.

5. The Peer Review Committee sent nine of Dr. Randall's cases for external peer review. T. 15.

6. The Peer Review Committee started to consider the external review findings in April 2010. T. 15-17, MEC Ex. 25-31, 48.

7. In June 2010, Dr. Edwards, in his capacity as Chief of Staff and Chairman of the Peer Review Committee, brought the results of the Peer Review Committee

review to the Credentials Committee. The Peer Review Committee determined that seven of the cases reviewed had problems. T. 17-18, MEC Ex. 45.

8. Following the presentation by Dr. Edwards, the Credentials Committee concluded that the cases sent for external review reflected the same types of problems that had been observed in the earlier review of Dr. Randall: the surgeon's technique with regard to handling of the bowel and judgment on timely returns to the OR. MEC Ex. 45.

9. Dr. Randall met with the Credentials Committee in July 2010 to discuss the cases that had been referred by the Peer Review Committee. MEC Ex. 18, 42, 43. The Committee informed Dr. Randall that it would recommend to the MEC that his reappointment be limited to one year pending the outcome of additional reviews. MEC Ex. 43.

10. In August 2010, another case came to the attention of the Peer Review Committee. It was forwarded for outside review. MEC Ex. 41.

11. In September 2010, the MEC considered the recommendation of the Credentials Committee. The MEC questioned whether the Credentials Committee recommendation was an adequate response to the concerns identified. T. 19-20. Dr. Jenkins, the chair of the Credentials Committee, informed the MEC that the Peer Review Committee had considerable knowledge of the matter and that the recommendation of the Credentials Committee to continue reappointment may not have been the right one. T. 34. The MEC thereupon appointed an ad hoc committee consisting of members of the Peer Review, Credentials and Medical Executive Committees to review the matter and make a recommendation to the MEC. T. 19.

12. The ad hoc committee sent Dr. Randall copies of seven outside review reports and asked Dr. Randall to respond in writing to the criticisms that had been made by the outside reviewers. T. 19-20, MEC Ex. 17, 40.

13. Dr. Randall provided a written response for the seven cases by letter, dated September 16, 2010. MEC Ex. 16.

14. After consideration of the outside review reports, Dr. Randall's written responses, pertinent portions of the medical records and the recommendations of the Peer Review and Credentials Committees, the ad hoc committee determined to recommend to the MEC that Dr. Randall's privileges for the performance of abdominal surgery, including herniorrhaphy, by either open or laparoscopic technique be revoked. The ad hoc committee informed Dr. Randall of its intention and invited him to meet with the ad hoc committee before it presented its recommendation to the MEC. MEC. Ex. 15, 38.

15. Dr. Randall met with the ad hoc committee on October 4, 2010. MEC Ex. 38.

16. After meeting with Dr. Randall, the ad hoc committee recommended to the MEC that Dr. Randall's privileges for the performance of abdominal surgery, including herniorrhaphy, by either open or laparoscopic technique be revoked. MEC Ex. 15. In a letter to Mr. Miller, the hospital CEO, the ad hoc committee noted that it had arrived at the determination taking into account internal peer review, external peer review, the pertinent portions of medical records and both the written and oral accounts offered by Dr. Randall. MEC Ex. 14.

17. The MEC accepted the recommendation for revocation of Dr. Randall's privileges to perform abdominal surgery, including herniorrhaphy, by either open or laparoscopic technique, on October 11, 2010. The MEC noted that it had based its recommendation on a series of Dr. Randall's cases, utilizing internal peer review, review by external experts and the oral and written remarks provided by Dr. Randall to the ad hoc review committee. The MEC also noted that it had become aware of two more recent cases and had considered the external expert review of these cases as well as an accounting of unplanned returns to the operating room by Dr. Randall and all other general surgeons. The MEC concluded that the surgical judgment and technique exhibited by Dr. Randall in the nine cases fell below the standards of the medical staff. MEC Ex. 13., T. 23-24.

18. Mr. Miller notified Dr. Randall of the adverse recommendation by letter dated October 15, 2010. MEC Ex. 12.

19. Shortly after the MEC made its recommendation for revocation, Dr. Edwards learned of another recent complaint involving a patient who had come in with a cholecystitis and postoperatively suffered an 11-unit bleed, a massive bleed. T. 25.

20. After review of the circumstances Dr. Edwards determined that he would invoke his authority to summarily suspend Dr. Randall's clinical privileges to perform abdominal surgery on the grounds that Dr. Randall's continued operating posed an imminent danger to patients. Dr. Edwards explained that at that point, there had been "many adverse outcomes, dangers, and even deaths, and we thought that that could happen to another patient imminently." He also noted that the MEC had considered summary suspension before recommending revocation. T. 25-27, MEC Ex. 11.

21. Dr. Randall received written notice of the summary suspension and the reasons for it by letter, dated October 15, 2010. He was offered an opportunity to address the MEC before the MEC determined to modify, continue or terminate the suspension. MEC Ex. 11.

22. By letter, dated October 18, 2010, Dianne West, the director of medical staff services, sent Dr. Randall copies of the external peer review results in the two new cases that had been considered by the MEC as well as the result of an analysis of returns to the OR within 30 days of the first operation for the period 2008 and January through July 2009. MEC Ex. 10.

23. Dr. Randall met with the MEC on October 25 to contest the summary suspension. He addressed the case involving the 11-unit bleed that had led to the summary suspension as well as two newer cases that had been sent for external review. He also discussed the cases that led to the recommendation for revocation. MEC Ex. 35.

24. At that meeting, he informed the MEC that the case that led to the summary suspension involved "a little bit of bleeding" but that the patient had done fine. The MEC concluded that 11 units was not a little bit of bleeding and that Dr. Randall had a lack of appreciation for the severity of the problems that existed. T. 31. In addition, Dr. Randall did not appear to recognize that anything was wrong in the three cases that had come to the attention of the MEC since it had met with him in September 2010. MEC Ex. 35.

25. By letter dated October 28, 2010 Dr. Edwards informed Dr. Randall that the MEC had determined to sustain the summary suspension of his abdominal surgery privileges and informed him of his right to contest the summary suspension as well as the earlier recommendation for revocation of his clinical privileges to perform abdominal surgery. Dr. Randall would retain his other privileges. MEC Ex. 7.

26. Dr. Randall requested a hearing to contest the adverse actions. MEC Ex. 8.

27. By letter dated November 4, 2010, Dr. Edwards gave Dr. Randall notice that a hearing would be conducted on January 12, 2011. MEC Ex. 6.

28. By letter, dated December 17, 2010, Dr. Edwards issued a Notice of Hearing and Grounds, setting forth a summary of Dr. Randall's hearing rights and informing him of the specific cases and matters in question. By agreement of the parties the hearing was rescheduled from January 12, 2011 to January 5 and 6, 2011. MEC Ex. 4.

29. By request dated January 3, 2011, the MEC requested postponement of the hearing for good cause pursuant to Article VIX, Section 4.C of the Bylaws of the Medical Staff because its expert had informed the MEC representatives that he could not attend the hearing because of a scheduling conflict. MEC Ex. 3.

30. By Second Request, dated January 5, 2011, the MEC requested that the hearing be postponed to a mutually agreeable date in February 2011 because its expert

witness had informed the MEC representative that he would no longer be available to testify as an expert. MEC Ex. 2.

31. The Medical Staff Bylaws permit postponement of the hearing beyond the time frames set forth in the Bylaws for good cause shown. Medical Staff Bylaws, Art. VIX, Section 4.C. The MEC had demonstrated good cause for requesting postponement of the hearing.

32. The hearing was conducted on the evenings of February 16 and 17, 2011 at Piedmont Medical Center before a panel of five physicians, none of whom is in economic competition with Dr. Randall and none of whom had previously participated in the formal consideration of the matter at any level.

33. Dr. Randall objected to the failure to include a general surgeon on the Hearing Committee. Defendant's Ex. 8. The Hearing Committee finds that the absence of a general surgeon did not materially affect the Committee's ability to consider the evidence and reach its decision in this matter.

34. The Medical Staff Bylaws do not require that a person in the same medical specialty as the affected physician be included on the Hearing Committee. On the contrary, the Bylaws require that no person in direct economic competition with the practitioner be appointed to the Hearing Committee. Medical Staff Bylaws, Article VIX, Section 3.A.

The Charges - General

1. By notice dated December 17, 2010, the MEC set forth the grounds for the summary suspension and recommendation for revocation of abdominal surgical privileges, including herniorrhaphy, by either open or laparoscopic technique. Generally, the grounds were that Dr. Randall had exhibited a pattern of surgical care that does not meet generally accepted standards of professional competence or the standards of the medical staff. In particular, the MEC cited 10 cases that provided the basis for the adverse action. MEC Ex. 4.

2. The recommendation for revocation was based on cases #1-9 listed in the December 17, 2010 notice together with an analysis of unplanned returns to the operating room as compared to Dr. Randall's peers following consideration of internal peer review, review by external experts and oral and written remarks provided by Dr. Randall. The summary suspension was based on case #10 taking into account review of the nine cases that had led to the recommendation for revocation. MEC Ex. 11, 7.

3. Dr. Paul Skudder, a board certified surgeon and vascular surgeon, testified as an expert witness on behalf of the MEC. MEC Ex. 60. There was no objection to his qualifications to serve as an expert.

4. Dr. Skudder testified that the presence of a complication does not, in and of itself, mean substandard care. Dr. Skudder also noted that good outcomes can occur in the context of very poor medical care. T.58.

5. Dr. Skudder testified that in his review of the cases underlying the MEC charges, he saw two over-arching themes: i) some cases reflected flawed judgment and some cases reflected significant technical weaknesses; and ii) the judgment or technical weaknesses contributed to a pattern of fecal contamination and other septic complication in several patients and to other complications in specific cases. T. 59, 134-136.

6. The Hearing Committee fully considered the testimony of all the witnesses who testified and all of the documentary evidence submitted by both parties. However, the following discussion is not intended as an exhaustive summary of the evidence; rather the focus is primarily on the adequacy of the evidence tendered in support of the MEC's findings, since the Committee's role is not to make independent factual findings but rather to determine whether the MEC's actions lack substantial factual support or are arbitrary, unreasonable or capricious.

The Specific Charges, the Corresponding Evidence, and the Hearing Committee's findings:

1. Patient RC (MR 334851):

   (a) The charge: The MEC alleged that the selection of the initial operative procedure was substandard or not indicated in that Dr. Randall performed procedures that subjected the patient to unnecessary complications. Specifically, it was not necessary to perform a left colectomy as the first operation, requiring him to operate on grossly distended bowel, when a simple diverting colostomy would have sufficed and subjected the patient to fewer complications and less risk. Moreover, his technique in handling the colon and colostomy was questionable. MEC Ex. 4.

   (b) The evidence:

      (i) Dr. Skudder testified that Dr. Randall's choice of initial operation (Hartmann's procedure for acute suppurative diverticulitis) was appropriate.

      (ii) Dr. Skudder testified that this case involved devascularization of the bowel during the course of the procedure. According to Dr. Skudder, ischemic transverse colon and splenic flexure developed the day following surgery and there is no clinical data to support the risk of spontaneously occurring ischemia as suggested by Dr.

Randall. According to Dr. Skudder, the ischemia was most likely associated with dissection around the splenic flexure, with the intent of mobilizing it to bring out a tension free transverse colostomy (as described in Dr. Randall's op note). For a combination of reasons, primarily some difficulty associated with mobilizing the splenic flexure, Dr. Randall abandoned these efforts and chose to bring out a descending left colostomy. Dr. Randall's note described this as being tension free. Dr. Skudder testified that any surgeon with experience in this area would have known that the transverse colostomy would have been "looser" and more easily traversed the abdominal wall, especially if the patient were obese as was the case with this patient. According to Dr. Skudder, Dr. Randall's manipulations resulted in a non viable colostomy the following morning. In Dr. Skudder's opinion, Dr. Randall's dissection technique resulted in ischemia and necrosis of bowel. T. 90-93.

(iii) The patient recovered after a total abdominal colectomy. The patient also had an incidental appendectomy. Dr. Skudder testified that although no problems could be attributed to this added procedure, the judgment to do this procedure in this setting was certainly subject to question. T. 94-95.

(iv) In Dr. Skudder's professional opinion, the colostomy would not have broken down had appropriate technique been used. T. 95.

(c) The Hearing Committee concludes that the MEC's criticism of Dr. Randall's choice of procedure lacks any substantial factual basis and is therefore unreasonable. However, this is the first of three presented cases involving unexplained ischemia, and the Committee concludes that the MEC's finding that Dr. Randall's technique in handling the colon and colostomy was questionable is supported by a substantial factual basis and was not arbitrary, unreasonable, or capricious.

2. Patient WC (MR 214222):

(a) The charge: The MEC alleged that in the course of performing a laparoscopic cholecystectomy, Dr. Randall exercised substandard judgment in further dissecting previously operated upon bowel in the right lower quadrant, such bowel not apparently contributing to the primary indications for surgery, and in the course of that dissection created an unrecognized and therefore unremedied injury to the intestinal tract that led to patient's very serious decline due to consequent sepsis and then death. MEC Ex. 4.

(b) The evidence:

(i) Dr. Skudder testified that this case involved bowel perforation during laparoscopic cholecystectomy, with apparent delay in re-exploration as the patient deteriorated with ongoing abdominal sepsis over several days. T. 97-100.

(ii) There was a technical issue (perforation during dissection of adhesions in the right lower quadrant, site of prior appendectomy with post op infection) and a judgment issue (delay in re-exploration). The patient expired with abdominal sepsis.

(iii) Dr. Skudder testified that in his opinion there were issues regarding who may or may not have been responsible for post-op care as Dr. Randall had signed the patient out to his partner on a Friday afternoon and did not return until the following Monday. However, the patient's outcome flowed from the unrecognized bowel perforation during dissection at the first operation. T. 100.

(iv) Dr. Randall acknowledged that the patient had a small bowel injury, that the patient should have been explored on the first post operative day and that he missed that, and that the care of the patient was substandard. Defendant's Ex. 1.

(v) The case was one of four that in Dr. Skudder's view showed what appeared to be direct trauma and injury to the hollow organs in surgeries Dr. Randall performed. T. 97.[1]

(c) The Hearing Committee concludes that the evidence does not support the MEC's finding that Dr. Randall exercised substandard judgment in his choice of procedure. However, the MEC's finding that Dr. Randall "created an unrecognized and therefore unremedied injury to the intestinal tract that led to patient's very serious decline due to consequent sepsis and then death" has a substantial factual basis and was not arbitrary, unreasonable, or capricious.

3. Patient CE (MR 342876):

(a) The charge: The MEC alleged that Dr. Randall elected to operate on this man in the face of very high risk factors for indications that appear to be marginal. The patient suffered multiple complications of life-threatening dimensions due to repeated technical failures, raising concerns about Dr.

[1] The other cases were Mahaffey, Walker and Parnell. T. 97.

Randall's technical as well as cognitive processes. MEC Ex. 4.

(b) The evidence:

(i) Dr. Skudder testified that a patient with what seems to have been a partial bowel obstruction was brought immediately to surgery, had a segmental small bowel resection, and suffered anastamotic breakdown and abdominal sepsis. Reoperation and a second anastamosis resulted in further leakage, and finally the patient underwent extensive bowel resection, left with short bowel syndrome. T. 78.

(ii) Dr. Skudder opined that Dr. Randall demonstrated judgment issues with respect to his decision to operate in a high risk morbidly obese patient with partial bowel obstruction (instead of pursuing initially a more conservative course) and technical flaws regarding the performance of the anastamosis, which should have had a low risk of breakdown and leakage. In fact, two consecutively performed small bowel anastamosis broke down in this individual. T. 77-80.

(iii) Dr. Skudder opined that each instance of anastamosis breakdown was attributed by Dr. Randall to localized ischemia in the vicinity of the anastamosis. According to Dr. Skudder, there was nothing in the medical record to suggest that the patient had ischemia of the bowel as a whole. According to Dr. Skudder, this led to the inevitable conclusion that the bowel margins, during dissection and preparation for anastamosis, were devascularized enough to culminate in anastamotic failure. T. 80-81.

(iv) Dr. Skudder opined that the reproducibility of the event in this patient, coupled with the cecal ischemia following dissection in the mesentery in patient Wilburn demonstrate a pattern of lack of expertise in handling the mesenteric blood supply in the bowel margins. T. 81.

(v) Dr. Skudder noted that the prior outside reviewer had viewed the cases similarly in that he attributed the failure of the anastamoses to devascularization during dissection and handling. Additional support for this mechanism of anastamotic failure is gleaned from Dr. Randall's 12/21 letter to the medical staff in which he states that the second anastamosis failed at its anterior portion. This refers to the antemesenteric wall of the anastamosis, furthest from the mesenteric blood supply and most vulnerable to ischemia. T. 81-82.

(vi) Dr. Randall defended his management of the ensuing fistulae. Dr. Skudder testified that while Dr. Randall's choice of surgical management may not have deviated from established standards of care regarding this specific issue, the development of the fistulae occurred only as a result of the repeated technical problems with devascularization of the bowel at the anastamoses. T. 82-83.

(vii) Dr. Skudder opined that the fundamental technical flaw was handling of the bowel in such a way that twice in a row a small bowel anastomosis fell apart. Dr. Skudder opined that there was nothing in the record to suggest any reason for the breakdown other than a failure of surgical technique. T. 83, 86.

(c) The Committee concludes that the evidence does not support that Dr. Randall's election to operate on this patient was a deviation from accepted standards of care. However, the Committee concludes that the MEC's findings concerning Dr. Randall's technical failures have a substantial factual basis and were not arbitrary, unreasonable, or capricious.

4. Patient JP (MR 156580):

(a) The charge: The MEC alleged that in the course of a laparoscopic cholecystectomy, Dr. Randall encountered an inflammatory mass that by his description made identification of the anatomic structures impossible, yet he persisted in laparoscopic dissection, converting to open only after observing the spillage of either bile or feculent matter. He resolved the uncertainty by resecting both gallbladder and colon, characterizing the latter as necrotic, though pathologic examination does not support that conclusion. MEC Ex. 4.

(b) The evidence:

(i) Dr. Skudder testified that this patient suffered injury to the colon (trocar or dissection) at the time of a laparoscopic cholecystectomy. The procedure was converted to open. A pre-existing ventriculoperitoneal shunt was divided and repaired in the course of open dissection. The patient went on to recovery. T. 116-119.

(ii) Dr. Skudder testified that in his view there were technical concerns surrounding the injuries. Questions of judgment include the initial decision to do the procedure laparoscopically, though many surgeons would probably have attempted this. Dr. Skudder's testimony does not support a finding of deviation from accepted standards of care in the selection of operative procedure.

(iii) Dr. Skudder noted that Dr. Randall's December 21 letter stated that there was no colon injury in this patient. Defendant's Ex. 1. There are at least 3 descriptions of the colon injury in the operative report. MR[2] 19-22, T. 119-121.

(iv) Dr. Skudder opined that in his opinion it was most likely that the colon was injured by trocar during the attempt at laparoscopy. T. 117. In any event, the failure to recognize or acknowledge this was very worrisome as Dr. Randall documented colon injury at the time of the operation. MR 19-22.

(c) Though the evidence is inconclusive as to whether the colon was in fact injured in this case, the Committee concludes that the MEC's findings concerning Dr. Randall's exercise of judgment have a substantial factual basis and were not arbitrary, unreasonable, or capricious.

5. Patient DS (MR 225223):

(a) The charge: The MEC alleged that Dr. Randall failed to appreciate and/or properly respond to the surgical urgency of the diagnosis of paraesophageal hernia; once in the operating room he neglected a fundamental part of the curative procedure, i.e. placement of a percutaneous tube gastrostomy which is important to the anchoring of the stomach and prevention of recurrent migration and torsion. Having initially neglected this, he returned the patient to the operating room to perform a tube gastrostomy, at a point at which a less invasive technique might have sufficed and for a reason (enteric nutrition) for which a tube gastrostomy is not likely to perform well in such a patient. Once the gastrostomy's failure in that regard was recognized, he yet again returned the patient to the operating room for a tube jejunostomy, from which there were several complications and repeat operations, the first of which was the unrecognized dislodgement of the tube with spillage into the peritoneal cavity. MEC Ex. 4.

(b) The evidence:

(i) This patient had a very large paraesophageal hiatal hernia repaired. The procedure was begun through the laparoscope, but converted to open given the technical challenges encountered. Post-operatively gastric retention became an issue. A gastrostomy tube, and later a feeding jejunostomy tube were placed. The

[2] "MR" refers to the patient's medical record. The numbers refer to the electronic page number.

jejunostomy became dislodged warranting further exploration and provoking a period of severe sepsis. The Nissen fundoplication remained intact.

(ii) Dr. Skudder acknowledged that this was a difficult operation, and seems to have been done technically well. According to Dr. Skudder the major concern was the timeliness of recognition of the dislodged jejunostomy tube. After this occurred pre-op orders were written at 1630 hours 4/21, but surgery not performed until 1030 the following day. The patient waited for surgery with a jejuna leak at the site of the jejunostomy tube contaminating the peritoneum in the context of free tube feedings (an excellent culture medium) in the peritoneum for 18 hours or longer. Dr. Skudder opined that this case should have been a higher priority than all but major trauma, vascular emergencies such as ruptured aneurysms, and a few other cases. T. 126-129.

(c) The Committee concludes that the MEC's findings have a substantial factual basis and were not arbitrary, unreasonable, or capricious.

6. Patient SW (MR 137911):

(a) The charge: The MEC alleged that Dr. Randall documented the significant co-morbidities in this case and proceeded with a non-emergency procedure despite them. The patient experienced multiple, life-threatening complications, due in part at least to substandard judgment and technique in the handling of the bowel, including at least one unintended injury, the repair of which failed. MEC Ex. 4.

(b) The evidence:

(i) This patient had repair of ventral hernias. He was morbidly obese. He had had prior gastric bypass. He developed multiple enterocutaneous fistulae after the procedure, reflecting bowel injury during dissection. T. 111.

(ii) Dr. Skudder testified that the judgment to use a laparoscopic approach might be questioned by some but is an acceptable option in many patients. The patient was re-explored the following day with bleeding from a trocar site. In addition to this, there was what was described in the chart as "necrotizing fasciitis" in the bowel wall. This had a malodorous quality. Exploration demonstrated a colon injury. Cultures showed 4 fecal organisms. T. 111-114.

(iii) Dr. Skudder opined that what the patient really had was a perforation of the bowel at the first surgery, likely from the trocar placement, resulting in a necrotizing synergistic aerobic and gram negative bowel wall infection and eventual colocutaneous fistulae. T. 114.

(iv) Dr. Skudder testified that one cannot attribute this patient's complications to an unexplained "necrotizing fasciitis," as though this were some unrelated development. Indeed, the common usage of this term refers to a gram positive infection acquired in a totally different set of circumstances. The attribution of the patient's complication to "necrotizing fasciitis" (in the hospital chart as well as in Dr. Randall's Dec 21 letter to the medical staff leadership) as though it were an unrelated event suggests a failure to recognize the reality of the situation - that the problem stemmed from a surgical complication. T. 114-115.

(c) The Committee concludes that, whether or not the bowel injury was caused by a trocar perforation, the MEC conclusion has substantial factual support, including the culture findings, and was not arbitrary, unreasonable, or capricious.

7. Patient CW (MR 178902):

(a) The charge: The MEC alleged that this young man upon whom Dr. Randall performed an apparently uncomplicated appendectomy returned shortly after discharge with signs of sepsis. Upon re-exploration the patient was found to have a focal defect in the cecum at his appendectomy site and feculent spoilage of the peritoneal cavity. The patient died. MEC Ex. 4.

(b) The evidence:

(i) This 34-year old patient died after developing cecal necrosis following an appendectomy. The case was one of three[3] in which unexpected necrosis of the bowel was present with no identifiable cause of ischemia present other than surgical manipulation. T. 68.

(ii) Dr. Skudder testified that there were almost certainly technical issues at play in this case. Dr. Skudder testified that he suspected that the right colic artery was injured or ligated during dissection of

[3] The three cases were the [redacted] and [redacted] cases. T. 68.

the mesoappendix (dissection being into the meson-colon). T. 69-70.

(iii) Dr. Skudder stated that he was concerned about Dr. Randall's response to the medical staff about this case. MEC Ex. 16. In his letter, Dr. Randall stated that there is absolutely no way that devascularization of the cecum could have occurred. Dr. Skudder opined that Dr. Randall's statement was contrary to the operative findings at the second operation. According to Dr. Skudder, attribution of the cecal necrosis to a low-flow state fails to account for the fact that the patient presented with abdominal symptoms and leukocytes before developing shock from sepsis. In other words, the changes in the cecum came first (as a result of devascularizing the colon) and the shock state followed this. Dr. Skudder observed also that a low flow state of the nature described by Dr. Randall would impact the small bowel far more commonly than the cecum and would be expected to demonstrate non localized patchy ischemia throughout the bowel which did not occur. According to Dr. Skudder, this patient's finding of localized ischemia to the cecum clearly reflects a different process, and it fits tightly together with the operative description of a troublesome mesenteric bleeder in the vicinity of the appendix (which is also in the vicinity of the cecum and its blood supply). T. 72-73.

(iv) Dr. Skudder voiced concern about Dr. Randall's apparent reluctance to see the reality of the patient's condition or concede it as a possibility. Even if other physicians participated in the patient's care during the second admission and had poor communication, the poor communication would not have mattered had the initial technical problem not occurred. T. 74.

(c) The Committee concludes that evidence supports that this is another unexplained case of bowel injury, and the MEC's findings have substantial factual support and were not arbitrary, unreasonable, or capricious.

8. Patient FM (MR 125214):

(a) The charge: The MEC alleged that Dr. Randall performed multiple procedures on this patient on two occasions, manifesting apparent confusion about the nature of the anatomic defects with which he was presented. In the course of performing the first surgery Dr. Randall apparently created a bladder injury that was not properly dealt with until the second operation. MEC Ex. 4.

(b) The evidence:

(i) This patient underwent right recurrent inguinal hernia mesh repair simultaneously with drainage of a purulent scrotal abscess on the opposite side. T. 102.

(ii) There was a sliding hernia on the right and the bladder wall protruded into the inguinal hernia, and was injured. The injury was suspected but not recognized. It became clear in the early post op period. The patient was re-explored, and a properitoneal repair of the sliding hernia (which was persistent) carried out, with a urologist simultaneously repairing the bladder. T. 106-107.

(iii) Dr. Skudder opined that the issues are of judgment in combining the two operations at the first procedure, as well as not opening above the inguinal ligament given the findings encountered at the first operation. Technical concerns about the first repair, with bladder wall injury and immediate recurrence of the hernia, are also warranted. T. 107.

(iv) Dr. Randall provided a letter stating that he had abandoned efforts at repair given the magnitude of the hernia, and planned a second surgery with a properitoneal approach (above the inguinal ligament). According to Dr. Skudder, such a decision can be reasonable because as long as no harm has been done it is always acceptable to "come back and fight another day" if it is believed that a better approach will be possible. In Dr. Randall's operative note, however, there is no reference to this decision, and such decision making certainly should have been documented if the surgeon was deliberately aborting the procedure. Second, there is no reason that the properitoneal repair could not have been done at the same setting. Third, the progress notes show absolutely no decision making regarding possible re-op until the bladder injury is identified. The December 21 letter also fails entirely to address the issue of operating on a known purulent abscess at the same time one is placing mesh in the hernia. T. 107-111. The Committee does not agree with Dr. Skudder's criticisms of Dr. Randall in this regard.

(c) The Committee believes that Dr. Randall exercised proper judgment and technique in this case, though his documentation was suboptimal. The MEC's findings were not arbitrary or capricious based on the evidence that it considered, but based on the totality of the circumstances the Committee concludes that the MEC's findings in regard to this case do not have a substantial factual basis and therefore were not reasonable.

9. Patient SJ (MR 137929):

(a) The charge: The MEC alleged that Dr. Randall operated upon this patient for gastric bleeding and performed a "sleeve gastrectomy", a procedure rarely or never employed for this indication. As a result of the performance of this procedure, the patient's stomach would not empty properly, and he returned the patient to the operating room and performed an extensive second operation, one more ordinarily utilized for the treatment of duodenal ulcer rather than for non-ulcer gastric outlet obstruction. This operation also failed to relieve the patient's gastric emptying dysfunction, and a tube jejunostomy was placed; the patient will be re-operated upon at an interval by another surgeon. MEC Ex. 4.

(b) The evidence:

(i) The patient had delayed gastric emptying after a partial gastrectomy for hemorrhage from a benign gastric ulcer. Antrectomy and gastrojejunostomy (Billroth II reconstruction) were carried out. The patient had persistent gastric retention for some time post operatively, but recovered eventually. The record was not available to determine whether the initial gastric outlet obstruction was a mechanical or technical complication of the first operation, or was a motility problem that would have reversed with time. The later operations seem to have been technically adequate. A retained portion of a broken needle in the abdominal wall was not recovered. A retained needle is not ideal but a decision not to retrieve it could be reasonable if the threat the retained portion of the needle presents is trivial. T. 133.

(c) The MEC did not find that Dr. Randall's conduct deviated from the generally accepted standards of care in this case. The Committee concurs with this conclusion.

10. Patient JR (MR 135540):

(a) The charge: The MEC alleged that Dr. Randall persisted in a prolonged laparoscopic cholecystectomy for a gangrenous gallbladder. The patient required eleven (11) units of transfused blood in the first 48 postoperative hours, and manifested the consequences of hemorrhagic blood loss in her requirements for critical care and ventilatory support. A CT of the abdomen demonstrated a large hematoma beneath the liver at the site of surgery; such bleeding is extraordinary and indicative of a surgical misadventure, and the decision to observe rather than attempt control of the hemorrhage is an example of questionable judgment. MEC Ex. 4.

(b) The evidence:

(i) This patient suffered an 11 unit bleed into the peritoneum after laparoscopic cholecystectomy for a gangrenous gallbladder. The procedure was not converted to an open procedure despite many statements regarding the difficulty of the procedure in the operative note and Dr. Randall's letter of 12/21/10. Many surgeons would have converted to an open procedure. Defendant's Ex. 1. The bleeding is thought to have arisen from the liver bed though this is not established. The patient developed sepsis and a small sub hepatic abscess later in her course. She recovered after a period of critical illness in the ICU. T. 59-63, Ex. 34.

(ii) Dr. Skudder testified that technical concerns surround the origin of the bleeding. Judgment concerns included the choice not to open despite the technical difficulties described in the operative note, and the decision not to re-operate as the patient was bleeding 11 units over the next two to three days. T. 63-64. Dr. Skudder testified that although the patient survived, that is not a guarantee of a good outcome. The patient's course was probably longer than it would have been if she had an uncomplicated open cholecystectomy. Also, the 11 units – about a gallon and a half hematoma in the belly – left the patient at risk for multiple complications. T. 64.

(iii) The only imaging available regarding this bleeding is a CT showing a hematoma below the liver. There was no study or intervention to help sort out the true source of the bleeding. Dr. Randall stated unequivocally that the bleeding was from the liver bed. Defendant's Ex. 1. According to Dr. Skudder, the liver bed is certainly a potential source of such bleeding, but is not the only source. Other sources might include the cystic artery or other vessels in the "Porta" Hepatis. Dr. Skudder testified that attribution of the bleeding to the liver bed may in some sense be self serving because it does not imply failure of ligation as does bleeding from the cystic artery, nor does it imply "collateral" injury to unintended structures (e.g. duodenal arteries). T. 65. Bleeding from a raw surface like the liver bed may have a bit better chance of spontaneous cessation and can be difficult to suture surgically, so this attribution might have been used to justify a conservative approach. The problem is that there is not evidence available to support the attribution of the bleeding to the liver bed rather than any other source. As pointed out by the first reviewer, this patient remained at risk following discharge for hematoma related complications, including infection, abscess formation, and azotemia or jaundice upon resorption of this volume of blood. T. 66.

(iv) Dr. Randall did not appreciate the magnitude of an 11 unit blood loss and his failure to explore the reasons for the blood loss was not consistent with generally recognized standards of care or compatible with patient safety. Whether the husband complained about his wife's care because she was a "southern porcelain princess" and he sought to "fix" her complaints was irrelevant. T. 423.

(v) Dr. Skudder testified further that allowing a patient to bleed 11 units, virtually the entire blood volume without considering or actually performing exploration, was a judgment error and the review committees were rightly concerned about it as it had clear implications for patient safety. T. 66-67.

(c) The Committee concludes that the evidence fully supports the MEC's conclusion that Dr. Randall deviated from generally accepted standards of care in this case to such an extent as to warrant the summary suspension of his privileges. The MEC's action has a substantial factual basis and was not arbitrary, unreasonable, or capricious.

Conclusions

1. Substantial evidence supports the conclusion that Dr. Randall has demonstrated a persistent pattern of judgment error and lack of technical proficiency with respect to abdominal surgery.

2. The evidence reasonably supports the conclusion that these patterns of error and technical deficiency differed in frequency and degree from those of other surgeons at Piedmont Medical Center, particularly with regard to themes of difficulties in preoperative assessment and planning, post operative care, intraoperative surgical technique and unplanned returns to the OR (even excluding the two cases that Dr. Randall explained were planned returns). No other surgeon had such a high number of cases coming through the peer review process. T. 29.

3. The evidence reasonably supports that these errors of judgment and skill led to the deaths of certain patients or caused others to suffer complications and prolonged hospitalizations. The outcomes for the patients at issue were adverse and severe in terms of morbidity and significant mortality. T. 29.

4. The evidence reasonably supports that Dr. Randall did not demonstrate that he appreciated the severity of the problems that existed in his surgical performance.

5. There was no evidence that Dr. Randall's patients were sicker or fatter or poorer than other patients treated at the hospital and thus more prone to complication. T. 424-427.

6. The MEC voted to recommend that Dr. Randall's abdominal surgery privileges be revoked based on a persistent pattern of cases demonstrating poor judgment in multiple cases, problems of technique and a failure to appreciate these problems as well as an analysis demonstrating more unplanned returns to the OR than any other surgeon on staff. T. 25-30

7. The MEC summarily suspended Dr. Randall's abdominal surgery privileges based on evidence that had accumulated demonstrating poor judgment, problems of technique, and a failure to appreciate these problems and a triggering case involving a patient who lost her entire blood volume over an approximate 3-day period of time without his going back to explore the source of the bleeding. T. 25-30.

8. The MEC could reasonably conclude that a surgeon who demonstrates such a persistent pattern of errors of judgment and technique would pose an imminent danger to patient safety.

9. According to the Bylaws of the Medical Staff, the MEC has the initial burden to present evidence in support of the summary suspension and recommendation for revocation of abdominal surgical privileges. Art. VIX, Section 4.G.

10. The MEC met its burden based on MEC exhibits 1-60 and the testimony presented by Drs. Edwards and Skudder.

11. Thereafter, the burden shifts to Dr. Randall to demonstrate that the grounds for the adverse action and recommendation "lack any substantial factual basis" or that the conclusions drawn there from are either arbitrary, unreasonable or capricious. Bylaws, Art. VIX, Section 4.G.

12. Dr. Randall has not demonstrated that there is not any substantial factual basis for the MEC's adverse recommendation or action or that the action or recommendation is arbitrary, capricious or unreasonable.

13. The MEC took action to summarily suspend Dr. Randall's privileges to perform abdominal surgery, including herniorrhaphy privileges, whether by open or laparoscopic technique, in the reasonable belief that the action was in the furtherance of patient safety and thus quality health care.

14. The MEC took action to recommend revocation of Dr. Randall's privileges to perform abdominal surgery, including herniorrhaphy privileges, whether by open

or laparoscopic technique, in the reasonable belief that the action was in the furtherance of patient safety and thus quality health care.

15. By reviewing the patient records, seeking external review of the subject records, taking into account Dr. Randall's view and considering the collected information carefully, the Medical Executive Committee and other involved medical staff committees made a reasonable effort to obtain the facts of the matter.

16. Dr. Randall was afforded the procedural rights to which he was entitled under the Medical Staff Bylaws, including fair hearing rights.

17. Dr. Patterson did not testify or otherwise participate in the hearing before this Review Committee, and he did not in any way influence the Hearing Committee's deliberations.

18. The recommendation for revocation and summary suspension of clinical privileges to perform abdominal surgery, including herniorrhaphy privileges, whether by open or laparoscopic technique, was warranted by the facts known to the MEC after making a reasonable effort to obtain the facts.

Order

Based on all of the findings and conclusions set forth above, the Hearing Committee recommends that the Medical Executive Committee recommendation for revocation and summary suspension of clinical privileges to perform abdominal surgery, including herniorrhaphy privileges, whether by open or laparoscopic technique, be upheld.

Respectfully submitted,

Hearing Committee

By: Robert E Thomas MD
Dr. Robert Thomas

March 28th, 2011
Rock Hill, South Carolina

Respectfully submitted,

Hearing Committee

By: _____
Dr. Sashi Naidu

Oncologist

March 29, 2011
Rock Hill, South Carolina

Respectfully submitted,

Hearing Committee

By: Richard L. Richter
Dr. Richard Richter

March 30, 2011
Rock Hill, South Carolina

Respectfully submitted,

Hearing Committee,

By:
Dr. Thomas Simpson

March 30, 2011
Rock Hill, South Carolina

ORAL SURGEON

Respectfully submitted,

Hearing Committee

By: _____
Dr. Neal Powell
orthopedic surgeon

March 29, 2011
Rock Hill, South Carolina

Presbyterian HEALTHCARE

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Meeting Summary
July 01, 2009

I was approached by PMG leadership to conduct interviews regarding the quality care of Dr. Bob Randall, a general surgeon in Rock Hill, SC. On July 1, 2009 Dr. Andrew Moller and I interviewed his three partners, as well as his nurse practitioner, Vicky Blackburn. We met with each of these practitioners on an individual basis.

Dr. Chris Schroeder:

He is Dr. Randall's long term partner. Chris noted he has enjoyed working with Dr. Randall they have a good professional relationship. He noted Dr. Randall was a hard worker and took care of his patients. He felt that he was engaged with appropriate judgement and skills. However, he was able to outline several cases during which outcomes were less than optimal. He did note a cp patient with a large paraesphogeal hernia that Dr. Randall attempted a repair first lapriscopically, then converting to an open procedure. That patient has had multiple take-backs to the OR, and has had a prolonged hospitalization.

Dr. Walter Revell, Jr.:

He has been a general surgeon in Rock Hill, SC since 1982. He notes that for a long time Dr. Randall has been "rough on tissue." Because of this inability to perform parts of a procedure gently he feels that this has resulted in multiple complications. He mentioned Dr. Randall is "always in a hurry," even when he has nothing later to do. Because of his speed he feels he is inattentive and does not have the discerning nature to know when to move along in an expedious factor, or when it's appropriate to slow down certain parts of a procedure. He was able to generate a long list of patients with significant complications; laproscopic cholecystectomies resulting in a hole in the deuodenum; he also mentioned a patient with cerebral palsy with a large paraesphogeal hernia. He also discussed a Dr. Schroeder patient who underwent a laproscopic cholecystectomy who died from an enterotomy from a take down of the right lower quadrant adhesions. Further, an appendectomy that resulted in death which sounded like a rupture of the secum also occurred.

He noted that patients have not been prepared properly for procedures under Dr. Randall's care. He also noted that many patients don't like him and don't want to be referred to him. Additionally, Dr. Revell also mentioned referring doctors are no longer referring to Dr. Randall. He mentioned that he had a discussion with Vicky Blackburn and she noted he has poor technique regarding sterility with out patient office procedures. Dr. Revell mentioned that during the weekends he has more calls from Dr. Randall's patients than any other physician in their practice. In talking to OR nurses, cases are now bloody and there are numerous take-backs. He also mentioned that a former senior partner, Dr.

Buddy Teetamin, also felt that he was "rough" on tissues. He concluded by saying that he, or Dr. Randall will need to leave the group as he will not continue practicing with him, feeling Dr. Randall is too great a liability.

Dr. Corey Cran:

Dr. Crane is a 54 year old general surgeon who has been practicing in Rock Hill since 1985, the end of his residency. He discussed the history of the group and their merger in 2008; they have been cross-covering for each other since 2007. He noted that Dr. Randall was quiet, and that he was having lots of personal complications - "more than his share." He has operated with him approximately 15-18 times, or 1-2 cases per month, and noted that Dr. Randall wasn't careful, didn't handle tissues well and wasn't respectful to tissues. He said he was always in a rush. He said he does not like to assist him or help him. He detailed four cases during which he had real concerns. He didn't like working with him in the OR because Dr. Randall would "take the case over," handle tissues roughly and create unnecessary complications.

Vicky Blackburn, CNP:

She has been a CNP since 2002, and an RN since 1980. Additionally, Vicky has worked med-surg and orthopedics and has been in the OR since 1987. She has been a circulator, a charge nurse and an educator. In October 2005 she joined Dr. Revell's and Crain's practice. She never thought Dr. Randall was a bad surgeon in the OR; he was at the top of her list for emergencies with no returns, and he wasn't sloppy. However, she notes that concerns have been brought forward, and because of her contacts in the OR, she has been approached by many staff who have asked about deep infections, and surgical site infections with significant bad outcomes. Rounding on his patients she found some concerns and she mentioned that on a couple of patients she has disagreed with his treatment plan, and felt that they would results in poor care. She has noticed he's begun to have some bad outcomes; she too brought up the cerebal palsy patient. She said many of her former OR colleagues have asked what was going on with Dr. Randall, that he was sloppy, and that patients are returning. She also noted that his referrals are down and that he doesn't use sterile technique in out patient procedures.

Of note, all three doctors insist that Dr. Randall see his own patients in follow up as they do not want to be involved due the outcomes, and the concern from a legal perspective.

Dr. Bob Randall:

I met with Dr. Randall on July 2, 2009 at 5:00 p.m. He was pleasant, calm, respectful and straight forward. In talking to him he outlined a long list of patients with complications. (My notes include nine patients). He talked about these patients and their complications. He felt that things were out of his control and problems were not due to his technique. Interestingly enough, he shared with me the prior night's complicaiton of July 1, 2009. This is the same patient Dr. Crane discussed with me when I interviewed him. Dr. Crain assisted Dr. Randall with an open signmoid colectomy. After the resection, it was apparent to both surgeons that the anastomosis cound not be completed without mobilizing the splenic flexture. Dr. Crain expressed frustration that Dr. Randalls' dissection was inappropriate; it was rushed, hurried, and rough and resulted in the colonic mesentary

being handled in such a way that the circulation of the splenic flexture was now greatly compromised. This resulted in colonic ischemia, and therefore converting a sigmoid colectomy into an extended, left hemi colectomy. With this, the patient needed a transverse colo-colostomy. Even with this, the anastomosis was under some tension, thus, the patient presented back on July 1, 2009 and required an exploration by Dr. Randall and a diverting colostomy, secondary to an anastomotic leak.

It was interesting that Dr. Crain has expressed so much frustration and noted that there was concern with the anastomosis, yet, Dr. Randall stated he could not understand why this patient had a complication and came back with a leak; two radically different perspectives.

Dr. Randall noted that he was tired but that he felt "ok," with no history of drugs or alcohol. He hasn't had any DUI's. He felt personally, as his partners noted, that he has gone through some rough changes in his life, having just completed his second divorce.

He did note that he would be willing to do anything and everything to remain in practice. It was shared that it would be difficult finding malpractice insurance for him because of his prior outcomes. We spoke for about one hour. The meeting ended on an upbeat note. I did share with him that others will be reviewing his outcomes and these interviews, and then will decide how to proceed.

Tom Zweng, M.D.
Sr. Vice President of Medical Affairs

9/10/2009
Date

STATE OF SOUTH CAROLINA COURT OF COMMON PLEAS

COUNTY OF YORK

ROBERT RANDALL, M.D.,

Plaintiff(s),

vs. Case No.: 2012-CP-46-167

AMISUB OF SOUTH CAROLINA, INC.
D/B/A PIEDMONT MEDICAL CENTER,
NATHANIEL EDWARDS, M.D., AND
RICHARD PATTERSON, M.D.,

Defendant(s).

C O N F I D E N T I A L

D E P O S I T I O N

WITNESS: ROBERT RANDALL, M.D.

DATE: Friday, July 19, 2013

TIME: 10:04 a.m.

LOCATION: Lewis, Babcock & Griffin, LLP
1513 Hampton Street
Columbia, South Carolina

TAKEN BY: Attorneys for the Defendants

REPORTED BY: SHERI L. BYERS
Registered Professional Reporter

- -

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exclusions they put on my privileges.

Q. I did see something about suspending privileges, what was it called, herniorrhaphy?

A. Correct. That's hernia repair.

Q. Any kind of hernia repair, whether it's in the abdominal area or not?

A. Correct.

Q. Okay. And I just assumed that hernias were only in the abdominal area. Where else do hernias --

A. Well, they're in the abdominal area, but can be within the incisions and groin and inguinal area.

Q. All right. So it would -- in your mind, it makes the suspension a little broader than --

A. Much broader.

Q. -- abdominal?

A. Correct.

Q. Okay. All right. What were you able to -- what elements of your privileges did you have left after the suspension in October of -- what would you still be able to do?

A. Amputations, debridement, wound care.

Q. Okay. Lipomas?

A. Yes. But that's not really a hospital-based procedure, but ...

Q. That's done in an outpatient setting, office?

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A. I mean, most of those office. Correct.
Q. Soft-tissue-type excisions, I guess would still be --
A. Yes. If they are -- yes, soft tissue excisions, I guess, are --
Q. Biopsies?
A. Correct.
Q. To include breast biopsies?
A. Yes. I was still doing breast biopsies.
Q. Any other biopsies that you could do?
A. Not to my knowledge.
MR. DAYHUFF: All right.
(Off the record.)
BY MR. DAYHUFF:
Q. I have a discovery response from you that I think lists some of the other places you've had privileges, and maybe that's the easiest way to kind of go through this.
A. Okay.
Q. Let me just try to wrap up a little on the Piedmont privileges. You obtained your privileges in 1982 --
A. Right.
Q. -- after completing your residency?
A. Yes.

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Q. All right. All right. But you had -- that's right. You had appealed it internally?

A. Correct.

Q. And you were still working through that process because as we've established earlier, that didn't end until spring of 2011?

A. Right.

Q. Okay. Your practice, leaving the Novant practice in July of 2009, why did you leave the Novant practice?

A. There was a series of cases, which primarily these cases, Novant is self-insured and they increased insurance risks and so we just can't continue your malpractice coverage.

Q. All right. So somebody -- the practice manager at Novant, I guess? I don't know how they run their physician practices.

A. I don't know who made the decision. I've forgotten his name. It was an Indian guy who was the final decision maker, but I don't know remember his name is.

Q. Okay. So he comes to you personally or does he send you a letter, or what happens?

A. Yeah. They first came and first said, "We could have a problem about you, and we want to talk

about it."

So I went and talked to one surgeon and one psychiatrist or internist. That addiction stuff, they wanted to know if there's any ongoing medical problem with drugs or alcohol. Which there was not. And after that, they terminated my malpractice.

Q. After they collected all the data they wanted to collect on the matter?

A. Yes.

Q. They terminated your malpractice? I guess terminated your employment agreement?

A. Correct. They carried the malpractice.

Q. I got you. I guess we should go back.

When you became part of Novant in 2008, what month was that?

A. I don't remember exact month. I think it was September.

Q. That's fine. I'm sure there's documents that reflect that.

Fall of 2008, they came to you and the structure of their relationship with you was you were going to be employed by them?

A. Correct. Correct.

Q. All right. And they offered employment to you. And did they offer employment to the other

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Q. Okay. All right. So they went back, and then in July you hear from them again. Was there any communication between April and July?

A. Yeah. As I said, I went to -- I don't remember the name. They had one general surgeon came down and talked to me. And I had to go see Dr. Bullard, who's an internist. Although it turns out he's an addictionologist or that sort of thing. I guess he was interviewing me to find out if there was a drug or alcohol problem.

Q. All right. Dr. Bullard, where is he out of? Is he out of Charlotte?

A. He's in Charlotte. He's in downtown Charlotte.

Q. And he was a guy who worked with Novant-owned practices on --

A. Yes. He is in a Novant-owned practice. He's very big into -- I mean, he is a recovering -- I think he's an alcoholic, but recovering something and big into AA and all the associated groups.

Q. So did he do a formal assessment of you?

A. No. He just -- we just sat and talked.

Q. Interview?

A. Interview, yes.

Q. And did he come to a formal conclusion as a

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result of that interview?

A. As far as I know, there was no problem.

Q. Okay.

A. I don't know. I did not -- I mean, I'm sure he reported back to somebody, but I never received anything to me.

Q. But he told you that as far as he was concerned, you were okay?

A. Correct.

Q. All right. The surgeon you talked to, who was that?

A. I don't remember his name.

Q. A surgeon from a Novant-owned practice?

A. Correct.

Q. What was the purpose -- I understand the checking you out from the purpose -- from the perspective of addiction, what was the surgeon doing?

A. I'm not sure. I mean, I think he was just coming for the same kind of thing, to see if there was problems with me or what was going on. We just sat in the office, and he just talked some about where I was, what I had been doing, what was going on.

Q. Did he talk about technique, talk about cases, talk about what?

A. There was no talk about cases. It was just

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A. Well, when I sent that, I didn't know what the status -- I just wanted to be moved inactive or retired, and they said that that category didn't exist.

I said, "Okay. What do I fit into?"

And they said, "Honorary."

"Well, put it to honorary."

Q. So they moved you to honorary and that ended your -- not just -- that ended all your privileges to operate at Piedmont --

A. Correct.

Q. -- when you moved to that status?

A. Correct.

Q. Included ending any privileges you would have had at Piedmont-affiliated ambulatory surgery centers?

A. Yes.

Q. Good.

Now, I have in my notes, I don't know if this is right, that you didn't seek reappointment in 2011. Do you recall -- I mean, I don't know that you would have even had the opportunity --

A. No.

Q. -- if you went to honorary status.

A. No. I did not seek reappointment.

Q. And you wouldn't have sought reappointment because you didn't have an appointment to begin with by

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2000 --

A. Well, I guess that would have been the normal period of time my privileges would have expired, I guess. Maybe that's how something came up. But I had already requested to go to honorary, retire, whatever they want to call it.

Q. There's no normal reappointment process to go through when you were on honorary status anyway?

A. Correct.

MR. DAYHUFF: Understood.

By the way, do you need a break? We've been rolling on. You just let me know.

(Off the record.)

(A recess transpired.)

BY MR. DAYHUFF:

Q. Doctor, let me -- just a couple of follow-up questions about Novant and your practice with Novant.

Did you have a written contract with Novant?

A. Yes.

Q. Employment contract?

A. Yes.

Q. Okay. And what was the term of that contract, was it annual?

A. I think so. I'd have to go back and review it.

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Q. Yes. All right. The letter looks like it references a review of 21 cases.

A. Uh-huh.

Q. And the focus seems to be on open hernia repair and carotid surgical procedures. And it notes that a reviewer, an external reviewer, noted issues with those two type cases.

A. We have complication -- concern about DVT, it's deep vein thrombosis, in my documentation.

Q. What is DVT?

A. It's deep vein thrombosis. Developing a clot usually in the legs post procedure.

Q. All right. It looks like the recommendation that is being noticed to you, "The Peer Review Committee recommends a hundred percent review of open hernia and carotids retrospective review."

What did you understand that to mean?

A. They would review cases I did over the next year, which I was fine with.

Q. No preclearance of cases, they just review your medical record after it's complete, right?

A. Correct.

Q. That's retrospective, in your understanding?

A. Yes.

Q. All right. Did that review occur?

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A. Yes.

Q. All right. And did you have -- did you perceive that you had quality issues with carotids at that time?

A. No.

Q. You believed your carotid practice was safe, appropriate, met the standard of care?

A. Yes.

Q. All right. How about with respect to open hernia repair at that time, did you believe you had any issues with your practice?

A. No.

Q. All right. You were operating safely, appropriately, within the standard of care for open hernia?

A. Yes.

Q. All right. What was your response, if any, to the peer review committee's decision in this regard? It's just a recommendation at this point.

A. I had no problem with them reviewing the cases, which they did do. I had no problems with those cases over the next year.

Q. Okay. Good. And, of course, you knew from being at Piedmont for a long time that there was this thing called the Peer Review Committee. And the Peer

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Review Committee just doesn't just review you, it reviews all the doctors at Piedmont Medical Center, right?

A. Correct.

Q. And the way they do that is they receive cases based on certain generic indicators?

A. I don't know what triggers peer review.

Q. Okay. I was wondering if you -- have you ever served on the Peer Review Committee?

A. No, I never have.

Q. So you really don't know how they get their cases?

A. No, I do not.

Q. Fair enough.

Do you know Dr. Alexander?

A. Yes.

Q. All right. Do you have any concerns about Dr. Anderson not treating you fairly, appropriately?

MR. GRIFFIN: Alexander.

THE WITNESS: Alexander.

MR. DAYHUFF: What am I saying?

THE WITNESS: Anderson.

MR. DAYHUFF: Alexander.

THE WITNESS: No, I don't.

BY MR. DAYHUFF:

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Q. No?
A. No.
Q. All right. So you believe that his concerns that he's voicing in his recommendation were motivated by legitimate quality and patient concerns?
A. As they viewed it, yes.
Q. Okay. All right. Of course, you disagree that you had a problem?
A. Well, the problem there, again, as they said, there was documentation that they didn't think I was stating enough in my notes about it, and it was complications of DVT because I did not at that time prophylactically use heparin because I thought that it was an increased bleeding, increased risk. And that was still the general recommendation, and I did subsequently switch and began using a prophylactic.
Q. Okay. And just to sum up then, you disagree with their findings that precipitated the recommendation for a hundred percent review?
A. Yes.
Q. But you don't question their motivation as being untoward in any way for imposing it?
A. No. I had no problem with them reviewing cases going forward.
Q. Good.

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happens in the fall, so that makes sense.

A. Yeah.

Q. All right. I understand you don't agree with calling it a finding. The idea that you had a problem with communication, you don't agree with that?

A. Well, they're stating that I -- I couldn't prove that, I guess. I did not think I had a problem with communication with physicians. I thought I communicated well to the families.

Q. Fair enough. And did you believe you had any quality issues with respect to abdominal surgery at that time?

A. No.

Q. So to the extent they believe that, you would disagree with that?

A. I would disagree strongly.

Q. Did you believe that this group, Earl Jenkins and whoever else was on the Credentials Committee, they say they're doing this on behalf of the Credentials Committee and Peer Review Committee, did you believe they were motivated by anything other than their concerns for patient care, quality of care?

A. Could you restate that.

Q. I can state it the other way. Do you believe that these guys had any improper motives?

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A. No.
Q. Bad faith motives?
A. No.
Q. So when they made this recommendation and when they based it on whatever they based it on, right or wrong, their motivations were concern for patients and care?
A. Correct.
Q. Okay. Fair enough.
All right. Let's move forward. September 2010. Let me just look over this.
Okay. Let's -- I'll let you read that one, September 14, 2010.
A. Yes.
Q. All right. Identify that, if you can, for the record. Is this a document you received?
A. Yes. It was a letter from the chief of staff stating that they had overruled. I had been cleared by the Credentials Committee, the Peer Review, reappointed or approved to go forward. Dr. Edwards reviewed that and overruled them and said it needed to go further.
Q. Okay.
A. So that's what that --
Q. All right. And it says that -- all right.
So your understanding is Dr. Edwards

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mean that.

Q All right. And every doctor would know -- that does this sort of thing -- that a leaking J-tube, a J-tube that's not in the right spot, one that is contaminating the abdominal cavity, is a serious hazard to the patient because you get peritonitis.

A Yes. Correct.

Q So if you're trying to be careful, which you guys are supposed to be under the law --

A Uh-huh.

Q -- right?

A Uh-huh.

Q In good practice.

A Uh-huh.

Q Right? What value to the patient is there in continuing tube feedings when what has been presented to you as the -- as the doctor, you know it's leaking from around the site and it could be something really bad, how are you being careful if you're continuing tube feedings and not stopping them to check its placement?

A Because it's not -- they're not being presented with changes that the patient's having tremendous pain, that there's a lot of changes in the patient, that there's other things going on. It's a patient

change our -- our tape, and then we're going to continue.

(Off the record from 11:25 a.m. until 11:31 a.m.)

THE EXAMINATION BY MR. MCGOWAN CONTINUES.

Q All right. So we finished pretty much with the -- with the 19th of April --

A Okay.

Q -- and let's move over to the -- the 20th.

A Which is where?

Q Which is the next tab. It's Tab No. 19.

A Okay.

Q And let's just go straight to the narrative assessment because that's when -- it seems like a lot of stuff kind of occurred on this date.

A Uh-huh.

Q All right. It appears as though the -- Dr. Schroeder, the night before, had ordered that the PICC line be removed and the tip be cultured, because we see that at oh -- looks like at oh --

A I'm sorry. What number are we on?

Q I'm sorry. Page 2701; the narrative notes.

A Twenty-one -- twentieth -- I'm off here somehow.

Q Yeah. You're -- now you -- you're on the right track, Doc.

bottom.

A. Yeah. I know I got this letter.

Q. Sure.

A. Yeah.

Q. It says on October 11, 2010, the MEC recommended your privileges, abdominal surgery, herniorrhaphy by open or laparoscopic be revoked. And then they delineate below. They make it clear that the remainder of your privileges are intact except as they involve one of the revoked. The MEC says they are basing this recommendation on a series of cases that include internal and external peer review, your oral and written remarks. So obviously you must have presented --

A. Yes, I presented.

Q. -- as you said?

A. I assume on that September 27. I don't remember the date, but I appeared before them.

Q. Sure. The MEC took into account two more recent cases and the external expert review of them and an accounting of unplanned returns to the OR.

All right. "MEC concludes that the surgical judgment and technique exhibited fell below the standards," et cetera, et cetera. They let you know you have the right the request a hearing. Is that

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true?

A. Correct.

Q. Okay. You mentioned three additional cases. They say two additional cases. I don't know. Do you understand why there's a distinction there?

A. Again, I'm going this from memory.

Q. Sure.

A. But there were three that they brought forward late, you know. Those three that I brought -- were then brought forward. I remember clearly being reviewed on two of them. It may not have been the third, but anyway --

Q. That's fine.

A. I don't recall.

Q. At least they're recognizing that there were two later cases.

A. Correct.

Q. All right. Well, the MEC is recommending your privileges be revoked. You disagreed with that recommendation at that time, correct?

A. Correct.

Q. All right. The basis of this recommendation, according to the letter, is that they had concerns about your surgical judgment and your technique. Did you believe you had problems with either surgical

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judgment or technique at that time?

A. No.

Q. Did you believe any of your cases fell below the standard of care for the medical staff?

A. No.

Q. All right. So you disagree with their findings.

Do you believe that the Medical Executive Committee, the members of the Medical Executive Committee, were motivated by bad faith, any untoward motivation in making that recommendation about you?

A. Well, I don't know about for Dr. Edwards because he just basically didn't like me.

Q. Let's set Dr. Edwards aside, then, if you want. How about the members of the MEC --

A. No.

Q. -- that made that recommendation?

A. No.

Q. All right. In other words, these members, whether you agreed or not with their belief about your practice, they made the recommendation they made out of concern for patients and quality of care?

A. Correct. As they understood them. However, there was not a surgeon among them who reviewed them.

Q. Okay. Maybe they didn't fully appreciate all

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the issues because of their lack of specialty in your area.

A. Correct.

Q. But their motivations were pure.

A. Yes. I have no problem with the motivations for their action.

Q. Fair enough. Now, Dr. Edwards, you want to carve him out of that?

A. Yeah. Dr. Edwards has a long, long going animosity towards me going back many years.

Q. Okay. Well, let me ask you I guess more pointedly. Do you believe that he was motivated by something other than concern for patients and quality of care?

A. Yes.

Q. All right. And explain to me what he was motivated by.

A. Well, as I said, he's got a personal animosity towards me going back many, many years. And I think that played a factor in this.

Q. Okay. And what was the -- do you know the origin of the personal animosity?

A. Yes. I don't remember the year, but well before this. His wife is a pediatrician who's -- well, she doesn't practice at all now, but at that time was

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mentioned to him the investment in the practice?

A. I'm sure I did.

Q. Okay.

A. Yeah.

Q. "I'm opening up my practice."

A. "I have to borrow a money bunch of money." I know I said that. I didn't say an amount to him. "I have to borrow a munch of money to start this practice. I need to know is there any problem with me having privileges and operating at this hospital."

Q. Okay. Fair enough. Fair enough.

At the time the MEC makes its recommendation, the recommendation is based on the cases, we haven't discussed the details of the cases, but ultimately, there are ten when you include the suspension also.

A. Uh-huh.

Q. Do you believe that your care provided in those cases that were in review by the MEC, that any of those cases fell below the standard of care?

A. Well, it depends on -- I do not feel it is below the standard of care. However, in W[redacted] C[redacted] there was malpractice because I missed an injury, then Corey Crain really missed the injury for three days. And that one, I don't know how -- I mean, I think that -- I've told, you know, Jay McKay represents me.

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Since I had to go to court, I had problems saying it was not malpractice on that one, so that one case. Excluding that one, I don't think there's a problem.

Q. Fair enough. So in all the other cases, it's your belief that your care did not fall below the standard of care?

A. Correct.

Q. All right. And do you believe -- and the W[redacted] C[redacted] case we'll set to the side, you believe there was malpractice there?

A. Right. Well, there was -- I don't know what the definition -- there was a missed injury that particularly under Dr. Crain's watch over the weekend I think should have been seen.

Q. But you also exonerate yourself --

A. No, because I was the one that operated on him initially.

Q. All right.

A. I operated on him on Thursday. I turned him over to the care of Dr. Crain on Friday afternoon, and he follows it all the way through the weekend getting sicker and sicker. And I pick him back Monday at 7:00 a.m. and say, "We have a problem here."

Q. Okay. This is a slightly different question about those cases. Setting aside standard of care, as

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state.

Q. Okay. You're not sure?

A. No.

Q. It may state that, it may not?

A. Yeah.

Q. Okay. Well, let's go to Randall 0994, which is where I started.

A. Yeah.

Q. I think this -- first, just identify this letter. This is for the record. It goes to 0994, 0995. You produced it to us, so I assume that means you received it. It is from Dr. Edwards.

A. Yes. Yes.

Q. It's to you. This letter differs from my review of it in that it mentions the summary restriction. Do you see that?

A. Yes.

Q. "I have determined that summary restriction of your privileges is warranted."

A. Right.

Q. All right. And he says that in the absence of that -- or he's doing this to ensure there will be no imminent danger to persons you might provide care to, right?

A. Correct.

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Q. Paraphrasing. Okay. And that applied to your abdominal surgery privileges, correct, including the hernia --

A. Right. That put it immediately into effect, whereas before I would have had appeals process before it went into effect.

Q. Right. So this takes the MEC's recommendation and makes it effective --

A. Immediately.

Q. Right. Immediately. Why did Dr. Edwards take this step?

A. He -- I think he -- from what I understood him, one case, that was the lady that had the gallbladder.

Q. Is that the J[redacted] R[redacted] case?

A. Correct.

Q. I think I have seen that case.

A. Yeah.

Q. Well, tell me what happened with the care of Jane Russell.

A. A lot of good things. J[redacted] R[redacted] presented in the ER. She's 67, I don't remember exactly but elderly lady. Very acutely ill and had a CT scan showing a really sick gallbladder and took her to the operating room. And she just had as bad a gallbladder

A. I strongly disagreed with that.

Q. Okay. All right. The next thing that I want to direct your attention to is Randall 9 -- do you see -- I want to make sure we notice that attached to Dr. Edwards' letter that announces the summary suspension, that's part of your bylaws, right?

A. I assume that's where it's come from.

Q. So he's providing you the bylaws that provide for your appeal rights, correct?

A. Correct.

Q. And you forwarded that on to Jay McKay, I assume, to analyze?

A. Well, I told him I'm immediately filing an appeal and what do we need to do to appeal this.

Q. Right. Right. All right. Take a look at the next letter which is 0987. Just identify that for us, if you can.

A. Yeah. That is the three cases I was talking about that when I went before Edwards and the committee that they didn't tell me were going to be reviewed.

Q. Okay.

A. And I had to do that just off the top of my head. Before I went back this time, I said, Look, I need -- I'm having to do this from memory, these records and things like that. After I had already

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as to the 10-25-10 meeting.

A. That may have been -- see, that may have been the meeting where --

Q. McKay was blocked?

A. McKay was blocked.

Q. That's okay.

A. I don't recall which meeting it was.

Q. Well, what I'm trying to make sure that you had the opportunity to do was, those new cases you're talking about --

A. Correct.

Q. -- you did get to go back before the MEC and discuss the new cases along with the old ones?

A. Yeah. That was an interesting meeting. I could have gone in there and danced naked on the table, it wasn't going to make a difference. That was just a doomed meeting. I knew that when I walked in the door. It was real apparent when I was in there. They didn't ask a single question. They didn't discuss anything. They never asked me one thing.

Q. I had in my notes that there were no questions asked, so we must be talking about the 10-25 meeting.

A. Right. Right.

Q. So your recollection of that meeting is you

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got to talk about the three new cases?

A. Correct.

Q. You got to talk about the unplanned returns to the OR?

A. I don't recall whether I did at that meeting or not. I'm not saying that. I don't recall. I remember talking about the cases.

Q. Okay. At least the three new cases. And then you also recounted some of the old cases, the other seven?

A. Correct.

Q. Okay. So you recall doing that. Do you recall whether Patterson was at that meeting?

A. I think he was.

Q. Okay. How about Charlie?

A. I don't think he was.

Q. Okay.

A. Patterson, yes. I don't think Miller.

Q. How about Edwards?

A. Yeah, he was there.

Q. Okay. And at the conclusion of your presentation, you recall no questions?

A. Correct.

Q. All right. And that may have been the meeting where McKay wasn't allowed in?

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A. Correct.
Q. All right. Then comes I think 0970. Take a look at that.
A. Okay. All right.
Q. All right. That's a letter from Dr. Edwards to you, correct?
A. Yes.
Q. That you received?
A. Yes.
Q. And it also has attached to it the bylaws?
A. Yes.
Q. So it's telling you you have a right to appeal; is that correct?
A. Correct.
Q. And it's saying that the Medical Executive Committee met on 10-25?
A. Yes.
Q. To consider your restriction and the MEC voted to sustain it.
A. Correct.
Q. All right. So from that point on, you could not practice abdominal?
A. From October 15th on, I couldn't. He puts a summary suspension in, that ended it then.
Q. You're right. You're right. So what could

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have happened is they could have revoked it?

A. They could have revoked that, let me go back, operate, and go through the appeals process. It was a summary suspension that put the -- where it should have been allowed a 90-day appeal process and still operate and go forward. The summary suspension put it in effect immediately.

Q. Got you. All right. Take a look at 0984. I'm just curious --

A. 0984. Okay.

Q. -- are they delivering this stuff to you certified mail? Is that how this stuff comes?

A. Yeah. It comes in certified mail.

Q. Okay. Is that true of all these notices? I guess it's hard to remember that.

A. A couple of them Patterson hand-delivered them. He would always deliver them at 5:00 on Friday, invariably. That's when they came. He would walk in at 5:00 on Friday and hand me one of them.

Q. All right. You request a hearing?

A. Yes.

Q. Your attorney requested a hearing on your behalf, and you appealed both the summary suspension and the revocation; is that correct?

A. Correct.

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Q. All right. Take a lock at the next document. Are you on 0208?

A. I don't see 0208.

Q. I have it right behind that registered mail.

A. Okay. Here, see if you can find it for me.

Q. This monstrously large exhibit seemed like a good idea. I'm not sure it was.

A. All right. I'm with you now.

Q. Identify that for the record, will you?

A. That's the letter from Dr. Edwards saying that I requested a hearing on my restrictions. It is going to be held January 12th of 2011, the formal hearing.

Q. So this is noting that he received the appeal?

A. Correct.

Q. And you're going to have a hearing?

A. Uh-huh.

Q. And you received this letter on or about November 4th, 2010?

A. I don't know the date of it, yeah.

Q. Okay. But you recall receiving this?

A. Yes. Yes.

Q. All right. And then let's go to the next page, 0956.

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A. Yes.

Q. It says by hand and U.S. Registered Mail.

A. Uh-huh.

Q. This is from -- it's a letter to you dated December 17, 2010, and it's from Dr. Edwards. It's a long letter. I'll let you take a look at it.

A. Okay.

Q. Is this the Notice of Hearing and Grounds?

A. Correct.

Q. All right. So you received this?

A. Yes.

Q. And this notice tells you that both the revocation and the summary suspension will be the subject of the hearing?

A. Yes.

Q. Right. And it tells you that the hearing is going to be conducted before a hearing committee of the medical staff, right?

A. Yes.

Q. On 0957. And it lists the members of the committee: Powell, Thomas, Fassler, Richter, McClelland.

A. Yes.

Q. All right. Tells you there's going to be a hearing officer, a guy named Dawes Cooke, Esquire?

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A. Correct.

Q. And he's going to what, he presides over the hearing like a judge essentially, doesn't he?

A. Yes.

Q. And there's a detailed list of the grounds. A detailed listing of the grounds, right?

A. Correct.

Q. And there are how many cases at issue?

A. I don't know. Let's see. Ten.

Q. All right. It looks on page 0959 after the individual listing of the cases, says, "The Medical Executive Committee's recommendation for revocation was based on 1 through 9. Is that your understanding?

A. Yes.

Q. And then 10 was the one that resulted in summary suspension?

A. Correct. That one placed by Dr. Edwards.

Q. Right. Now, is it your understanding that after the summary suspension was imposed by Dr. Edwards, that the MEC had to meet and vote on whether to continue it or not? Did you know that?

A. At some point they did. I don't know when that occurred. That was already in place.

Q. Well, he imposed it?

A. Correct.

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Q. And then you get to go back before the MEC, right, and your make your presentation?
A. Right.
Q. And you got no questions, I recall that.
A. Correct. Yes.
Q. And then they voted on whether to continue it or not; is that correct?
A. Correct.
Q. And it's your understanding they voted to continue it?
A. It was continued so I assume that's what happened.
Q. All right. This hearing notice on the bottom of 0959 says you will have the right to be represented by counsel.
A. Yeah.
Q. You were allowed to have Jay McKay appear at that hearing?
A. Yes.
Q. And did he question witnesses?
A. Well, ultimately, when we finally had the hearing.
Q. When you had the hearing.
A. Which was months later.
Q. So he was allowed to, what, bring witnesses

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on your behalf --

A. Correct.

Q. -- to testify?

A. Correct.

Q. Was he allowed to cross-examine witnesses offered by the MEC's attorneys?

A. Correct. But see, the big part of this, too, I was supposed to do it between 30 days and three months. Well, I was going to waive the 30 days because at 30 days, it got reported to the National Data Bank. Once it's there, you're cooked. That's what happened. But they wouldn't do it in 30 days. So they go to 90 days, well, that put it to the very end, the very last time into January.

Well, they come two or three days before we hold that hearing, "Our expert witness won't come, we need two more weeks." All right. We postpone it two more weeks. Two or three days before that hearing, "He's not going to come. We don't have an expert witness." So that moved it two more months. It was six months before, at least before I finally had any hearing. Well outside of any 90-day period of time.

Q. All right. So you're offering that to me because you didn't want it to extend that long?

A. No. I didn't want it to extend that long,

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Q. Okay.
A. Or in the record or whatever.
Q. All right. Fair enough.
Going forward, it looks like you sent another letter on December 28th.
A. Where are you?
Q. The very next letter.
A. Okay.
Q. You have a number?
A. Yes. 608. Piedmont.
Q. Okay. Okay. Just identify that for the record.
A. Correct. As I stated here, I mean, I wanted a general surgeon on the panel and respectfully requested they add a general surgeon on the hearing panel.
Q. You had seen who was on the panel in the hearing notice?
A. Correct.
Q. Was that your only objection to the panel?
A. Correct. Yes.
Q. Okay. So you were okay with the individuals?
A. Other than --
Q. Other than you wanted general surgery expertise.

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Q. Is that because they had changed the dates, they were going to need new members of the committee, is that what that's about, or do you know?

A. I don't remember. I mean, they stated they were going to name three additional people, so I was wondering who they were or who they were going to be.

Q. All right, sir. Who ultimately were the members? Here it is. Look at 0221. It's several letters ahead.

A. 221. Okay.

Q. I'm trying to get to who was actually on your hearing committee.

A. Yeah. Okay. That was the --

Q. You received this notice or your attorney received this notice, is my guess, and then you saw it?

A. Yes. It went to Jay McKay.

Q. This is 221. And they provide you notice that Robert Thomas will be on it, Neal Powell, David Nix, Richard Richter, Shashi Naidu.

A. Yeah.

Q. And Thomas Simpson.

Did you have any objection to any of these individuals?

A. Not them as individuals. Again, I objected, particularly in this panel, there was nobody who did

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any surgeries at all, any abdominal surgeries, any kind of surgeries other than oral surgery and orthopedic surgery, which was totally unrelated to these cases.

Q. So you preserved that or you remade that objection again or your attorney did on your behalf?

A. On my behalf, right.

Q. Now, any of these guys, do you have concerns about their motives?

A. No.

Q. All right. So these guys are straight shooters?

A. Right. I had no problem with them as individuals. My problem, again, was they are not surgeons or not doing -- you got an oral surgeon and an orthopedics, and that's it for surgery.

Q. So these guys when they were doing their job as members of the hearing panel and when they made their recommendations, they were motivated by concerns for care and concerns for patients?

A. But they have no idea what's required for general surgery patients. They don't know the standards of care. They don't know what you do in an operation.

Q. Understood. You question whether they had the knowledge to review you and your cases?

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A. Yes, I do.
Q. But you question that their motivation was patients and quality of care?
A. No. Well, I think they're honorable people. I don't know what their motivations were. I don't think they had anything personally against me or that type thing, if that's your question.
Q. Okay. These guys could be fair?
A. They're fair. Right.
Q. You don't believe that they were qualified in their skill set --
A. Correct.
Q. -- to analyze you and your cases?
A. Correct.
Q. But they weren't motivated by kind of malice --
A. No.
Q. -- or anything else in what they decided?
A. Correct. I don't think that.
Q. Okay. What about, how did Dawes Cooke do as your judge?
A. He was fine.
Q. Fine? No problems?
A. Yeah.
Q. Do you think he operated in a fair manner?

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reviewed the hearing panel's report, it has a lot of -- in fact, Jim, did I give you my copy? Is there any yellow in that?

(Off the record.)

THE WITNESS: Where are we going to be?

BY MR. DAYHUFF:

Q. Let's do this. We've got this cover letter from Charlie to you.

A. Correct.

Q. And inside the cover letter is a cover letter from the judge, Dawes Cooke. I call him the judge, the hearing officer.

A. Yes.

Q. And he says, okay, enclosed, Mr. Miller, is the decision of the committee, the transcript. See all that? It's one back.

A. Okay. Do you have a number, a page number?

Q. Yeah. It's 0231.

A. Okay.

Q. So let's just establish, Dawes Cooke is the hearing officer?

A. Correct.

Q. And he has sent, among other things, the decision of the hearing committee and the transcript to Charlie, who then forwards it to you.

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A. Correct.

Q. Okay. And in the findings of fact -- let's see what I want to ask about.

All right. I guess what I'm getting at there, they certainly look at some of the process, but are they not also making some findings of fact that relate to the technical surgical skills and the judgment?

A. That was interesting because their own expert, Dr. Scudder, when he came in came up with a totally -- he found totally different things wrong than the outside reviewers had. So he changed. I mean, Scudder had never done any laparoscopic procedures at all. Zero laparoscopic procedures.

Q. Well, maybe let me ask it this way. Scudder certainly testified on behalf of the MEC that there were problems with surgical skills and judgment?

A. Correct.

Q. Correct?

A. Yes.

Q. You disagreed with that?

A. Strongly, yes.

Q. And you had your own expert who testified?

A. Correct.

Q. Dr. Tribble, I recall.

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A. Right.

Q. Did Dr. Tribble find any flaws in your judgment or technical skills?

A. No. The problem with Dr. Tribble, though, I met with him in Virginia and picked him. I met him two days before. It was real apparent that he'd not very well reviewed the cases. He really didn't know them. He got up and they would ask him certain questions, and he wouldn't know or had to fumble through. He was not a very effective witness.

Q. I see. Did he at any time concede that certain cases violated the standard of care or any of that?

A. Not to my recollection.

Q. You were there, I imagine, the whole time?

A. Yeah.

Q. Okay. And then the hearing committee makes its judgment about the process and about the cases that were presented, right?

A. I was told by Neal Powell that they were only to review process. That's all I can say.

Q. Okay. Well, I'm looking at a bunch of factual findings. There's a lot of stuff here about cases.

A. Right. But, you know, it's just a repeat of

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what was stated earlier. So it's not like they reviewed it or heard what I said on the cases.

Q. Okay. All right. Well, suffice it to say, to the extent there were findings about your care and about your judgment in here, you disagree with them?

A. Strongly.

Q. Okay. All right. But that doesn't change your opinion that you offered me a moment ago that you still think these folks, the panel, were not motivated by kind of animus or bias?

A. I agree with that.

Q. Okay. All right.

Did you tell me whether, was Patterson present for the hearing?

A. Yes.

Q. And what about Charlie, did he sit through that?

A. He was there, I think, as I recall.

Q. How many days did it last?

A. Three, I think.

Q. Okay. Was it done at night?

A. Yeah.

Q. Yeah, usually those things are done at night.

Okay. All right. The next thing that I believe happens is you all are notified that you have

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appeal rights. That may be at the very end of this package.

A. Right.

Q. No, it's -- in fact, it's the front page. "This letter serves as notice of your right to an appellate review by the board of the adverse hearing committee recommendation." Because it's still a recommendation by them at this point.

And did you request an appeal?

A. Yes.

Q. And your attorney helped you handle that?

A. Yes.

Q. Do you recall what that involved?

A. Well, it was -- I don't remember the exact number, like two physicians and two or three people off the hospital board.

Q. All right. The hospital board would have assigned a subcommittee to review, make your appellate review?

A. I don't know. Yeah. I don't know how their process was, but there were two or three, I forgot, of the hospital board.

Q. Wasn't the full board as far as you know?

A. No. No, it wasn't the full board.

Q. So they convene an appellate review?

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about the cases. I don't think he was on that board, though.

Q. All right. Did Dr. Edwards appear before the appellate group?

A. Yes.

Q. Did he present just like you did?

A. Yes.

Q. All right. So one witness and then each attorney for each side presented, sounds like?

A. As I recall, yes.

MR. DAYHUFF: All right. And then I've got another peer review process document.

(DEFT. EXH. 4, Letter Dated July 12, 2011, PMC.00004771 through 4781, was marked for identification.)

BY MR. DAYHUFF:

Q. All right. Doctor, this is Number 4, appears to be a letter sent from Douglas Pratt-Thomas to Dr. Randall and Jay announcing the final decision of the governing board.

A. Yes.

Q. And Douglas Pratt-Thomas advised the board, I believe.

A. Yes.

Q. Is that right?

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A. Correct.

Q. And you received the final decision of the board, correct?

A. Correct.

Q. And the board took the decision, if you look, the appellate review committee, their decision is attached as an exhibit to this. And I'm at 4774.

A. Okay. All right.

Q. This is a group that you appeared before that you mentioned, some of the board members, you had your attorney there?

A. Right.

Q. They came out with this report?

A. Right.

Q. Which affirmed the hearing committee.

A. Yes.

Q. And then the full board got together and voted and affirmed the appellate review group.

A. If you say. I don't know what the process was after the hearing. I'm not denying it. I don't know what the process was.

Q. As far as you knew, at the end of the process the full board had affirmed your suspension and revocation and that was the end of the process at Piedmont for you?

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A. Correct.

Q. Okay. And then your next step was to file the suit?

A. Correct.

Q. Understood. The members of the Appellate Review Panel, do you believe that their -- they were motivated by anything other than concern for patients and/or concern for quality of care?

A. No.

Q. Okay. Their motivations were pure in short?

A. Yeah. I don't think there was any personal animus.

Q. Of course, you disagree with their findings?

A. Correct.

Q. All right. Same question with the final board that looked at this. Were their motivations concern for patients and health care?

A. I don't know who the final board, I mean ...

Q. You don't know who the board of Piedmont is?

A. Is or was at that time, no.

Q. Okay. Well, maybe I'll put it this way. You don't allege, do you, that the board members acted out of animus?

A. No.

Q. Bad faith?

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A. No.

Q. Fair enough. But you disagree with them affirming the findings that they did?

A. Again, strongly, yes.

Q. Because you believe your surgical judgment, surgical technique did not merit --

A. Right.

Q. -- revocation?

A. And I had 30 years of record of cases there from 1982 until they ended it. There's 30 years they could look at.

Q. Did you perceive in your own practice in I guess the mid 2000s an increase in complications that you may have suffered, or did you -- did your practice pretty much go like this?

A. No, there was an increase in complications over a period of time.

Q. All right. Have you thought about what that was attributed to?

A. I know what that period of time was because I started doing more advanced, difficult laparoscopic ventral hernias and started to get a lot of those referred to me and had some bowel injuries and stuff that were repaired and did all right. It was entering into a new, much more difficult surgery.

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Q. I see. I see.

Okay. So it seems to me the only two guys that you're concerned about their participation in this peer review are Edwards and Patterson?

A. Correct.

Q. Is that right?

A. Yes.

Q. And your concern with Patterson is that he's a company man that was looking out for Tenet or Piedmont's medical malpractice exposure?

A. Right. And I don't think he liked me personally, but you know ...

Q. Okay. And I didn't understand -- well, I don't know why that would be the case, would you?

A. Yeah. We just didn't interact. I didn't particularly like him either. He knew I viewed him as not -- I mean, not -- the job description was supposed to be liaison to physicians and Tenet.

Q. Right.

A. He was not that at all to me. He was just pretty much a hack.

Q. I've been to some hospitals where the CMO always seems to have a tough job because he's half and half, right?

A. Right.

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A. Yeah.

Q. Fair enough. But you're right, the timing makes some sense.

What were the other one, oh, C[redacted]k, that deposition was --

A. No, that's not -- that's not the --

Q. That deposition was last month?

A. Right. Right.

Q. Okay. All right. Do you know what the NDB report on you says? Have you seen it?

A. I've seen it. I don't recall what it states there.

Q. Okay. I've got part of it, I think. I don't know that I have the whole thing. I'll show it to you.

A. Okay.

(DEFT. EXH. 5, Adverse Action Report, PRIV-PREPROD00000184 and 185, was marked for identification.)

BY MR. DAYHUFF:

Q. All right. I want to take that look at the text of it. It's on the second page of, what is this, 5?

A. Yeah.

Q. It says -- I'm sorry, it begins on the prior page. "The abdominal surgery privileges of Robert

Electronically signed by Sheri Byers (001-367-405-8786)
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Randall, Jr., M.D., were summarily suspended by Piedmont Medical Center on October 15, 2010, on the grounds that surgical judgment and techniques exhibited by Dr. Randall fell below the standard of care of the medical staff and to ensure there would be no imminent danger to patients who might receive such services."

Now, certainly that's accurate. The MEC did summarily suspend you on that date, right?

A. I don't argue, I mean, the facts as presented here. It's the whole process.

Q. I got you. I got you. Well, so that's true, that's what they did and the reasons they said they did it?

A. Correct.

Q. You just disagree that they are right?

A. Yeah. With that there, it ended any possibility of me functioning as a surgeon anywhere, anytime.

Q. Then it describes the privileges that were suspended, and that goes all the way down to almost the very end to adrenal. Do you see that?

A. Yeah.

Q. So that's true, those are the privileges they suspended, right, that's the same list that's on the list of the letter?

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A. Correct.

Q. Then it says, "The summary suspension extends to the provision of consultation that relates to those." That's true, they suspended everything that related to it, right?

A. Right.

Q. "All other privileges remain unrestricted," that's true?

A. What's left, yeah.

Q. What's left. I hear you. "Dr. Randall denies all allegations and has requested a hearing to review and challenge the findings." That's true?

A. Correct.

MR. DAYHUFF: Jim, do we have the rest of the NPDB, the one that's on the revocation? Do you have any idea?

MR. GRIFFIN: Where did this come from? Did this come from you?

MR. DAYHUFF: Yeah, we produced this, but I assumed you guys had it just because you get a copy if you're the practitioner.

MR. GRIFFIN: He's not provided it to us.

THE WITNESS: No, I don't.

BY MR. DAYHUFF:

Q. Have you ever received a copy of one of these

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A. Right.
Q. And present all of it. We established that.
A. Again, that's when I said I could have gone in there and danced naked on the table.
Q. Okay.
A. There was no questions, no response, nothing.
Q. All right. But at least you got to present, but you feel like they didn't ask questions. They did not ask questions.
A. They did not ask questions.
Q. Okay. All right. Dr. Patterson, I understand. I think I understand.
Do you have any -- we've been through a lot of notices and the like. You don't have any concerns about the notices that you received, they weren't --
A. No. They delivered them 5:00 on Friday, but other than that, no.
Q. Other than the delivery time at the end of the day --
A. No.
Q. -- they provided you notice of everything?
A. They provided with notice, yes.
Q. All right. And you don't have any -- you don't quibble with the process of the actual hearing where you had Jay there and they had the two ladies

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there?

A. Okay. Not the process of the hearing.

Q. Right.

A. No.

Q. All right. Do you have any concern about the investigation of your cases, did they do a thorough investigation of your cases?

A. They did none. They never talked to any -- Dr. Crain, Dr. Schroeder. They never talked to anybody else on any of those cases.

Q. Okay.

A. Zero.

Q. So you would have preferred that they -- you believed it appropriate for them to talk to other physicians who were involved in the care of the ten cases?

A. Correct.

Q. And you don't believe that happened?

A. I know it didn't happen.

Q. Okay. And in particular you would have believed it appropriate for them to talk to Crain and Schroeder. Is there anybody else?

A. Well, Dr. Revell is involved in them. That's primarily those three. I guess the intensivist at the time, but primarily Crain, Schroeder, and Revell.

Electronically signed by Sheri Byers (001-367-405-8786)

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Piedmont Medical Center

Committee: Peer Review

Date: December 18, 2006

Agenda	Findings/Discussion	Conclusions/ Recommendations	Actions/Follow-Up
Call Meeting to Order	A quorum was established and the meeting was called to order to discuss Practitioner 4018.		
	As discussed at the December 7th meeting, the Credentials Committee has requested this Committee's consideration of the results of an outside review for Practitioner 4018 following identification of trends at his reappointment. Twenty-one (21) cases that were reviewed by this Committee within the past two years were re-examined by an outside reviewer. The findings are as follows: - The cases demonstrate various errors in judgement and technique. One impression is a lack of appreciation of the morbidity and mortality of large abdominal hernia repairs in the elderly. Another impression is the lack of surgical experience in handling difficult dissections around the portal structures and pelvic retroperitoneum. The access to critical care and medical specialists seems adequate; however, no detection of involvement by the surgeon after procedures. There does not seem to be tightly defined "return to OR" criteria for re-explorations based on physiologic parameters. The use of anticoagulation in all its forms and the indication for use should be reviewed formally with the surgeon, his colleagues, and internists/hematologists, as the appropriate use is often overlooked.	The Committee recommended 100% review of open hernia repairs and carotid surgical procedures be retrospectively reviewed over the next 12 months. A letter should be sent to Practitioner 4018 to include the above and the noted opportunities for improvement in documentation and management of DVT.	Chairman will contact Practitioner 4018 and discuss findings as well as send a letter explaining the conclusions of the outside reviewer and this Committee's recommendations.
Adjournment	There being no further business, the meeting was adjourned.		

RANDALL 1123



December 21, 2006

Dr. Robert Randall
1721-07 Ebenezer Road
Rock Hill, SC 29732

Dear Robert:

The Credentials Committee recently reviewed and accepted your reappointment; however, they requested the twenty-one 21 charts that had been previously reviewed by the Peer Review Committee be re-examined by an outsider reviewer. This review consisted of complications, risk management complaints, and mortalities. The results of this review were returned in November and forwarded to our Committee this month.

The purpose of the peer review process is not punitive; however, is meant to provide education and advice. The twenty-one (21) cases reviewed identified a higher than expected complication rate with your open hernia repair and carotid surgical procedures. There was also a concern by the reviewer regarding complications of DVT and with your documentation in general.

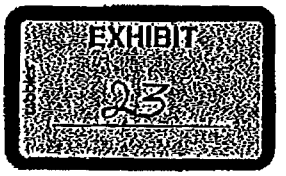
The Peer Review Committee's goal is to protect the physician, patient, and hospital. As you are aware, regulatory agencies such as the Centers for Medicare and Medicaid Excellence, JCAHO, etc., are becoming more involved in reviewing individual physicians and hospitals to ensure appropriate patient care. These reviews include looking at complications, medical necessity, and documentation.

The Peer Review Committee has recommended 100% review of your open hernia repairs and carotid surgical procedures be retrospectively reviewed over the next 12 months.

In conclusion, I realize this comes to you without warning. You are encouraged to contact me concerning this letter and to arrange a time to examine the outside reviewer's comments.

Sincerely,

Robert Alexander, MD
Chairman, Peer Review Committee



Agenda	Findings/Discussion	Conclusions/Recommendations	Action/Follow-Up
Peer Review Committee	The Peer Review Chairman reported the following: • During Practitioner 4018's reappointment the Credentials Committee requested an outside review be performed of this practitioner's peer review cases due to the number and outcomes. The outside review was received in December which were reviewed by the Credentials and Peer Review Committees. These Committees have recommended 100% review of open hernia repairs and carotid surgical procedures. These cases will be reviewed retrospectively. A letter and verbal conversation has been held with Practitioner 4018 who voiced understanding of the review. The letter also reminded this practitioner of the opportunity for improvement in documentation and management of DVT. • Three other cases were reviewed all of which were rated appropriately.	For information only.	No action required.
Emergency Medicine Department	REDACTED		
Radiology Department			
Pathology Department			

RANDALL1122

RANDALL 1122

EXHIBIT 55

Agenda	Findings/Discussion	Conclusions/ Recommendations	Actions/Follow-Up
Practitioner 4018 4th Quarter 2007	The Committee reviewed the results for the 4th Quarter External Review for Practitioner 4018. As recommended last year, all open hernia repairs and carotid endarterectomies will be reviewed for 2007 by an external review. The results are as follows: Open Hernia Repair - Total - 24 MR: 294179 MR: 320089 MR: 242504 MR: 22461 MR: 297999 MR: 174747 MR: 320883 MR: 27709 MR: 8966 MR: 320480 MR: 321282 MR: 178250 MR: 259218 MR: 195215 MR: 246958 MR: 141049 MR: 322328 MR: 82256 MR: 12975 MR: 267686 MR: 137826 MR: 323069 MR: 279724 MR: 324163 Carotid Endarectomies - None	Following discussion, the Committee recommended all cases be rated as follows and no further review is necessary based on the findings of the reviews throughout 2007. Q1 - Outcome acceptable or not unexpected. U1 - Utilization acceptable or not unexpected. M1 - Management appropriate or not routine, but not unacceptable. B1 - Behavior/conduct is acceptable or not unexpected.	No further action required and review will be discontinued based on findings throughout 2007. Practitioner 4018 will be notified of findings.
REDACTED	REDACTED →	→	
Adjournment	There being no further business, the meeting was adjourned.		

RANDALL1114

RANDALL 1114

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EXHIBIT 110

State of South Carolina	)	
	)	
County of York	)	
Robert Randall, M.D.,	)	2012-CP-46-167
	)	
Plaintiff,	)	
	)	
vs.	)	Deposition
	)	
Amisub of South Carolina, Inc., d/b/a/ Piedmont Medical Center, Nathaniel Edwards, M.D., and Richard Patterson, M.D.,	)	of
	)	Nathaniel Edwards, M.D.
	)	
	)	
	)	
Defendants.	)	
	)	
	)	
	)	

Deposition of Nathaniel Edwards, M.D., taken before Sandra J. Ayers, a notary public in and for the State of South Carolina, commencing at the hour of 1:15 p.m., Friday, July 26, 2013, at the Piedmont Medical Center, 222 South Herlong Avenue, Room D - Ground Floor, Women's Tower, Rock Hill, South Carolina.

Reported by
Sandra J. Ayers

Dianna (as spoken) West.

Q Okay. So --

A I think.

Q So it's your understanding that -- that, when you're chief of staff, you -- you have under this -- under the bylaws, you know, the ability to assign yourself to different committees?

A No. You know, it's -- it's -- later on, I think it says you work -- I think, it -- in the bylaws, it states that the chief of staff will serve as chairman of peer reviews. And I think that's in -- that's in the bylaws and not up to the discretion of the chief.

Q Okay. And that -- and that -- that does lead to my line of questioning. What -- what other committees did you serve on when you were the chief of staff in 2010?

A The only other on that I can recall is the ad hoc review committee that we created later in this process.

Q And the ad hoc review committee consisted of members of the medical executive committee, the peer review committee, and the credentials committee?

A Yes, sir.

MR. GRIFFIN: (To Mr. Dayhuff) I'm skipping over this for now.

MR. DAYHUFF: Okay.

MR. GRIFFIN: (To the court reporter) Two. Plaintiff's Exhibit Number 2, Credentials Committee agenda; "Peer Review Activities for Practitioner 4018"; "Summary of Cases for Practitioner 4018."

Q Dr. Edwards, I've marked Exhibit 2, which is a -- a four-page document that starts with 2994 and it goes through 2997 with the prefix PMC. And -- and, again, I'll just advise you that this document was produced to us in discovery, and -- and it's -- it's been represented that it -- these are the minutes of the credentials committee of a meeting dated June 10th, 2010. And it references Dr. Nat Edwards as a guest present. And then, give you the opportunity to -- to read the information. But do you recall appearing at the June 10, 2010, credentials committee meeting?

A Honestly, very vaguely.

Q Okay.

A To be honest.

Q Do you have any -- well, before today, did -- have you reviewed these minutes of this meeting?

A Yes.
Q Okay. And as best of your recollection, did --are these minutes accurate?
A Yes.
Q Okay. And -- and at the -- in the minutes reference under -- it says, "Peer Review Committee Presentation." And as -- as I understand it, you -- were you the chairman of the peer review committee in 2010?
A Yes.
Q Okay. And do you recall whether you were invited to come to the credentials committee and speak, or -- or you requested the opportunity to speak?
A I don't recall.
Q Attached -- and as part of the Exhibit 2, there -- there on two pages; one, it says -- Number 2996, it says, "Peer Review Activities for Practitioner 4018." I represent to you that that is -- is Dr. Randall, as the records indicate. And then, 2997 says, "Summary of cases for Practitioner 4018." And do you recall bringing these two documents to the credentials committee meeting on June 10th, 2010?
A I'm sure that I did, but I don't actually recall it.

A -- before --
Q -- your time.
A -- read it --
Q Please take --
A -- a little bit.
Q Please take your time.
A So this looks like the letter sent to him informing him of his summary restriction of privileges.
Q Okay. And who made the decision to summarily suspend Dr. Randall's privileges?
A I did.
Q And did you do that in your capacity as chief of staff?
A Yes.
Q And you had that authority under the bylaws; is that correct?
A Yes, sir. And I felt that I had it -- I felt comfortable in sending this letter because there was such a strong feeling among -- among the medical executive committee member meetings and the previously referenced meeting.
Q Okay. What transpired from October 12th, 2010, when you wrote a letter to Mr. Miller, which is Exhibit 10, saying that the recommendation that -- will not be forwarded to the Board of Governors

until Dr. Randall has had -- has exhausted his rights under the bylaws, until October 15th and Exhibit 11 when you, in your capacity as chief of staff, summarily suspended him?

A There was a complaint by, as I recall, a family member of J[redacted]R[redacted]l about a large bleed after abdominal surgery, who was a patient of Dr. Randall's.

Q Okay. Where did you learn of that complaint?

A Dr. -- I'm pretty sure, Dr. Patterson told me of that complaint.

Q And when did he tell you of that complaint?

A I don't recall.

Q Did he tell you of the complaint on the 15th, or did you know prior to the 15th?

A I don't know.

Q Did you know of the case of Ms. R[redacted] on -- on October the 12th, when you wrote a letter to Mr. Miller?

A No.

Q Did you know --

A I don't --

Q -- of the --

A -- think so.

Q -- case on October the 10th, at the time of the MEC

meeting?
A No.
Q Okay. So you believe you had learned of that case sometime after October the 12th --
A Based on these letters, yeah.
Q -- but before October 15th?
A Yes.
Q And what did Mr. -- Dr. Patterson tell you about Ms. R[redacted]'s case?
A That she had had abdominal surgery and -- again, my recollection's fuzzy, but she had had, I think, cholecystitis, had had surgery by Dr. Randall, and then had bled for several days after, getting transfused and having an 11-unit bleed. Ultimately, she was discharged from the hospital and went to rehab.
Q Did -- were you provided any medical records of Ms. R[redacted] to review?
A I don't recall, but I think there was a paper record, and we also have electronic record in the computer. But I don't, honestly, recall.
Q Do you recall whether you looked at the records?
A I don't honestly recall, to be honest.
Q Do you know whether Dr. Patterson had looked at the records?

A I feel confident he did, but I can't tell you.
Q Did he give you any recommendation as what you should do in response to this additional --
A Yeah.
Q -- complaint?
A He was concerned that this was another case that should prompt summary restriction of privileges.
Q Okay. And was -- was he advocating summary restriction of privileges?
A I don't know that he was advocating it, but he certainly brought it to my attention, saying -- based on the discussions in the prior MEC, you know, that there was a strong feeling about summary restriction. Yeah. "This -- the -- and here's another case that came in."

Throughout the process, as we were looking at those original seven or eight cases, you know, additional cases were coming in. And that, I think, made the MEC more concerned about ongoing potential harm to patients. And then, here was another case, you know, coming in. And so we felt -- I felt, at that point, there was certainly was imminent danger to patients and that something needed to be done.

Q And when you felt that imminent -- that there was a

A I don't recall.
Q Okay. And you had the authority to make up the composition of the appeals panel; is that correct?
A Yes. With the exception that the bylaws don't allow economic competitors to be on the committee.
Q And were any members -- were there any general surgeons on the panel?
A No.
Q Why not?
A Because they were all either competitors or current or former partners. But we had, as I said before, surgical sub-specialists on the panel and -- and -- and physicians who were familiar with operating rooms, such as the anesthesiologist, obstetricians who do abdominal and pelvic surgery.
Q Can you think of any circumstance where a -- a physician who is -- who is a specialist whose -- whose privileges are being revoked within their area of specialty and wishes to come -- to have a hearing before an appeal panel, that a member of this staff, who is also in the same specialty, would either -- who would not be a competitor or -- or in economic --
A Right.
Q -- relationship with them?

it's not in my nature to be loud --
Q Okay.
A -- or yell or angry.
Q All right. Well, I was wondering about that -- that description of the exchanging of paint. So it may have been Dr. Randall's car --
A It may have.
Q -- that you hit and then apologized to him? Is that what you're --
A That's --
Q -- suggesting?
A -- the way that I would -- that's what I would imagine happened, but I don't really recall it being Dr. Randall.
Q All right. All right. Fair enough.

In this complaint -- in Dr. Randall's complaint, you've been named as an individual defendant, along with Dr. Patterson. Do you understand that?
A Yes.
Q And -- and that complaint alleges that you participated in a conspiracy, through this peer review process, to harm Dr. Randall? Did you understand that?
A Yes.

Q Have you participated in any -- in any kind of a conspiracy to harm Dr. -- Dr. Randall through peer review process?
A I have not.
Q Have you engaged in any other kind of conspiracy to harm Dr. Randall?
A No, sir.
Q All right. You sat on the peer review committee; you sat on the ad hoc committee; you sat on the MEC committee; is that correct?
A Yes.
Q In sitting in on those committees, did you hear anything or observe anything that will cause you to believe that the folks on those committees, when they were considering Dr. Randall's care, were motivated by anything untoward?
A No, sir. Not at all.
Q All right. When you were on the peer review committee, describe for me what motivated you and the others, if you can -- let's start with you, when you were considering the cases of Dr. Randall's that were under review.
A Well, I'm not sure that I understand that question, what motivated us? But we were concerned about the quality of care being delivered to the patients in

the hospital.
Q All right.
A And that was the only motivation.
Q All right. I understand. And that was your -- your motivation and your concern, and, from what you could tell, that was the others' concern?
A Absolutely.
Q All right. Now, we've -- we've talked about the members on these committees. Dr. Patterson attended some of these committee meetings?
A Yes.
Q He was not a member of the committee, was he?
A Right. He did not have voting rights in any committees that I recall.
Q Okay. And that's because he's not a member of the medical staff, right?
A Correct.
Q He is a part of administration as the chief medical officer.

Now, Dr. Patterson testified in a deposition not too long ago, and said that when he was sitting in on committees, he, if asked a question that involved surgery, because he was a general surgeon, he would answer it. Do you recall him having questions asked of him and answering?

Q All right. Did he conspire in any way?
A No, sir.
Q All right. We've talked a little about this, but I want to make sure I understand. The MEC meeting, when you make -- when the committee decides to recommend revocation of Dr. Randall's privileges, why did -- it -- it was a unanimous vote, correct?
A Yes.
Q Why did you vote to revoke -- to recommend the revocation of privileges?
A Because I was concerned that there had been a -- there had been a body of cases in which there were problems with pre-operative assessment, intra-operative technique, and post-operative care, as well as -- I think, that meeting, we also had the return-to-OR data suggesting a high volume of return to OR. And, during the whole process, we had -- I don't recall other cases coming in that were of concern from any other general surgeon. We continued to have a large volume of cases coming in with Dr. Randall, and they continued to come in throughout the process more -- more. And they were raised by physicians, hospital employees, as well as patient families. So it wasn't all coming from one source.

Q Okay. And you put that all together and, for you, that was enough to recommend revocation?
A Yes.
Q All right. Now, October 15th, you sent out the letter summarily suspending Dr. Randall's privileges. And that was, if I understood your testimony, precipitated, in part, by the J[redacted] R[redacted] case?
A Yes.
Q Were you reviewing the J[redacted] R[redacted] case in a vacuum when you were making that decision?
A No. And, like I said, that decision had been -- come -- come close to having been made at the previous medical executive committee meeting anyway. So it was the body of evidence that the decision was based on, primarily. And I think I testified to that in the hearing panel testimony.
Q I see. Now, there was some question about whether you could've called Dr. Randall up to chat with him before you summarily suspended him?
A Yes.
Q And I think the implication of that was: how about another chance to discuss this matter. By the time of October 15th, had Dr. Randall had an opportunity to discuss all of the cases, with perhaps the

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Piedmont Medical Center

Committee: Credentials

Date: June 10, 2010

Members Present: Drs. Jenkins, Revell, and Taylor; Mr. Miller, Dr. Patterson, Ms. Marten and Ms. West

Guest Present: Dr. Nat Edwards, COS & Chairman, Peer Review Committee

Earl Jenkins MD
Chairman

Agenda	Discussions/Findings	Conclusions/Recommendations	Action/Follow-up
Meeting Called to Order	The meeting was called to order by Dr. Jenkins, Chairman.		
[redacted]			
Peer Review Committee Presentation	Dr. Edwards was in attendance to discuss concerns of the Peer Review Committee involving practitioner 4018. A summary of all peer review activities for this practitioner since July 2006 through May 2008 was distributed and reviewed. A summary of an additional eight cases was provided and discussed in detail by Dr. Edwards. Each of these cases was reviewed by an external peer reviewer, as well as, reviewed by the Medical Staff Peer Review Committee. The Committee members discussed various options that could be recommended, which included 1) no recommendations, 2) concurrent review of all abdominal cases, 3) proctoring of all abdominal cases which would require a board certified general surgeon being present in the OR for all abdominal cases and to oversee the management of each case, and 4) restriction of all	The Committee concluded these cases identified the same concerns that had been identified in previous peer reviews, 1) surgeon's technique (handling of the bowel), and 2) judgment on timely returns to the OR. Recommendation was made to defer action at this time to allow the Chairman and CMO to review the Medical Staff Bylaws to determine all steps that are to be taken before making a recommendation to the MEC.	Chairman and CMO to review Medical Staff Bylaws.

PMC.00002994
PMC.00002994

Agenda	Discussions/Findings	Conclusions/Recommendations	Actions/Follow-up
Peer Review Presentation Cont.....	abdominal procedures. The members also discussed whether additional CME courses on basic surgery technique would be beneficial at this point in the surgeon's career.		
[redacted]			

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PMC.00002995
PMC.00002995

RANDALL1100

Committee: Credentials

Date: July 13, 2010

Members Present: Drs. Jenkins, Taylor and Patterson; Ms. Martin, and Ms. West

Earl Jenkins, MD
Chairman

Guests Present: Dr. Robert Randall

Agenda	Discussion/Findings	Conclusions/Recommendations	Action/Follow-up
Call the Meeting to Order Case Presentations by Dr. Randall	The meeting was called to order by Dr. Jenkins at 7:05 a.m. The main purpose of today's meeting was for the Credentials Committee to hear from Dr. Randall regarding care he provided to the nine patients that had been referred to them by the Peer Review Committee. Case 1: 51 year-old male, who was a non-compliant diabetic, weighing 350 lbs. He had presented to the ED and was admitted by the hospitalist and Dr. Randall was consulted. Upon discussion with the patient and his wife that he would need an amputation due to gas gangrene being present, his wife was insistent that the patient's problem was gout and she was not realistic about what care was needed for him. He agreed that he was aggressive with the wife and told her that unless the amputation was done "now", he would die. He stated that he did not understand why this case was submitted but felt that he acted appropriately due to the seriousness of the patient's condition. This patient recovered and was discharged. Case 2: 93 year-old male admitted with mesenteric ischemia and multi-system organ failure. Surgeon reported he had talked with the family regarding whether to put the patient through surgery at his age. The decision was made by the family to pursue surgery. The patient expired within 24 hours, which according to the surgeon, is expected in this type of case. Again, Dr. Randall stated he did not understand why this case was referred to the Peer Review Committee. It was noted that the ratings assigned by the outside reviewer were all 1s which indicates no problems were identified with the care provided. Case 3: 50 year-old male who had surgery performed in Virginia at some time prior to presenting to PMC with an incarcerated ventral incision hernia and small bowel obstruction. The patient was taken to the OR on 1-30-09 where part of the small bowel was re-sected. Multiple adhesions were noted. The patient initially did well, but a week later began to run a fever. The patient was taken back to the OR for re-exploration on 2/7/10 with one of his partners assisting in surgery. Neither of them identified there was a leak present. Again, the patient did well for a week and then was taken back to the OR on at which time another partner assisted him in surgery and a leak was identified was discharged. . The surgeon stated he disagrees with the external reviewer's findings. He agrees there was a technical		

RANDALL1100

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EXHIBIT
12

RANDALL1101

Agenda	Discussion/Findings	Conclusions/Recommendations	Action/Follow-up
Case Presentations by Dr. Randall Continued.....	Case 3 Cont...: problem in identifying the leak earlier, but felt it was managed appropriately once identified. Patient recovered and was discharged. Case 4: 57 year-old female with VP shunt, hemi paresis and PEG admitted with acute cholecytitis. He noted this patient had surgery for a brain tumor in the past which left her with deficits. The patient also had a PEG placed previously and was limited with her communicating when she felt pain. The patient was very sick upon admission. The surgeon began with a laparoscopic cholecystectomy; however, had to convert to an open procedure. The surgeon disagreed with the external reviewer's findings that there was a Trocar injury. There is nothing documented in the medical record to substantiate this finding. A mass had been noted on imaging studies prior to the surgery. The surgeon did agree that the J-tubing was cut and repaired. The surgeon disagreed that there was a problem with the care. Case 5: 30 year-old female with cerebral palsy, mental retardation and hiatal hernia was admitted. The patient had been living in a group home for several years and was not able to eat. Surgery was performed on 3-24-09. The patient initially did well but later her stomach would not empty and a Gastrostomy tube was placed. The surgeon also noted that this patient had Schizophrenia and pulled out her tube from the bowel (not entirely out). This was something that the surgeon did not have any control over. This patient survived and returned to the group home. Case 6: 45 year-old male with diabetes mellitus and rheumatoid arthritis was admitted for an incarcerated ventral hernia. This patient had weighed 450 lbs but had lost down to 225 lbs at the time of this admission. The patient was taking Prednisone daily for arthritis. The patient was taken to surgery and while in recovery, the patient did experience tachycardia. On the first post-op night, his Hgb was 10. The outside reviewer indicated the Hgb was 6.2 but this can not be substantiated by the medical record. On the first post-op day, the patient's Hgb was 9.3 and 10.5. Dr. Randall noted that while in recovery one of the nurses told him that the trocar site smelled like dead fish. The surgeon agreed that it did and the patient was returned to the OR and it was found that the fachia had pulled apart. The patient was doing well following this surgery and could have gone home; however, he was homeless. This patient grew 5 organisms out of this site. The patient stayed about 1-1/2 months in the hospital and had another trip to the OR. The patient survived and was transferred to MUSC by ambulance.		

RANDALL 1101

Agenda	Discussion/Findings	Conclusions/Recommendations	Actions/Follow-up
Case Presentations by Dr. Randall Continued....	Case 6 cont...: Charleston and had more surgery. Dr. Randall stated that he did recognize sepsis quickly and managed it appropriately, and he did agree there was an injury to the colon. The outside reviewer indicated Neosynephrine was ordered and should not have been. The order was not written by this surgeon, but by the intensivist. Case 7: 71 year-old male admitted with abdominal pain, gallstones, and "cystic" mass in RLQ at site of prior appendectomy which was complicated by multiple abcesses. The patient's past history consisted of having surgery at which time he had renal failure and had a long hospitalization. On 4/24/10, the surgeon performed a laparoscopic cholecystectomy. On first post-op day, the patient was doing alright, but his creatinine was 3.2. The surgeon consulted the nephrologists and cardiologist and moved the patient to the Intensivist on ICU. This was on a Friday, and the care of the patient was transferred to one of his partners at 5:00 p.m. for which he was on call until 7:30 a.m. on Monday. The initial surgeon was off for the week-end; however, he was in town and no communication was received from his partner of the patient's condition. The on-coming physician did get a CT and there was no leak identified; however, the patient's condition continued to worsen throughout the weekend. On Monday morning when Dr. Randall returned, the patient was on a ventilator. He immediately made the decision to take the patient to surgery; however, the son did not want his father cared for by this group and another general surgery group was contacted and the patient was taken immediately to surgery. The patient expired December 11, 2009. Dr. Randall stated he missed the diagnosis of bowel injury and he agrees with the reviewer's findings; however, he was not called by his partner and feels that he would have taken the patient back to the OR over the weekend if he had known. Case 8: 34 year-old male with RLQ pain with nausea and vomiting presented to the ED. Surgeon was consulted and patient taken to the OR where he underwent an uneventful open appendectomy. This patient was 6'2" tall and weighed 225 lbs. The surgeon wanted to keep the patient for a day or two and on the 2nd post-op day, the patient was up walking around and wanted to go home. Patient was discharged. The patient returned to the ED three days later (Friday) and was admitted by one of Dr. Randall's partners. There was no communication to Dr. Randall by the admitting physician that the patient had returned.		

RANDALL1102

Agenda	Discussion/Findings	Conclusions/Recommendations	
Case Presentations by Dr. Randall Continued....	On the next Tuesday evening, another partner was on call and was contacted by nursing since they were unable to reach the admitting surgeon by pager. It was at this time that he was notified by his partner that the patient had returned. The patient did return to surgery, but Dr. Randall disagrees that there was a small bowel perforation. The patient expired on 12/11/09. Autopsy showed the patient had 95% coronary artery disease in three vessels which was not known by the surgeon prior to surgery. Case 9: 48 year-old male with past history of constipation and at the time of admission, he had not had a bowel movement for 10 days. This patient was scared of physicians, was uninsured and wanted to stay home as long as he could. However as the pain continued to increase he presented to the ED. The patient was taken to surgery and a colostomy was performed on 7/18/09. He was admitted to ICU. His condition did not look good, white count was down, and the surgeon took the patient back to the OR on 7/19/09 for an ischemic bowel requiring wound VAC and subsequently had a prolonged hospital course. The surgeon disagrees with the reviewer's findings that the patient's entire complex hospitalization could have been avoided had diverting colostomy been done initially with a later elective left hemicolectomy after stabilization and treatment of his biventricular disease. He felt he had done a good job with a very difficult case. Dr. Randall asked the Committee if they had any questions. No questions were voiced. Dr. Randall then discussed some of the potential recommendations that the Committee could make. He noted that it would be difficult for him to perform 100 cases with another surgeon. He stated he had borrowed a lot of money to establish a new practice and did not feel he could continue if his privileges were		

RANDALL1103

Agenda	Discussion/Findings	Conclusions/Recommendations	Actions/Follow-up
Case Presentations by Dr. Randall Continued....	restricted in this manner. He advised that he had worked at a trauma center in North Carolina in November and December, 2009, and felt this had been good experience for him. Dr. Randall was thanked for coming and talking with the Committee and he was excused from the meeting. The members discussed the various potential recommendations that could be made. REDACTED	The physician committee members felt that Dr. Randall was safe to continue performing surgery. It was noted they have observed him to be more aggressive in returning patients to the OR when it is indicated than some other general surgeons in that group. Now that he is covered by a different group who is more aggressive in returning patients to the OR, communications between physicians may be improved. The following recommendations were made: 1) Communication between physicians and family/patients must be improved. 2) Perform concurrent monitoring through the hospital's Peer Review process for all of Dr. Randall's abdominal and hernia cases for six months. If concerns with the care are identified, it is recommended for the case to be referred for outside review. 3) If during this six-month period there are significant concerns identified, the Credentials Committee will meet with Dr. Randall to discuss. 4) Dr. Randall's reappointment to the Medical Staff will be recommended for one year.	Dr. Patterson and Dr. Jenkins will prepare a letter to Dr. Randall outlining the Committee's recommendations. These recommendations which will be submitted to the MEC in August.

RANDALL1104

EXHIBIT 43

Committee: Medical Executive Committee

Members Present: Drs. Baker, Benson, Bilbrey, Edwards, Eller, Grewal, Maynard, Paxter, and Pillai; Mr. Cline, Ms. Douglass, Mr. Miller, and Mr. Pennisson and West

Date: August 9, 2010

Chief of Staff

Agenda	Discussions/Findings	Conclusions/Recommendations	Action/Follow-up
Call to Order	The meeting was called to order by Dr. Edwards, Chief of Staff.		
Review of Previous Minutes	The minutes of the previous meeting were distributed to the committee members prior to the meeting. The floor was opened for discussion.	Being there was no discussion, a motion was made and seconded to approve the minutes as submitted.	Minutes approved.
[redacted]			

Agenda	Discussions/Findings	Conclusions/Recommendations	Action/Follow-up
[redacted]			
Credentials Committee Activities	The Credentials Committee recommended the following appointments, reappointments, OPPE, additional privileges and deletions for the Medical Staff and AHPs: [redacted]	All appointments, reappointments, OPPE, additional privileges and deletions for the Medical Staff and AHPs will be recommended to the Governing Body, with the exception of: [redacted] 2) Dr. Randall's reappointment of one year was approved; however, a request will be made to the Credentials Chairman to discuss with the MEC the meeting they held with Dr. Randall, and provide documentation that was provided by the Peer Review Committee to the Credentials Committee, the number of cases	CEO will present these appointments, reappointments, OPPE, additional privileges and deletions to the Governing Body at their August meeting. Additional information will be made available to the MEC regarding previous review for Dr. Randall. Chairman of Credentials Committee will be asked to attend the next meeting.

PMC.00005371

Agenda	Discussions/Findings	Conclusions/Recommendations	Action/Follow-up
Credentials Committee Report Cont....	[redacted] • Review of Medical Staff On-Going Performance Practice Evaluation A. Robert D. Randall, Jr., MD, Department of Surgery, Sub-specialty of General Surgery, Active [redacted]	Dr. Randall did during the first review period and the number of complications reviewed by the Peer Review Committee. It was also recommended that the monitoring time be increased from six months to one year.	

PMC.00005372

Committee: Executive Committee

Date: September 13, 2010

Members Present: Drs. Baker, Benson, Billman, Edwards, Eller, Hubbard, Kessler, Maynard, McKinney, and Paxton, Mr. Douglass, Ms. Halterman, Mr. Miller, Dr. Patterson, and Ms. West

Guests Present: Drs. B. Jenkins from the Credentials Committee; Drs. Kessler, Ramos, and Raymond from Peer Review Committee

Agenda	Discussion/Findings	Conclusions/Recommendations	Action/Follow-up
Call to Order	Dr. Edwards called the meeting to order at 5:35 p.m.		
Review of Previous Minutes	The minutes of the previous meeting were distributed to the members prior to the meeting. The floor was opened for discussion.	Being there was no discussion a motion was made by Dr. Maynard, seconded by Dr. Hubbard to approve the minutes as submitted.	Motion carried. Minutes approved.
[redacted]			

Agenda	Discussion/Findings	Conclusions/Recommendations	Actions/Follow-up
[redacted]			
MEC, Peer Review & Credentials Committee Review	At this time, the administrative team was excused in order for the physician members of the MEC, Peer Review and Credentials Committees to discuss specific physician information. Dr. Edwards advised that the purpose of the meeting was to have the Peer Review, Credentials, and Medical Executive Committees review information together that each of these committees had reviewed in the past to arrive at recommendations regarding physician 4018. As Peer Review Committee Chairman, Dr. Edwards presented details of nine cases to support his Committee's recommendation to the Credentials Committee.	After a lengthy review and discussion, the decision was made to: 1) Request physician 4018 to provide a written, point by point review of each of the 7 cases defined by the Committee, to the Medical Staff Office within 5 business days of the date of the written request. 2) Physician members of the MEC, Peer Review and Credentials Committees will hold another informal meeting with the practitioner present on 9/27/10. 3) Complete copies of the medical records for these 7 cases will be available at the 9/27/10 meeting. 4) CMO will determine whether an external physician in this specialty	

PMC.00005362

Agenda	Discussion/Findings	Conclusions/Recommendations	Action/Follow-up
MEC, Peer Review & Credentials Committee Review Continued.....	As Chairman of the Credentials Committee, Dr. Jenkins advised that a letter had been prepared and submitted to the physician regarding the Committee's concerns with the care of these 9 patients. The physician was asked to come and discuss each case with the Credentials Committee. Dr. Jenkins presented details of the physician's presentation of these cases. Specific trends were identified.	could be added to the 9/27/10 meeting. 5) Following meeting with physician and members of the three committees, everyone will be excused except the MEC members so a final determination can be made regarding this matter.	Letter will be prepared and delivered to physician on 9/14/10. Additional meeting will be held on 9/27/10 with physician.
Adjournment	There being no further business, the meeting was adjourned at 7:35 p.m.		

PMC.00005363

Committee: Ad hoc Review - MEC/Peer Review/Credentials

Date: September 27, 2010

Members Present: Dr. Baker, Dr. Benson, Dr. Billman, Dr. Edwards, Dr. Eller, Dr. Hubbard, Dr. McKinney, Dr. Paxtor, Dr. Forrester, Dr. Gilleland, Dr. Ramos, Dr. Raymond, Dr. E. Jenkins, Dr. Taylor, Dr. Patterson and Ms. West

Chief of Staff

Agenda	Discussion/Findings	Conclusions/Recommendations	Action/Follow-up
Call the Meeting to Order	The meeting was called to order by Dr. Edwards, Chief of Staff at 5:40 p.m.		
Review of Practitioner 4018	Dr. Edwards summarized the informal review and recommendations made by the MEC, Peer Review, and Credentials Committee members on September 13, 2010. A letter was sent to Practitioner 4018 requesting written information on each of the 7 cases being reviewed. Written information was received and provided to the ad-hoc committee members prior to the meeting. Dr. Patterson reminded the group that this is still an informal review process. Each case was reviewed in detail along with the written information provided by Practitioner 4018, copies of the medical records, and external peer review findings.	Recommendation made to revoke privileges for the performance of abdominal surgery, including herniorrhaphy, by either open or laparoscopic technique. In keeping with the Medical Staff Bylaws, the practitioner will be afforded the opportunity to meet with the ad hoc group before the recommendation for corrective action is submitted to the Medical Executive Committee.	Letter will be sent by Chief of Staff to practitioner 4018 outlining the recommendation to be made to the MEC and offering a meeting date of October 4, 2010, with this review group.
Adjournment	There being no further business, the meeting was adjourned at 8:35 p.m.		

RANDALL 1096

EXHIBIT 39

Committee: MEC/Peer Review/Credentials Ad hoc Review

Date: October 4, 2010

Chief of Staff

Members Present: Drs. Baker, Benson, Billman, Edwards, Grewal, E. Jenkins, Hubbard, Kessler, Maynard, McKinney, Nichols, Paxton, Pillai, Raymond and Patterson; Ms. West

Guest Present: Dr. Robert Randall

Agenda	Discussion/Findings	Conclusions/Recommendation	Action/Follow-up
Call the Meeting to Order	The meeting was called to order by Dr. Edwards, Chief of Staff, at 5:40 p.m.	The group recommended to move forward with the same recommendation as stated at the September 27th meeting: Privileges for the performance of abdominal surgery, including herniorrhaphy, by either open or laparoscopic technique to be revoked.	Chief of Staff will forward letter to the CEO of the recommendation that will be made to the Medical Executive Committee on October 11, 2010.
Continued Informal Review of Practitioner 4018	Dr. Edwards informed the group that a letter had been sent to Dr. Randall following the September 27th meeting advising him of the group's recommendation and offering time for him to address this group. Dr. Randall went through details of each patient's medical condition and care he provided to the 7 cases. Following these reviews, he informed the group that if restrictions were placed on his privileges that he would not be able to continue to practice. Following Dr. Randall's dismissal from the meeting, the floor was opened for questions. No additional questions were raised.	One request was made to review all general surgeons' return to surgery that have been trended during this same time period (2008/2009) prior to the MEC meeting on October 11, 2010.	Director of Medical Staff Services will provide information on general surgeons' returns to surgery that have been trended in 2008 and 2009.
Adjournment	There being no further business, the meeting was adjourned at 7:30 p.m.		

RANDALL 1095

EXHIBIT 38

PIEDMONT
MEDICAL CENTER

September 28, 2010

Robert D. Randall, Jr., M.D.
MEC Surgical
1665 Herlong Court
Suite A
Rock Hill, South Carolina 29732

Dear Dr. Randall,

An ad hoc group comprised of members of the medical staff at Piedmont Medical Center has reviewed a series of your cases, the internal and external reviews of those cases, and your written summaries of them.

The group was charged by the Medical Executive Committee with conducting an informal review and formulating a recommendation to the Medical Executive Committee based upon that review.

The ad hoc group will recommend to the Medical Executive Committee that your privileges for the performance of abdominal surgery, including herniorrhaphy, by either open or laparoscopic technique be revoked.

This revocation includes but is not limited to privileges and procedures related to:

- The alimentary tract
- The adrenal glands and the pancreas
- Abdominal wall surgery to include hernia surgery
- Anal and rectal surgery
- Diagnostic laparoscopy
- Cholecystectomy
- Appendectomy
- Splenectomy
- Operative choledochoscopy
- Paracentesis, peritoneal lavage
- Surgery of the uterus, ovaries, kidney, bladder, and adrenals

The Bylaws of Piedmont Medical Center afford you the opportunity to meet with the ad hoc group before this recommendation for corrective action is presented to the Medical Executive Committee. If you wish to take advantage of that opportunity, please notify the Medical Staff Office at 329-6868, and the meeting will be held in the Doctors' Dining Room at 5:30 p.m., October 4, 2010.

Sincerely,

EXHIBIT 15

Nathaniel Edwards, M.D.
Chief of Staff

222 S. Herlong Avenue • Rock Hill, SC 29732 • phone: 803-329-1234 • fax: 803-329-0979 • www.piedmontmedicalcenter.com

State of South Carolina	)	
	)	
County of York	)	
	)	
Robert Randall, M.D.,	)	2012-CP-46-167
	)	
Plaintiff,	)	
	)	
vs.	)	Deposition
	)	
Amisub of South Carolina, Inc. d/b/a/ Piedmont Medical Center, Nathaniel Edwards, M.D., and Richard Patterson, M.D.,	)	of
	)	Everett Earl Jenkins, Jr., MD
	)	
Defendants.	)	
	)	
	)	
	)	

Deposition of Everett Earl Jenkins, Jr., MD, taken before Susan A. Wyant, a notary public in and for the State of South Carolina, commencing at the hour of 8:07 a.m., Monday, August 12, 2013, at the office of Piedmont Medical Center, 222 South Herlong Avenue, Room D - Ground Floor, Women's Tower, Rock Hill, South Carolina.

This deposition contains confidential peer review information.

Reported by
Susan A. Wyant

A -- put me at a --
Q Fair enough. Fair enough.
A -- poor position -- imposition.
Q Let me ask it this way: Do you believe that any of these folks that were sitting around at this meeting and the prior meeting, deliberating and making these recommendations and decisions -- do you have any concerns that they were motivated by bad faith?
A Bad --
Q Bad faith? Bias?
A No. No. I don't think so.
Q Okay.
A I think it was their true opinions.
Q Do you think they were motivated by the fact that Dr. Randall had sold his practice to Novant?
A I have no knowledge of that --
Q Okay.
Q -- that that would be the case.
Q All right. Were you concerned that that is the basis for this action?
A No. No. That really was not on my mind.
Q Okay.
A And as -- and as far as Bob being with Novant, it was -- I thought it was good for him if that's --

Q Okay. Nothing you considered as part of the decision-making you made here?
A Not that I know of. No.
Q Okay.
A It was never a thought that went --
Q All right.
A -- through my mind.
Q All right. The meeting that preceded this was a -- was a meeting in October where the MEC gets together and they vote for the -- the recommendation -- now we're going back in time --
A Okay.
Q -- for revocation of his privileges; do you recall voting at that meeting?
A You know, I -- I -- yes. I --
Q Okay.
A I was -- I was with the group on that. But I would just say I -- I was with the group.
Q Okay.
A I didn't feel I could stand up and argue on Bob's behalf or on the issues here.
Q And I -- and I certainly understand the personal conflict and you were concerned that you weren't capable to judge the nuance of abdominal surgery, and I understand that.

A Correct. Correct. Correct.
Q But you -- you voted to terminate?
A I would be in -- I was with the group. I thought --
Q Okay.
A -- they should go through the process and --
Q And was that because you were --
A -- come to a conclusion.
Q -- concerned about the care that was being provided and concerned about patients?
A Yes. I felt that this should be discussed and --
Q Understood. There was some discussion of Patterson and Edwards, that they "brought up questions," I think was the way you phrased it. Were you concerned about either Dr. Patterson or Dr. Edwards in their role? Did they behave fairly in this, from your perspective?
A I used them as a source of valid information. As I said, I had no reason to -- not to.
Q Okay. Let's see. Your credentials committee got together and reviewed these cases and that, you know, peer review committee looked at a lot of cases; you're aware of that, right?
A Yes. Yes.
Q Then you all looked at a lot of cases and had to

Committee: Medical Executive Committee

Date: October 10, 2010

Members Present: Drs. Benson, Billman, Edwards, Biller, Grewal, Hubbard, Maynard, McKinney, Patterson, and Paxton, Ms. Cline, Ms. Douglass, Mr. Miller, Mr. Pennisson, Ms. West and Ms. Kaplan

Chief of Staff

Guest Present: Dr. Kessler, V-Chairman Surgery Department, and Ms. Bryson, Pharmacy Director

Agenda	Discussion/Findings	Conclusions/Recommendations	Action/Follow-up
Call the Meeting to Order	The meeting was called to order by Dr. Edwards at 5:40 p.m.		
Review of Previous Minutes	The minutes of the previous meeting were reviewed.	Recommendation made to accept minutes as submitted.	Minutes approved.
[redacted]			

Agenda	Discussions/Findings	Conclusions/Recommendations	Action/Follow-up
Recommendation From Adhoc Review Group	Dr. Edwards reported the medical executive Committee has received a recommendation from the Adhoc Review Group to submit a corrective action regarding practitioner 4018 for consideration. He read the letter sent to Mr. Miller, CEO, that the MEC had received a request for adverse action, i.e. revocation of privileges of abdominal surgery, including hemiorrhaphy, by either open or laparoscopic technique for this practitioner. As requested at the last meeting of the Adhoc Review Group, data of returns to the OR within 30 days of the first operation was provided and reviewed. Results of two additional cases which had been received from the external peer reviewer were distributed and reviewed. The floor was opened for discussion or questions. None were voiced.	After review of the two additional cases, it was concluded that these cases identify the same trends as previous reviews. A motion was made and seconded to approve the request for adverse action from the Adhoc Review Group. Privileges will not be restricted for practitioner 4018 during the 30 days he can request a hearing; however, monitoring of cases will be continued.	Recommendation approved unanimously. Chief of Staff will send letter to the CEO of the MEC's decision.
Adjournment	There being no further business, the meeting adjourned at 6:45 p.m.		

PMC.00005358
PMC.00005358

PIEDMONT MEDICAL CENTER

October 15, 2010

Robert D. Randall, Jr., M.D.
1665 Herlong Court, Suite A
Rock Hill, SC 29732

Dear Dr. Randall,

On October 11, 2010, the Medical Executive Committee of Piedmont Medical Center recommended that your privileges to perform abdominal surgery including herniorrhaphy, by either open or laparoscopic technique, be revoked. This revocation includes those procedures in your delineation of privileges related to:

- The alimentary tract
- The adrenal glands and the pancreas
- Abdominal wall surgery to include hernia surgery
- Anal and rectal surgery
- Diagnostic laparoscopy
- Cholecystectomy
- Appendectomy
- Splenectomy
- Operative choledochoscopy
- Paracentesis, peritoneal lavage
- Surgery of the uterus, ovaries, kidney, bladder, and adrenals

The remainder of your privileges in that delineation will remain intact, except as they involve one of the revoked privileges (e.g. management of the trauma patient).

The Medical Executive Committee based its recommendation on a review of a series of your cases, including internal peer review, review by external experts, and the oral and written remarks provided by you to the ad hoc review committee. The Medical Executive Committee also took into account two more recent cases and the external expert review of them and an accounting of unplanned returns to the operating room by all general surgeons with privileges at Piedmont Medical Center. The Medical Executive Committee concluded that the surgical judgment and technique exhibited by you in those cases fall below the standards of the medical staff.

EXHIBIT 12

222 South Herlong Avenue • Rock Hill, SC 29732 • tel: (803) 329-1234 • fax: (803) 329-0979 • www.piedmontmedicalcenter.com

Under the medical staff bylaws, you have the right to request a hearing to challenge this recommendation. That request must be delivered to me by either hand or by certified or registered mail, return receipt requested, within thirty (30) days of your receiving this notice. Failure to request a hearing within that time limit will constitute acceptance of the recommendation and the waiver of all rights to such a hearing or appellate review under the bylaws.

Your rights in this matter are detailed in the enclosed sections of the bylaws.

Sincerely,

Charles F. Miller
Chief Executive Officer

Enclosure

Initials

PIEDMONT
MEDICAL CENTER

October 15, 2010

Robert D. Randall, Jr., M.D.
1665 Herlong Court
Suite A
Rock Hill, South Carolina 29732

Dear Dr. Randall,

As Chief of Staff at Piedmont Medical Center, having taken into account the case materials previously presented to you and, in addition, three more recent cases and an analysis of your unplanned returns to the operating room compared to the records of your peers, I have determined that summary restriction of your privileges is warranted to ensure there will be no imminent danger to persons for whom you might provide services under those privileges.

This restriction applies to your privileges to perform abdominal surgery including herniorrhaphy, whether by open or laparoscopic technique, including those procedures detailed in your delineation of privileges:

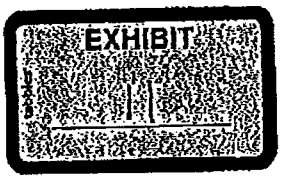
- The alimentary tract
- The adrenal glands and the pancreas
- Abdominal wall surgery to include hernia surgery
- Anal and rectal surgery
- Diagnostic laparoscopy
- Cholecystectomy
- Appendectomy
- Splenectomy
- Operative choledochoscopy
- Paracentesis, peritoneal lavage
- Surgery of the uterus, ovaries, kidney, bladder, and adrenals

This restriction also extends to your providing general surgery coverage in the Emergency Department at Piedmont Medical Center and to your providing consultation at Piedmont Medical Center regarding any conditions that might possibly relate to those delineated privileges.

Under the medical staff bylaws at Piedmont Medical Center (see enclosure), you have the right to an informal interview regarding this summary restriction, which takes effect immediately upon your receipt of this notice. Your written request for an informal interview with the Medical Executive Committee must be received within seven (7) days, and it may be addressed to my attention at the Medical Staff Office.

The Medical Executive Committee will take action on this summary restriction within 14 days, in accordance with the bylaws. The Medical Executive Committee may modify, continue for a definite or indefinite period, or terminate the summary restriction. If the Medical Executive Committee determines that the restriction should be terminated, you have the right to a hearing at which the sole issue will be whether or not there was probable cause for the summary restriction.

Should the Medical Executive Committee sustain the summary restriction, your rights are as provided in the enclosed excerpts from the medical staff bylaws.



If the duration of the restriction exceeds thirty (30) days, the action is reportable to the National Practitioner Data Bank and South Carolina licensing board.

Sincerely,

Nathaniel Edwards, M.D.
Chief of Staff

Copies: Chief Executive Officer
Chair of the Governing Board
Members of Medical Executive Committee

ARTICLE VIII

CORRECTIVE ACTION

Section 2 - Summary Suspension

A. Grounds; Authority. All or any portion of a practitioner's clinical privileges may be summarily suspended or restricted where the failure to take summary action may result in imminent danger to the health or safety of any individual. The following persons are authorized by the medical staff to take summary action: the Chief of Staff, the chairman of affected practitioner's clinical department, or any of its elected officers of the medical staff. Suspension or restriction pursuant to this paragraph shall be temporary and effective only until further action is taken by the Medical Executive Committee pursuant to Section 3 D of this Article. When no person referenced above is available to impose a summary suspension or restrict clinical privileges, the board, or its designee, may take such action if a failure to do so would be likely to result in an imminent danger to the health or safety of any individual. Prior to exercising this authority, the board, or its designee, must make reasonable attempts to contact the Chief of Staff, as the designee of the medical staff, another medical staff officer or the chairman or designee of the affected practitioner's clinical department or other elected officer of the medical staff. Summary action by the board which has not been ratified by the Chief of Staff, as the designee of the medical staff, or another elected officer of the medical staff within two (2) working days, excluding weekends and holidays, shall terminate automatically without prejudice to further summary or other corrective action as warranted by the circumstances.

B. Effective Date; Notice. A summary suspension or restriction shall become effective immediately upon imposition and the person or body imposing same shall promptly give written or oral notice of the suspension or restriction to the suspended practitioner, stating by whom it was imposed and the reasons for same. The notice shall be deemed to have been given on the date on which it is either personally delivered or mailed to the suspended practitioner, whichever occurs first. The notice, or a written confirmation of it, shall inform the suspended practitioner: (1) of his or her right to an informal interview upon his or her written request under Section 3 C of this Article; (2) whether the action is reportable pursuant to any State or Federal Statute; (3) if the suspension could be reportable to the National Practitioner Data Bank; and (4) that even if the suspension or restriction is terminated when the Medical Executive Committee takes further action under 3 D of this Article, the practitioner will be entitled to a hearing at which the sole issue will be whether there was probable cause for the summary suspension or restriction. A copy of the notice shall promptly be delivered to the Chief Executive Officer, the Medical Executive Committee, and the board.

C. Investigation. The Medical Executive Committee, before taking further action, shall conduct such investigation as it deems necessary, which shall include at least one (1) meeting of the Medical Executive Committee; and may include an informal interview with the suspending party. An informal interview with the affected practitioner may be held if the affected practitioner delivers a request for an informal interview in writing within seven (7) days after notice of the suspension was given to him. The Medical Executive Committee's investigation may include chart reviews, if applicable, and informal interviews with or reports from other persons or relevant departments or committees. Neither the investigation nor any other activities of the Medical Executive Committee in taking its further action shall constitute a hearing; they shall be informal, and none of the hearing and

appeal rights under these bylaws shall apply. In the event the affected practitioner resigns his of her medical staff membership or privileges during the course of an investigation pursuant to this section, such resignation shall be reported to the required agencies in accordance with State and Federal law.

ARTICLE VIII

CORRECTIVE ACTION

Section 2 - Summary Suspension

D. Further Action; Time. Within fourteen (14) days after the date of the suspension, the Medical Executive Committee shall take further action with respect to the suspension, and may modify, continue for a definite or indefinite period, or terminate the summary suspension or restriction. Such further action shall remain in effect unless and until altered or terminated pursuant to other provisions of these bylaws. If the Medical Executive Committee upholds a summary suspension, it shall also decide whether to recommend that the affected practitioner's medical staff membership and clinical privileges should be terminated. The Medical Executive Committee shall promptly give written notice of its further action to the suspended practitioner, the Chief Executive Officer and the person or body who imposed the suspension or restriction (if other than the Medical Executive Committee).

E. Rights to Hearing. Following the decision of the Medical Executive Committee regarding further action, the provisions of these Bylaws shall govern the hearing and appeal rights.

F. If the Medical Executive Committee's action pursuant to Section 2.B of this Article is to terminate the suspension and/or to cease all further corrective action, notice of such action shall be transmitted immediately, together with all supporting documentation, to the Board. Thereafter, the procedure to be followed shall be as provided in these Bylaws as applicable.

ARTICLE VIX

HEARING AND APPELLATE REVIEW PROCEDURE

Section 1 - Grounds for Hearing

A. Any of the following actions shall, if based on professional conduct or competence and deemed adverse pursuant to Section 1-B of this Article, entitle the Practitioner affected thereby to a hearing:

1. Denial of initial Staff membership.
2. Denial of Staff membership renewal.
3. Suspension of Staff membership.
4. Revocation of Staff membership.
5. Denial of requested advancement in Staff category.
6. Reduction in Staff category, except in accordance with the request of the Staff member.
7. Limitation or suspension of Privileges.
8. Denial of requested Department affiliation.
9. Denial of requested Clinical Privileges.
10. Reduction in Clinical Privileges.
11. Suspension of Clinical Privileges.
12. Revocation of Clinical Privileges.
13. Terms of probation.
14. Individual requirement of consultation.

B. When Deemed Adverse: An action enumerated in Section 1A of this Article shall be deemed adverse only when it has been:

1. Taken or recommended by the Medical Executive Committee; or
2. Taken by the Board contrary to a favorable recommendation by the Medical Executive Committee.

Unless otherwise provided in the Medical Staff Bylaws all adverse actions shall become final and effective in accordance with the provisions of this Article.

ARTICLE VIX

HEARING AND APPELLATE REVIEW PROCEDURE

C. Notice of Adverse Action: A Practitioner against whom an adverse action has been taken or recommended which constitutes grounds for a hearing pursuant to Sections 1.A & 1.B of this Article shall promptly be given notice of such action by the Chief Executive Officer. Such notice shall be in writing and hand delivered or sent by certified or registered mail, return receipt requested, and shall

advise the Practitioner of his/her right to a hearing and shall include statements: (a) That an adverse action has been taken or recommended to be taken against the Practitioner; (b) Of the reasons for the action; (c) That the Practitioner has the right to request a hearing to challenge the adverse action or recommendation; (d) Of the time limit within which to request a hearing; (e) A general summary of the Practitioner's rights in the hearing; and (f) a copy of the Article on Hearing and Appeals Rights of these Bylaws.

D. Request for Hearing: A Practitioner shall have thirty days following the receipt of notice pursuant to Section 1.C of this article to file a written request for a hearing. Such request shall be delivered to the Chief Executive Officer either by hand delivery or by certified or registered mail, return receipt requested.

E. Waiver By Failure To Request A Hearing: A Practitioner who fails to request a hearing within the time and in the manner specified in Section 1.D hereof shall be deemed to have accepted the action and shall be deemed to have waived any right to such hearing and to any appellate review to which he/she might otherwise have been entitled.

Section 2 - Notice of Hearing

A. Upon receipt of a proper and timely request for a hearing, the Chief Executive Officer shall deliver such request to the Chief of Staff and shall notify the Medical Executive Committee of such request. Within fifteen (15) days after receipt of such request, the Chief of Staff shall schedule and arrange for a hearing by a Hearing Committee. The Chief Executive Officer shall send the Practitioner notice of the time, place and date of the hearing. The hearing date shall be not less than thirty (30) days nor more than ninety (90) days from the date of receipt of the request for hearing.

B. Notice of Grounds and Witness List: As a part of, or together with the notice of hearing required by Section 3.A above, the Chief of Staff, on behalf of the Medical Executive Committee, shall provide the affected Practitioner with written notice of the act(s) or omission(s) with which the Practitioner is charged, including a list of the specific or representative patient records being questioned, the grounds upon which the adverse action was taken or recommended, and/or the other reasons forming the basis for the adverse action which is the subject of the hearing. The affected Practitioner shall be provided a list of witnesses expected to testify at least fifteen (15) days before such hearing, including addresses of the individuals. The witness list shall be amended when additional witnesses are identified. The affected Practitioner shall provide and amend a list of witnesses expected to testify on the Practitioner's behalf on the same schedule.

Section 3 - Composition of Hearing Committee

A. When a hearing is properly requested, the Chief of Staff shall appoint a Hearing Committee composed of at least five members of the active Medical Staff and alternatives as appropriate. The members and alternatives to serve on the Hearing Committee shall not have actively participated in the formal consideration of the matter at any previously level and shall not be in direct economic competition with the Practitioner. Knowledge of the matter involved shall not preclude a member of the active Medical Staff from serving as a member of the Hearing Committee. In the event that it is not possible to appoint a fully qualified Hearing Committee from the active Medical Staff, the Chief of Staff may appoint qualified members of the Courtesy Staff or qualified Practitioners from outside the Staff. One of the members so appointed shall be designated as Chairman.

B. A majority of the members of the Hearing Committee may act for the Hearing Committee. No committee member may vote by proxy.

Section 4 - Conduct of Hearing

A. A court reporter shall record the proceedings to permit an informed and valid judgment to be made by any group that later may be requested to review the record and render a recommendation or decision in the matter. The Hospital shall bear the costs of the reporter's appearance and the parties shall share the cost of the transcript.

B. The personal presence of the Practitioner for whom the hearing has been scheduled shall be required. A Practitioner who fails without good cause to appear and proceed at such hearing shall be deemed to have waived his/her rights in the same manner as provided in Section 1.E of this Article and to have accepted the adverse recommendation or decision involved, and the same shall thereupon become and remain in effect as provided in said Section 1.E.

C. Postponement of hearing beyond the time set forth in these bylaws shall be made only with the approval of the Hearing Committee. Granting of such postponements shall only be for good cause shown and in the sole discretion of the Hearing Committee.

D. The affected Practitioner shall be entitled to be accompanied by and/or represented at the hearing by a member of the Medical Staff in good standing, by a member of his/her local professional society, by legal counsel, or other person of the practitioner's choice.

E. The CEO, in concurrence with the Chief of Staff of the Medical Staff, shall appoint a hearing officer on behalf of the Board. The hearing officer shall be an attorney at law qualified to preside over an administrative hearing such as this, but attorneys from a firm regularly utilized by the hospital, the medical staff or the involved medical staff member or applicant for membership for legal advice regarding their affairs and activities shall not be eligible to serve as hearing officer. The hearing officer shall gain no direct financial benefit from the outcome and must not act as a prosecuting officer or as an advocate. The hearing officer shall endeavor to assure that all participants in the hearing have a reasonable opportunity to be heard and to present relevant oral and documentary evidence in an efficient and expeditious manner, and that proper decorum is maintained. The hearing officer shall be entitled to

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determine the order of or the procedure for presenting evidence and argument during the hearing and shall have the authority and discretion to make all rulings on questions which pertain to matters of law, procedure or the admissibility of evidence. If the hearing officer determines that either side in a

hearing is not proceeding in an efficient and expeditious manner, the hearing officer may take such discretionary action as seems warranted by the circumstances. If requested by the judicial review committee, the hearing officer may participate in the deliberations of such committee and be a legal advisor to it, but the hearing officer shall not be entitled to vote.

F. The hearing need not be conducted strictly according to rules of law relating to the examination of witnesses or presentation of evidence. Any relevant matter upon which responsible persons customarily rely in the conduct of serious affairs shall be considered, regardless of the existence of any common law or statutory rule which might make evidence inadmissible over objection in civil or criminal action. Either party shall, prior to or during the hearing, be entitled to submit memoranda concerning any issue or procedure or fact and such memoranda shall become a part of the hearing record.

G. When a hearing relates to a denial of initial Staff membership, a denial of requested advancement in Staff Category, a denial of requested Department affiliation, or a denial of requested Clinical Privileges, the Practitioner who requested the hearing shall have the burden of proving, by clear and convincing evidence, that the adverse action lacks any substantial factual basis or that such basis or the conclusions drawn there from are arbitrary, unreasonable or capricious. Otherwise, the body or committee whose adverse action occasioned the hearing shall have the initial burden to present evidence in support thereof. Thereafter, the burden shall shift to the Practitioner to support his/her challenge to the adverse action by a preponderance of the evidence that the grounds therefore lack any substantial factual basis or the conclusion drawn there from are either arbitrary, unreasonable or capricious. In all cases, the Hearing Committee shall rule against the Practitioner unless the Hearing Committee determines that the Practitioner has met his/her burden of proof.

The Medical Executive Committee or the Board, whichever body's action occasioned the hearing, shall either select legal counsel or appoint one of its members or another member of the active Medical Staff to represent it at the hearing, to present the evidence and arguments in support of its action, to examine and cross-examine witnesses.

H. Each of the parties shall have the following rights: to call and examine witnesses, to introduce written evidence, to cross-examine any witnesses on any matter relevant to the issue of the hearing, to challenge any witness and to rebut any evidence and to ask the Hearing Committee members questions which are directly related to determining whether they are impermissibly biased and to challenge such members. If the Practitioner does not testify in his/her own behalf, he/she may be called and examined as if under cross-examination.

I. The hearings provided for in these bylaws are for the purpose of resolving, on an intra-professional basis, matters bearing on professional competency and conduct. However, the foregoing shall not be deemed to deprive the Practitioner, the Medical Executive Committee of the Medical Staff, or the Board, of the right to legal counsel throughout the hearing process, including at the hearing itself.

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J. The Hearing Committee may, without special notice, recess the hearing and reconvene the same for the convenience of the participants or for the purpose of obtaining new or additional evidence or consultation. Upon conclusion of the presentation of oral and written evidence, the hearing may be closed. Each party shall have the right to submit a written statement within 10 days of the close of the hearing, providing arguments and authorities in support of its position. The Hearing Committee may thereupon, within thirty days after receiving post-hearing written submissions of the parties, render a written decision in the matter, which shall include a written statement of the basis for the decision. The Hearing Committee may forward the written decision, together with the hearing record and all other documentation considered, to the Chief Executive Officer. The Hearing

Committee's decision shall contain findings and facts, which shall be in sufficient detail to enable the parties, the Board or any other appellate review body to determine the basis for the Hearing Committee's decision on each matter contained in the notice of charges. The decision shall be supported by reference to the hearing record and all other documentation considered by the Hearing Committee.

K. BASIS OF DECISION: The decision of the Hearing Committee shall be based on the evidence produced at the hearing. This evidence may include, but shall not be limited to, oral testimony of witnesses, briefs or memoranda of points and authorities presented in connection with the hearing, any material contained in the Medical Staff's credential files regarding the person who requested the hearing, any and all applications, references and accompanying documents, all officially noticed matters, and any other relevant evidence considered by the Hearing Committee. The Hearing Committee shall also be entitled to consider all other information that may be considered, pursuant to the Medical Staff Bylaws, in connection with applications for membership to the Medical Staff and for Clinical Privileges.

L. NOTICE OF DECISION: The Chief Executive Officer shall promptly send by hand delivery or by registered or certified mail a copy of the Hearing Committee's recommendation to the Practitioner, the Chief of Staff, the Medical Executive Committee, and to the Board.

M. EFFECT OF DECISION: If the Hearing Committee's decision is adverse to the Practitioner in any of the respects listed in Section 1.A of this Article, the notice required by Section 5.L hereof shall inform the Practitioner of his/her right to request an appellate review by the Board as provided in Section 6 of this Article. If the Hearing Committee's decision is adverse to or modifies the Committee's decision action which occasioned the hearing, the notice required by Section 5.L hereof shall inform the Medical Executive Committee or the Board, as the case may be of the right to request an appellate review by the Board as provided in Section 6 of this Article. In the event that each party fails to request an appellate review within the time and in the manner specified in Section 6.A of this Article, the Hearing Committee's decision shall be deemed final and the matter shall be considered closed.

Section 5 - Appeal to Board

A. Within thirty days following receipt of the Hearing Committee's decision, either party may file a written request for an appellate review by the Board. Such request shall be delivered to the Chief Executive Officer either by hand delivery or by certified or registered mail, and it shall include a brief statement of the reasons for appellate review. The reasons for the appellate review shall be:

1. Substantial failure of any person to comply with the procedures required by these Bylaws or applicable law in the conduct of the hearing and the rendering of the recommendations or decision so as to deny the Practitioner a fair hearing; or
2. The action was taken arbitrarily, unreasonably, or capriciously.

B. A party who fails to request an appellate review within the time and in the manner specified in Section 6.A above waives any right to such review. Such waiver shall have the force and effect as provided in Section 1.E of this Article.

C. Upon receipt of a proper and timely request for appellate review, the Chief Executive Officer shall deliver such request to the Board. As soon as practicable, the Board shall schedule and arrange for an appellate review which shall be conducted not less than thirty days from the day of receipt of the appellate review request; provided, however, that the appellate review for a practitioner who is under a suspension then in effect shall be held as soon as arrangements for it may reasonably be made but not later than twenty days from the date of receipt of the request for appellate review. The Board, through the Chief Executive Officer, shall promptly deliver to the Practitioner notice of the time, place, and date of the appellate review.

D. The appellate review shall be conducted by the Board or by a duly appointed Appellate Review Committee of the Board of not less than five members. Knowledge of the matter involved shall not preclude any person from serving as a member of the Appellate Review Committee, so long as the person did not participate in a prior hearing on the same matter.

E. The Practitioner or the Medical Executive Committee or the Board, as the case may be, may submit a written statement detailing the findings of fact, conclusions, and procedural matters with which he/she disagrees, and the reasons for such disagreement. This written statement may cover any matters raised at any step in the hearing process and legal counsel may assist in its preparation. The statement shall be submitted to the Board through the Chief Executive Officer at least ten (10) days prior to the scheduled date of the appellate review, except if such time limit is expressly waived by the Board. A written statement in reply may be submitted by the Practitioner or the Medical Executive Committee or the Board, as the case may be, and if submitted, the Chief Executive Officer shall provide a copy thereof to the other party at least five (5) days prior to the scheduled date of the appellate review.

1. The Board or its designated Appellate Review Committee shall permit the parties or their representatives to appear personally and to make oral statements in favor of their positions at the designated time, place, and date of appellate review. Any party or representative who appears personally shall be required to answer questions put to him/her by any member of the appellate review body.

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2. The Board or its designated Appellate Review Committee shall have all the power granted to the Hearing Committee and such additional powers as it deems, in its sole discretion, to be reasonably appropriate to the discharge of its responsibilities.

3. A majority of the Board or its designated Appellate Review Committee must be present throughout the review and deliberations. If a member of the Board or Review Committee is absent from any part of the proceedings, said member shall not be permitted to participate in the deliberations or the decision.

F. The proceedings by the Board or its Appellate Review Committee shall be in the nature of an appellate review based upon the record of the hearing before the Hearing Committee, which committee's decision, and all other documentation considered by the Hearing Committee. The standard of review shall be the same as that provided in Section 5 of this Article. The Board shall also consider the written statements, if any, submitted pursuant to Section 6E of this Article and such other material as may be presented and accepted under this Section.

G. New or additional matters or evidence not raised or presented during the Hearing Committee hearing may be introduced if requested by the Board or its designated Appellate Review Committee in the exercise of its sole discretion or if accepted by the Board or its designated Appellate Review Committee after a foundation showing that such evidence could not have been made available to the Hearing Committee in the exercise of reasonable diligence and subject to the same rights to cross-examination or confrontation provided at the Hearing Committee hearing. The Board or its designated Appellate Review Committee alternatively may remand the matter to the Hearing Committee for the taking of further evidence and for decision.

H. The Board or its designated Appellate Review Committee may refer the matter back to the Hearing Committee for further review and recommendation to be returned to the Board within sixty days and in accordance with its instructions.

I. The appellate review shall not be deemed to be concluded until all of the procedural steps provided in this Section 6 have been completed or waived. Where permitted by the Hospital Bylaws, all action required of the Board may be taken by a committee of the Board duly authorized to act. The chairman of the Board or the chairman of the designated Appellate Review Committee shall permit postponements or extension of the appellate review only on good cause and upon request therefore made as soon as reasonably practicable. Such postponements and extensions shall automatically extend for an equal number of days the time set forth in this Section 6 for the appellate review. In all cases, such time period shall be extended until the transcript of the Hearing Committee hearing is completed.

J. The Chairman of the Board, or its designated Appellate Review Committee shall be the presiding officer, unless a hearing officer is appointed, in which case the hearing officer shall be the presiding officer. The presiding officer shall determine the order of procedure during the appellate review, make all required rulings, and maintain decorum.

K. The use of a hearing officer to preside at any appellate review hearing is optional. The use and appointment of a hearing officer shall be determined by the Board, in its sole discretion, after consultation with the Chief of Staff. If a hearing officer is used for the appellate review, the same standards set above for the hearing officer at the hearing will apply.

L. Notwithstanding any other provision of these Bylaws, no Practitioner shall be entitled to more than one evidentiary hearing and one appellate review with respect to each adverse action.

M. If at any time receipt of notice of an adverse action or decision, a Practitioner fails to make a required request or appearance or otherwise fails to comply with the provisions of this Article or to proceed with the matter, the Practitioner shall be deemed to have consented to such adverse action or decision and to have voluntarily waived all rights to which he/she might have otherwise been entitled to in these Bylaws with respect to the matter involved.

Section 6 - Final Decision by Board

A. If the Appellate Review Committee conducts the appellate review, within fifteen days after the conclusion of its review, it shall forward its proposed decision to the full Board. In rendering its final decision after review of the Appellate Review Committee's proposed decision, the Board shall either adopt the Appellate Review Committee's decision or modify that decision; in no case, however, shall the Board's modification result in the imposition of a greater penalty or restriction upon the effect of Practitioner than that which would have resulted from implementation of the initial adverse action. The Board must render its final decision in writing within thirty days after conclusion of the appellate review. The Board shall, through the Chief Executive Officer, deliver a copy of its final decision, by hand delivery or by certified or registered mail, to the Practitioner, the Chief of Staff, and the Medical Executive Committee. The final decision of the Board shall be effective immediately and shall not be subject to further review.

A. If an adverse ruling or recommendation is made with respect to a Practitioner's staff membership, staff status or Clinical Privileges at any time, regardless of whether he/she is an applicant or a Medical Staff member, he/she must exhaust the remedies afforded by these Bylaws before resorting to formal legal action challenging the decision, the procedures used to arrive at the decision, or any claim against the Hospital or participants in the decision process.

Section 7 - Reporting

The authorized representative shall report an adverse action to the National Practitioner Data Bank and any other state or federal agency as required by laws, but only upon its adoption as final action and only using the description set forth in the final action as adopted by the Board. The authorized representative shall report any and all revisions of an adverse action, including, but not limited to, any expiration of the final action consistent with the terms of that final action.

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Section 8 – Disputing Reported Language

A member who is the subject of a proposed adverse action report to state or federal agencies may request an informal meeting to dispute the text of the report filed. The report dispute meeting shall not constitute a hearing and shall be limited to the issue of whether the report filed is consistent with the final action issued. The meeting shall be attended by the subject of the report, the chief of staff, the chair of the subject's department, and the hospital's authorized representative, or their respective designees.

SENDER: COMPLETE THIS SECTION

- Complete items 1, 2, and 3. Also complete item 4 if Restricted Delivery is desired.
- Print your name and address on the reverse so that we can return the card to you.
- Attach this card to the back of the mailpiece, or on the front if space permits.

1. Article Addressed to:

Dr. Robert Randall
1605 Herlong Court Ste A
Rock Hill SC
29732

COMPLETE THIS SECTION ON DELIVERY

A. Signature ☐ Agent ☐ Addressee

B. Received by (Printed Name) C. Date of Delivery 10/4/10

D. Is delivery address different from item 1? ☐ Yes
If YES, enter delivery address below: ☐ No

3. Service Type
☒ Certified Mail ☐ Express Mail
☐ Registered ☒ Return Receipt for Merchandise
☐ Insured Mail ☐ C.O.D.

4. Restricted Delivery? (Extra Fee) ☐ Yes

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RANDALL 1008

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PIEDMONT
MEDICAL CENTER

October 18, 2010

Robert D. Randall, Jr., M.D.
1665 Herlong Court
Suite A
Rock Hill, South Carolina 29732

Dear Dr. Randall,

Enclosed are copies of the following documents you requested Dr. Patterson to send to you:

- External Peer Review Results – Fred Mahaffey, Sr.
- External Peer Review results – Stanley Jones
- Returns to OR Within 30 Days of First Operation 2008 through July 2009

Should you have any questions, please let me know.

Sincerely,

Dianne M. West
Director, Medical Staff Services

Enclosures (3)

EXHIBIT 10

RANDALL 0987

RANDALL0987

State of South Carolina)
)
County of York)

Robert Randall, M.D.,	)	2012-CP-46-167
Plaintiff,	)	
vs.	)	Deposition
Amisub of South Carolina, Inc. d/b/a/ Piedmont Medical Center, Nathaniel Edwards, M.D., and Richard Patterson, M.D.,	)	of
	)	Julius W. "Jay" McKay, II, Esq.
Defendants.	)	

Deposition of Julius W. "Jay" McKay, II, Esq., taken before Angela M. Barrett, a notary public in and for the State of South Carolina, commencing at the hour of 10:39 a.m., Wednesday, August 14, 2013, at the office of Lewis, Babcock & Griffin, LLP, 1513 Hampton Street, Columbia, South Carolina.

Reported by
Angela M. Barrett

Suffice it to say, at this meeting, on the 25th, attorneys were not expressly something that was provided for by the bylaws.

A I -- I do not know.

Q Fair enough.

When Dr. Patterson told you, you couldn't participate, what did you say to him, if you recall?

A I'm not sure. But I -- I agreed to leave.

Q Okay.

A He told me I had to leave, and I did.

Q All right. So you didn't -- you didn't go to the chief of staff or anybody else and say, "I'm not going to leave."

A No. It was probably seven o'clock at night, so I didn't think I'd find anybody there that didn't have to be there, so, no.

Q Okay.

A I think Dr. Patterson was chief of staff when --

Q Chief of medical officer.

A Chief medical office, okay.

Q Right.

Q Dr. Edwards was the chief of staff.

Q Correct. The chief of -- chief of the -- chief of staff -- chief of the medical staff runs the

medical executive committee meetings.
A Okay.
Q Did you know that?
A I wasn't sure. I can't remember.
Q Okay. Well, it's -- suffice it to say, when Dr. Patterson asked you to leave, you agreed to leave?
A Yes.
Q All right. And then Dr. Randall went in and presented?
A That's my understanding of it.
Q Okay. All right. And then coming out of that meeting, it is your understanding, that -- that well, during that meeting -- after he presented, the MEC then decides whether to affirm the suspension, revoke it, or modify it?
A That -- I understood they had that authority. And this was before he was reported to the data bank, and that's why I thought it was so important to get this thing to facilitate him with it. You know, maybe these physicians on there didn't recognize the importance of what was happening and what was going to happen with it, so -- and that's why I wanted to be sure that Dr. Randall was able to effectively communicate the gravamen of what was -- what was happening.

A I can't recall that. They certainly could have. I don't -- I don't believe Dr. Randall had any objections to the individuals who were on there, but he wanted a general surgeon on there.

Q I see. Well, let me show you.

A I mean, I don't believe there was anyone on that panel that he particular did not like or get along with.

Q Okay. Let me show you this, and we may make it another exhibit. I think this is a -- it's a long letter, but take a minute and review it.

A Okay.

Q And that's the letter I recall.

What's the date on that letter?

A It looks to be dated December 17, 2010.

Q And it was sent to Dr. Randall?

A Yes. That's what it says.

Q All right. And did Dr. Randall provide you this letter?

A I assume he did.

Q Okay. If you look on the second page. It's got Bates 0957 on the bottom. It says, "The hearing will be conducted before a hearing committee of the medical staff. Members are Powell, Thomas, Fassler, Richter, McClelland."

A Okay.
Q And a little further down, "Please inform me in writing immediately if you object to the appointment of any of these individuals and state the bases for your objection." So you-all received that. And I think you just testified that Dr. Randall and you didn't have any objection to the individuals, per se.
A Yes.
Q So you believe that they were fair folks?
A Yeah. He didn't have any particular issue with any of them to my recollection.
Q Okay. So he didn't worry that any of them were biased against him?
A The ones he knew, he didn't have any objection to.
Q Okay. Good.
But you did submit an objection that said, "Look we would -- we believe there should be a general surgeon on the panel."
A Yes.
Q Okay. Now, eventually, because it took a while to get this thing scheduled, another letter went out to you-all that said -- and we may even have made that one an exhibit. It's the February 4th letter, which is Exhibit 7.

objected to an individual on the hearing panel?
A I don't know.
Q Fair enough.
I guess the larger point is you could've made an objection to individuals and you didn't, true?
A That's correct.
Q Take a look at Exhibit 8 for me for a minute. This is -- this is your objections. Your first objection we've talked about -- the general surgeon.
A Okay.
Q Do you know -- do you know what the bylaws say about whether a general surgeon could've been on the panel?
A No.
Q Okay. Number 2 is the 90-day issue.
A Right.
Q And you -- and you mention, I think in your testimony with -- with Jim, that this -- this -- this caused irreparable harm.
I guess here's my question: The hearing panel ultimately affirmed the MEC's recommendation of revocation and suspension, right?
A That's the documentation we got back.
Q Right.

care. I don't know what their -- you know -- I know generally what their -- types of physicians they were. Whether they understood the nuances of the surgery issues in the -- in this preceding, I just don't know. I can't speak for them. They'd have to speak for themselves.

Q Okay. So you -- you wouldn't -- you wouldn't testify that they were unqualified to serve in the capacity they served in?

A No.

Q Okay. Fair enough.

It looked like -- and we can pull out the exhibit if you want to look at it -- that the first continuance of the hearing -- the hearing was originally scheduled for early January?

A I believe so, and it kind of got --

Q It looked like --

A -- I can't remember.

Q -- you agreed to the first continuance. Is --

A Yeah.

Q -- that true?

A Somebody had a vacation or -- yeah. That was fine. And I think we just -- I want to say we just postponed it, I thought, for a week, maybe, if I'm --

Q Yeah. You're probably right. I don't think it was that long.
A It was -- it wasn't a long period of time.
Q But -- but you did -- you did on behalf of Dr. Randall --
A Yeah.
Q -- consent to the first extension?
A Right. Because I didn't think it would change things, and it would give us another week to try to prepare.
Q Yeah. I could imagine that would be something you would want with nine cases.

All right. I'm looking at Exhibit 1. So "By agreement of the parties the hearing in this matter is scheduled for January 5 and 6."

A I think so, yeah. We had talked about -- we kicked dates around and when people could do it and when people could be available. And I'm usually pretty -- try to be pretty flexible with those things.
Q Okay. So when the medical executive committee asked for the next postponement, that would've taken you to sometime in February.
A Right.
Q Did you -- did you object -- file some sort of an objection to Dawes Cooke or --

A -- possible.
Q All right. So during the hearing, you got to represent Dr. Randall and you got to cross-examine their witnesses -- the MEC's witnesses?
A Yes.
Q You got to put up your own witnesses?
A That's correct.
Q You brought an expert surgeon to testify on Randall's behalf.
A I did.
Q What was his name?
A Benjamin Tribble.
Q All right. And how did you find him? Was it you or Dr. Randall?
A I found him. He's a surgeon in Columbia who I've known. I've used him expert witness in the past.
Q Okay. All right.
A He's a young -- and I wanted him -- I say "I wanted him particularly" -- he went through a similar training path that Dr. Randall did. I -- medical school and -- I know he went through the same residency, I think, Dr. Randall went through. It used to be called "Bowman Gray."
Q Right. Wake Forest.
A And Dr. Tribble -- yeah -- went through that, so

A -- those would be records that the hospital has.
Q Sure.
MR. DAYHUFF: I think I'm just going to look through my notes.
THE DEPONENT: Okay.
MR. DAYHUFF: And I'm almost done. I'm sorry, Jim, if this is taking --
THE DEPONENT: That's all right.
MR. DAYHUFF: -- too long.
(Off the record from 1:51 p.m. until 1:53 p.m.)
THE EXAMINATION BY DAYHUFF CONTINUES.
Q During the hearing process, did you present any evidence to the hearing panel related to -- or make any argument related to this notion that the peer review action was illegitimate or was in furtherance of a conspiracy?
A No. I -- I think my argument, basically, was it was based on flawed data was the -- was really the --
Q You presented the case on the medicine?
A Basically. And some procedural objections, yeah. Basically --
Q Okay. The ones we talked about.
A Hit the medicine head on; that was basically it.

Q All right. Did you make any arguments to the appellate review committee -- that -- that group you appealed to -- that the peer review action -- that the MEC's recommendation or that the suspension was in furtherance of a conspiracy and not legitimate?

A I don't think I did. But, I mean, you know, not that I can recall. I did have some arbitrary-capricious-type language in what I presented to them. You know, that the -- you know, not based on the facts, that type of thing. But I --

Q That was on the medicine --

A Yeah.

Q -- too, wasn't it?

A But the, you know, conspiracy, those were not -- you know, that -- those were not things I was looking at. My role in this was try to -- try it on the medicine and then whatever technical issues we had. Some of things -- you know, some of the things I learned that I mentioned earlier about another hospital having an application; I think I learned that Dr. Randall's former group had been notified that they were no longer going to get call. I think they -- I -- they addressed that with their attorneys. These are the things I

learned later -- just bits and pieces, so . . .
Q Okay.
A This was not something -- I don't think this was anything I knew at the time.
Q All right. Well, you certainly had Dr. Randall offering to you that Dr. Patterson was out to get him, right?
A That's what he thought. And I don't know. You'll have to ask him --
Q Right.
A -- why he thought that and on what basis.
Q Right.
A Because I've seen Dr. Patterson -- you know, I don't live in Rock Hill. I don't work in that hospital, so . . .
Q But you didn't make any arguments to the hearing panel or the appellate review panel -- committee or the board that Dr. Patterson had somehow exercised undue influence over this process, did you?
A I think I brought something to their attention that I did not want Dr. Patterson involved in the process.
Q Oh, no. I -- I saw that part.
A That was in there, and that's probably something that -- I'm sure that's something I got from Dr.

Randall from his -- whoever he talked to around the hospital giving him information.

Q Oh, I -- you wanted him excluded from the hearing process --

A Yes.

Q -- and the appellate process --

A Exactly.

Q -- and the board's consideration. I understood that.

But you didn't make any arguments or offer any evidence that he was a conspirator who had somehow foiled this peer review process?

A No.

Q Okay. Understanding that you -- that you put up your case on the medicine; setting aside for a moment whether you think that decision was right or not, do you think that, considering that evidence they had before them, that the hearing panel -- that a reasonable mind looking at that evidence could've come to the same conclusion that the hearing panel did?

A I don't know. That's really their decision. I can't answer that.

Q Fair enough.

MR. DAYHUFF: Jim, any follow-up?

State of South Carolina)
)
County of York)

) C/A no. 2012-CP-46-167

Robert Randall, M.D.,)
)
Plaintiff,)
)
vs.)
) Deposition of
Amisub of South Carolina,) Charles Richard
Inc. d/b/a Piedmont Medical) Patterson, M.D.
Center, Nathaniel Edwards,)
M.D., and Richard)
Patterson, M.D.,)
)
Defendants.)
)
)

CONFIDENTIAL

Deposition of Charles Richard Patterson, M.D., taken before Carolyn M. Beam, a notary public in and for the State of South Carolina, commencing at the hour of 1:15 p.m., Wednesday, July 24, 2013, at, 1742 Cavendale Drive, Rock Hill, South Carolina.

Reported by

Carolyn M. Beam

that Dr. Randall brought an attorney to this?
A Was this the meeting? Then I was there.
Q Okay.
A Yes. Yes, I was there.
Q Okay.
A I don't know why I'm not listed.
Q Okay. And the -- and what do you recall about -- about Mr. Randall -- Dr. Randall bringing an attorney?
A Well, Dr. Randall, excuse me, appeared with someone who appeared to be an attorney.
Q Right.
A He was well-dressed and had a briefcase and he wasn't one of our doctors.
Q Did he represent himself to be an attorney?
A Well, I -- I said, could we step into the hall? And so the three of us stepped into the hall, and he introduced himself as Dr. Randall's attorney. And I explained that, under our bylaws, this was still an informal process, a collegial process, and that there was to be no outside representation for either medical staff, hospital or the physician at that meeting. And he said, fine, give me a call. And he left.

A I do recall the request. I don't recall at which point it was made and at which forum. But I do recall that being a request. And I think it was in writing. I believe it was in writing.

Q And do you recall whether -- that there was an -- that there was an issue as to whether they could find a general surgeon to serve on the committee who didn't have a conflict?

A Yes. The -- the bylaws specified that neither a direct noncompetitor nor partner or former partner. And certainly no one involved in any of the cases could serve on a hearing panel. And that eliminated all of our remaining general surgeons.

Q And under what circumstances could there -- I'm just trying to think. Where you have a specialist, under what circumstances could you ever have someone in the same specialist serve on a hearing panel who --

A Well, I never --

Q -- would -- who wasn't a --

A I've never --

Q -- competitor?

A Yeah. I -- I -- I understand your question

A Yes.
Q And what did the bylaws, do you recall, say of how soon Dr. Randall was entitled to a hearing after the MEC affirmed his summary suspension?
A The bylaws do state what the time period was in which a hearing is to be convened. I don't remember the number of days.
Q Okay. And -- and was it -- to your knowledge, was the hearing convened within that time period?
A No, it was not.
Q And do you know why it was not?
A It was not because the witness, upon whom the MEC was relying, reneged. I -- I can't think of another term. He -- we heard indirectly that he wasn't coming.
Q And do you know why he reneged?
A No, I do not.
Q Do you know whether he was -- do you -- this -- the witness who reneged, was he retained by AllMeds or AMR?
A One of the two companies. And he had reviewed the cases. He was the reviewer upon whom the peer review committee and MEC, et cetera, had relied. And our medical staff office

communicated with either AllMeds or AMR about his appearance and, yes, and -- and then suddenly, around -- I remember it as being Christmas Eve, but maybe not. But I was told that we had been informed that he wasn't coming and that we were not to contact him about it.

Q And -- and did that cause you to question the veracity of his reviews?

A No. It called into question the wisdom of doing business with that company anymore, if they couldn't support the entire process, which was -- I never read our contract. But it was my implicit understanding that reviews are to be supported by testimony in the due process, not necessarily in a court of law, if necessary, at the expense of the medical staff and the hospital.

Q Sure.

A But no, I -- it didn't make me question the validity of conclusions. Because the external reviewer was only being used as a consultant anyway. The ultimate decision about how to score any case was that of the peer review committee consensus. They only used the

hernia privileges.

Q What do you recall motivated the MEC when they made that decision? We talked about the motivations of the peer review committee. I guess we've talked about the ad hoc committee. Why did the MEC take the action that they took, the revocation --

A Right.

Q -- the recommendation of revocation?

A The general sense of -- of my listening to their concerns was that the gravity, the number of complications, the similarity, suggesting technique deficiencies and lack of insight into the difficulties.

Q Do you recall whether the MEC's vote was unanimous or not?

A As I recall, it was.

Q It was unanimous, okay. That recommendation occurs. Shortly thereafter, Dr. Edwards summarily suspends Dr. Randall's privileges?

A Yes.

Q Sends out a letter. The MEC convenes to consider that summary suspension. And that's required under the bylaws?

A It is.

Q And you were there for that meeting?
A As I recall, yes.
Q Okay. What do you recall their decision was?
A It was to uphold the summary suspension. But I really -- that may be the one from which all the rest of us were excused. I -- because I don't recall any -- I don't recall the details of the meeting.
Q I see. Okay. Do you have any concern that when they met to consider summary suspension, that they were motivated by anything untoward?
A No. This was -- this was hard duty taken seriously by everyone. If anyone had any motive, other than patient safety and concern for a colleague as well, I never heard or saw any evidence of it.
Q Have you engaged in any kind of a conspiracy to harm Dr. Randall through this process?
A I have not.
Q Have you engaged in any kind of a conspiracy outside of this process? And by this process, I'm talking about the peer review process, to harm Dr. Randall?
A I have not.
Q You talked a little bit about the hearing

Committee: Medical Executive Committee

Members Present: Drs. Baker, Benson, Edwards, E. Jenkins, Paxton, Pillai, and Singhi and Ms. West, Recorder

Guest Present: Dr. Robert Randall

Date: October 25, 2010

Chairman

Agenda Item	Findings/Discussion	Conclusions/ Recommendations	Actions/Follow-up
Call to Order	The meeting was called to order by Dr. Edwards, Chairman.		
Purpose of Meeting	Dr. Edwards informed the members that the purpose of this meeting was to provide Dr. Randall the opportunity for an informal interview with the Committee regarding the summary restriction which was instituted on October 15, 2010. He reported that in keeping with the Medical Staff Bylaws, the Medical Executive Committee is required to take action on this summary restriction within 14 days. The Committee may modify, continue for a definite or indefinite period, or terminate the summary restriction.		
Presentation by Practitioner 4018	The meeting was then turned over to Dr. Randall who informed the members that if this restriction is upheld, as a general surgeon he feels he will not be able to continue to practice. He noted this restriction would be reportable to the National Practitioner Data Bank and he feels this would keep him from practicing anywhere. Dr. Randall reviewed details of two additional cases with the Committee that had been sent to external peer review. He responded to the reviewer's comments and gave his reasoning with the care he provided. He discussed the care of a third patient who had laporoscopic surgery and required 11 units of blood post procedure Dr. Randall went through the other eight cases that he had presented at a previous meeting. No additional information was received. The members were asked if they had any questions. None were		

RANDALL 1091

EXHIBIT 35

Presentation by Practitioner 4018	voiced. Dr. Randall once again informed the Committee that he had been on staff since 1982, and that he performed the first surgical procedure when this facility opened. He stated he worked at Memorial Mission Hospital in Ashville, North Carolina, in 2009 and there were no problems. He indicated the pathologists and anesthesiologists had worked with him during these years and know the kind of care he provides. He stated he does not believe that he did anything wrong in the care provided to the last three patients he discussed. Dr. Randall was excused from the meeting. Dr. Edwards opened the floor for discussion.		
Committee's Review of Presentation	Various members indicated they felt that the same trends were identified in the last three cases as were identified in the other eight cases that have been reviewed. This included lack of technical and judgment skills. It was also noted that Dr. Randall did not appear to recognize anything was wrong in these last three cases and this concerned the committee members.	Motion was made and seconded to uphold the summary restriction.	The motion passed unanimously. Dr. Randall will be notified by letter of the MEC's decision to uphold the summary restriction of privileges.
	Dr. Patterson informed the Committee that the practitioner is requesting a formal hearing. The process for this hearing was discussed, including the need for a general surgeon to be part of the Hearing Committee.	Formal hearing will be arranged as outlined in the Medical Staff Bylaws. The external peer review companies that are being used may be asked if they have any general surgeons that would be able to serve in this capacity.	CMO and COS will arrange for formal hearing.
	REDACTED →		

RANDALL 1092

PIEDMONT
MEDICAL CENTER

October 28, 2010

Robert D. Randall, Jr., M.D.
1665 Herlong Court
Suite A
Rock Hill, South Carolina 29732

Dear Dr. Randall,

On October 25, 2010, the Medical Executive Committee met to consider the summary restriction of your privileges enacted on October 15, 2010. The Medical Executive Committee took into account the case materials made available to you and the comments you made during the informal interview prior to its subsequent deliberations.

The Medical Executive Committee voted to sustain the summary restriction of your privileges as enumerated in previous notices to you, i.e. the performance of abdominal surgery including herniorrhaphy, by either open or laparoscopic technique, including those procedures detailed in your delineation of privileges:

- The alimentary tract
- The adrenal glands and the pancreas
- Abdominal wall surgery to include hernia surgery
- Anal and rectal surgery
- Diagnostic laparoscopy
- Cholecystectomy
- Appendectomy
- Splenectomy
- Operative choledochoscopy
- Paracentesis, peritoneal lavage
- Surgery of the uterus, ovaries, kidney, bladder, and adrenals



This restriction also extends to your providing general surgery coverage in the Emergency Department at Piedmont Medical Center and to your providing consultation at Piedmont Medical Center regarding any conditions that might possibly relate to those delineated privileges.

The bylaws of the Piedmont Medical Center medical staff entitle you to certain rights, including the right to a formal hearing on this matter. The Chief Executive Officer of Piedmont Medical Center is in receipt of your letter (October 22, 2010) requesting a formal hearing regarding the prior adverse recommendation from the Medical Executive Committee entailing the privileges delineated above.

That hearing request already received subsumes the issues incident to the summary restriction upheld by the Medical Executive Committee on October 25, 2010, and a second request will not be necessary.

As Chief of Staff, I am charged with making arrangements for the requested hearing within fifteen (15) days of receiving your request. The hearing can occur no sooner than thirty (30) days and no more than ninety (90) days from the receipt of your request on October 22, 2010. I will notify you of those arrangements as soon as they are final.

222 S. Herlong Avenue • Rock Hill, SC 29732 • phone: 803-329-1234 • fax: 803-329-0979 • www.piedmontmedicalcenter.com

Your rights and the appertaining processes are described in the attached excerpts from the bylaws of the medical staff of Piedmont Medical Center.

Sincerely,

Nathaniel Edwards, M.D.
Chief of Staff

cc: Charles F. Miller, Chief Executive Officer

Enclosure

ARTICLE VIII

CORRECTIVE ACTION

Section 1 - Procedure

A. Whenever the activities or professional conduct of any Practitioner with Clinical Privileges are, or are reasonably likely to be, lower than the standards of the medical staff, detrimental to patient safety or to the delivery of quality patient care; in violation of the medical staff bylaws, rules and regulations, or policies of the hospital, medical staff or any medical staff department or committee thereof; or to be in violation of the ethics of their profession; corrective action against such Practitioner may be requested by any officer of the Medical Staff, by the Chair of any Department, by the chair of any standing committee of the Medical Staff, by the Chief Executive Officer, or by any member of the Active medical staff or the Board. Corrective action may be requested against any Practitioner who makes a knowing misstatement or misrepresentation on any staff application forms or if a Practitioner's license is placed on probation or if a practitioner is the subject of a pending review by the appropriate state-licensing agency. All requests for corrective action shall be in writing, shall be made to the Medical Executive Committee, and shall be supported by references to the specific activities or conduct, which constitute the grounds for the request.

B. Prior to the making of such report, the Practitioner against whom corrective action has been requested shall have an opportunity for an interview with the reviewing committee. At such interview, he/she shall be informed of the general nature of the charges against him/her, and shall be invited to discuss, explain or refute them. This interview shall not constitute a hearing, shall be preliminary in nature, and none of the procedural rules provided in these Bylaws with respect to hearing under these Bylaws shall apply thereto.

C. At anytime during the focused review or corrective action processes the subject practitioner may be referred to the Medical Staff Health Committee if there is reason to believe that the practitioner may be suffering from a potentially impairing health condition. Such referral may be in a addition to the corrective action process, , as appropriate.

D. The Medical Executive Committee shall take action on the receipt of a recommendation for corrective action or having received an inquiry directly and having determined, after a review, that correction action is appropriate, within 30 days or within such reasonable additional time, as the Medical Executive Committee deems necessary. If the request is unwarranted and constitutes an abuse of the process, corrective action against the requesting party may be requested.

E. The action of the Medical Executive Committee on a request for corrective action following a review may be to reject or modify the request for corrective action, to issue a warning, a letter of admonition, or a letter of reprimand, to impose terms of probation or a requirement for consultation, mandatory proctoring, or co-admitting, to recommend that Clinical Privileges be reduced, suspended, terminated, modified or sustained, or to recommend that the Practitioner's Staff membership and / or privileges be suspended or revoked, or to take or recommend other actions deemed appropriate by the Medical Executive Committee.

F. The Chairman of the Medical Executive Committee shall promptly notify the Chief Executive Officer in writing of all requests for corrective action received by the Committee and shall continue to keep the Chief Executive Officer informed of all action taken in conjunction therewith.

ARTICLE VIII

CORRECTIVE ACTION

Section 2 - Summary Suspension

A. Grounds; Authority. All or any portion of a practitioner's clinical privileges may be summarily suspended or restricted where the failure to take summary action may result in imminent danger to the health or safety of any individual. The following persons are authorized by the medical staff to take summary action: the Chief of Staff, the chairman of affected practitioner's clinical department, or any of its elected officers of the medical staff. Suspension or restriction pursuant to this paragraph shall be temporary and effective only until further action is taken by the Medical Executive Committee pursuant to Section 3 D of this Article. When no person referenced above is available to impose a summary suspension or restrict clinical privileges, the board, or its designee, may take such action if a failure to do so would be likely to result in an imminent danger to the health or safety of any individual. Prior to exercising this authority, the board, or its designee, must make reasonable attempts to contact the Chief of Staff, as the designee of the medical staff, another medical staff officer or the chairman or designee of the affected practitioner's clinical department or other elected officer of the medical staff. Summary action by the board which has not been ratified by the Chief of Staff, as the designee of the medical staff, or another elected officer of the medical staff within two (2) working days, excluding weekends and holidays, shall terminate automatically without prejudice to further summary or other corrective action as warranted by the circumstances.

B. Effective Date; Notice. A summary suspension or restriction shall become effective immediately upon imposition and the person or body imposing same shall promptly give written or oral notice of the suspension or restriction to the suspended practitioner, stating by whom it was imposed and the reasons for same. The notice shall be deemed to have been given on the date on which it is either personally delivered or mailed to the suspended practitioner, whichever occurs first. The notice, or a written confirmation of it, shall inform the suspended practitioner: (1) of his or her right to an informal interview upon his or her written request under Section 3 C of this Article; (2) whether the action is reportable pursuant to any State or Federal Statute; (3) if the suspension could be reportable to the National Practitioner Data Bank; and (4) that even if the suspension or restriction is terminated when the Medical Executive Committee takes further action under 3 D of this Article, the practitioner will be entitled to a hearing at which the sole issue will be whether there was probable cause for the summary suspension or restriction. A copy of the notice shall promptly be delivered to the Chief Executive Officer, the Medical Executive Committee, and the board.

C. Investigation. The Medical Executive Committee, before taking further action, shall conduct such investigation as it deems necessary, which shall include at least one (1) meeting of the Medical Executive Committee; and may include an informal interview with the suspending party. An informal interview with the affected practitioner may be held if the affected practitioner delivers a request for an informal interview in writing within seven (7) days after notice of the suspension was given to him. The Medical Executive Committee's investigation may include chart reviews, if applicable, and informal interviews with or reports from other persons or relevant departments or committees. Neither the investigation nor any other activities of the Medical Executive Committee in taking its further action shall constitute a hearing; they shall be informal, and none of the hearing and appeal rights under these bylaws shall apply. In the event the affected practitioner resigns his of her medical staff membership or privileges during the course of an investigation pursuant to this section, such resignation shall be reported to the required agencies in accordance with State and Federal law.

ARTICLE VIII

CORRECTIVE ACTION

Section 2 - Summary Suspension

D. Further Action; Time. Within fourteen (14) days after the date of the suspension, the Medical Executive Committee shall take further action with respect to the suspension, and may modify, continue for a definite or indefinite period, or terminate the summary suspension or restriction. Such further action shall remain in effect unless and until altered or terminated pursuant to other provisions of these bylaws. If the Medical Executive Committee upholds a summary suspension, it shall also decide whether to recommend that - the affected practitioner's medical staff membership and clinical privileges should be terminated. The Medical Executive Committee shall promptly give

written notice of its further action to the suspended practitioner, the Chief Executive Officer and the person or body who imposed the suspension or restriction (if other than the Medical Executive Committee).

E. Rights to Hearing. Following the decision of the Medical Executive Committee regarding further action, the provisions of these Bylaws shall govern the hearing and appeal rights.

F. If the Medical Executive Committee's action pursuant to Section 2.B of this Article is to terminate the suspension and/or to cease all further corrective action, notice of such action shall be transmitted immediately, together with all supporting documentation, to the Board. Thereafter, the procedure to be followed shall be as provided in these Bylaws as applicable.

....

ARTICLE VIX

HEARING AND APPELLATE REVIEW PROCEDURE

Section 1 - Grounds for Hearing

A. Any of the following actions shall, if based on professional conduct or competence and deemed adverse pursuant to Section 1-B of this Article, entitle the Practitioner affected thereby to a hearing:

1. Denial of initial Staff membership.
2. Denial of Staff membership renewal.
3. Suspension of Staff membership.
4. Revocation of Staff membership.
5. Denial of requested advancement in Staff category.
6. Reduction in Staff category, except in accordance with the request of the Staff member.
7. Limitation or suspension of Privileges.
8. Denial of requested Department affiliation.
9. Denial of requested Clinical Privileges.
10. Reduction in Clinical Privileges.
11. Suspension of Clinical Privileges.
12. Revocation of Clinical Privileges.
13. Terms of probation.
14. Individual requirement of consultation.

B. When Deemed Adverse: An action enumerated in Section 1A of this Article shall be deemed adverse only when it has been:

1. Taken or recommended by the Medical Executive Committee; or
2. Taken by the Board contrary to a favorable recommendation by the Medical Executive Committee.

Unless otherwise provided in the Medical Staff Bylaws all adverse actions shall become final and effective in accordance with the provisions of this Article.

ARTICLE VIX

HEARING AND APPELLATE REVIEW PROCEDURE

C. Notice of Adverse Action: A Practitioner against whom an adverse action has been taken or recommended which constitutes grounds for a hearing pursuant to Sections 1.A & 1.B of this Article shall promptly be given notice of such action by the Chief Executive Officer. Such notice shall be in writing and hand delivered or sent by certified or registered mail, return receipt requested, and shall advise the Practitioner of his/her right to a hearing and shall include statements: (a) That an adverse action has been taken or recommended to be taken against the Practitioner; (b) Of the reasons for the action; (c) That the Practitioner has the right to request a hearing to challenge the adverse action or recommendation; (d) Of the time limit within which to request a hearing; (e) A general summary of the Practitioner's rights in the hearing; and (f) a copy of the Article on Hearing and Appeals Rights of these Bylaws.

D. Request for Hearing: A Practitioner shall have thirty days following the receipt of notice pursuant to Section 1.C of this article to file a written request for a hearing. Such request shall be delivered to the Chief Executive Officer either by hand delivery or by certified or registered mail, return receipt requested.

E. Waiver By Failure To Request A Hearing: A Practitioner who fails to request a hearing within the time and in the manner specified in Section 1.D hereof shall be deemed to have accepted the action and shall be deemed to have waived any right to such hearing and to any appellate review to which he/she might otherwise have been entitled.

Section 2 - Notice of Hearing

A. Upon receipt of a proper and timely request for a hearing, the Chief Executive Officer shall deliver such request to the Chief of Staff and shall notify the Medical Executive Committee of such request. Within fifteen (15) days after receipt of such request, the Chief of Staff shall schedule and arrange for a hearing by a Hearing Committee. The Chief Executive Officer shall send the Practitioner notice of the time, place and date of the hearing. The hearing date shall be not less than thirty (30) days nor more than ninety (90) days from the date of receipt of the request for hearing.

B. Notice of Grounds and Witness List: As a part of, or together with the notice of hearing required by Section 3.A above, the Chief of Staff, on behalf of the Medical Executive Committee, shall provide the affected Practitioner with written notice of the act(s) or omission(s) with which the Practitioner is charged, including a list of the specific or representative patient records being questioned, the grounds upon which the adverse action was taken or recommended, and/or the other reasons forming the basis for the adverse action which is the subject of the hearing. The affected Practitioner shall be provided a list of witnesses expected to testify at least fifteen (15) days before such hearing, including addresses of the individuals. The witness list shall be amended when additional witnesses are identified. The affected Practitioner shall provide and amend a list of witnesses expected to testify on the Practitioner's behalf on the same schedule.

Section 3 - Composition of Hearing Committee

A. When a hearing is properly requested, the Chief of Staff shall appoint a Hearing Committee composed of at least five members of the active Medical Staff and alternatives as appropriate. The members and alternatives to serve on the Hearing Committee shall not have actively participated in the formal consideration of the matter at any previously level and shall not be in direct economic competition with the Practitioner. Knowledge of the matter involved shall not preclude a member of the active Medical Staff from serving as a member of the Hearing Committee. In the event that it is not possible to appoint a fully qualified Hearing Committee from the active Medical Staff, the Chief of Staff may appoint qualified members of the Courtesy Staff or qualified Practitioners from outside the Staff. One of the members so appointed shall be designated as Chairman.

B. A majority of the members of the Hearing Committee may act for the Hearing Committee. No committee member may vote by proxy.

Section 4 - Conduct of Hearing

A. A court reporter shall record the proceedings to permit an informed and valid judgment to be made by any group that later may be requested to review the record and render a recommendation or decision in the matter. The Hospital shall bear the costs of the reporter's appearance and the parties shall share the cost of the transcript.

B. The personal presence of the Practitioner for whom the hearing has been scheduled shall be required. A Practitioner who fails without good cause to appear and proceed at such hearing shall be deemed to have waived his/her rights in the same manner as provided in Section 1.E of this Article and to have accepted the adverse recommendation or decision involved, and the same shall thereupon become and remain in effect as provided in said Section 1.E.

C. Postponement of hearing beyond the time set forth in these bylaws shall be made only with the approval of the Hearing Committee. Granting of such postponements shall only be for good cause shown and in the sole discretion of the Hearing Committee.

D. The affected Practitioner shall be entitled to be accompanied by and/or represented at the hearing by a member of the Medical Staff in good standing, by a member of his/her local professional society, by legal counsel, or other person of the practitioner's choice.

E. The CEO, in concurrence with the Chief of Staff of the Medical Staff, shall appoint a hearing officer on behalf of the Board. The hearing officer shall be an attorney at law qualified to preside over an administrative hearing such as this, but attorneys from a firm regularly utilized by the hospital, the medical staff or the involved medical staff member or applicant for membership for legal advice regarding their affairs and activities shall not be eligible to serve as hearing officer. The hearing officer shall gain no direct financial benefit from the outcome and must not act as a prosecuting officer or as an advocate. The hearing officer shall endeavor to assure that all participants in the hearing have a reasonable opportunity to be heard and to present relevant oral and documentary evidence in an efficient and expeditious manner, and that proper decorum is maintained. The hearing officer shall be entitled to

ARTICLE VIX

HEARING AND APPELLATE REVIEW PROCEDURE

determine the order of or the procedure for presenting evidence and argument during the hearing and shall have the authority and discretion to make all rulings on questions which pertain to matters of law, procedure or the admissibility of evidence. If the hearing officer determines that either side in a hearing is not proceeding in an efficient and expeditious manner, the hearing officer may take such discretionary action as seems warranted by the circumstances. If requested by the judicial review committee, the hearing officer may participate in the deliberations of such committee and be a legal advisor to it, but the hearing officer shall not be entitled to vote.

F. The hearing need not be conducted strictly according to rules of law relating to the examination of witnesses or presentation of evidence. Any relevant matter upon which responsible persons customarily rely in the conduct of serious affairs shall be considered, regardless of the existence of any common law or statutory rule which might make evidence inadmissible over objection in civil or criminal action. Either party shall, prior to or during the hearing, be entitled to submit memoranda concerning any issue or procedure or fact and such memoranda shall become a part of the hearing record.

G. When a hearing relates to a denial of initial Staff membership, a denial of requested advancement in Staff Category, a denial of requested Department affiliation, or a denial of requested Clinical Privileges, the Practitioner who requested the hearing shall have the burden of proving, by clear and convincing evidence, that the adverse action lacks any substantial factual basis or that such basis or the conclusions drawn there from are arbitrary, unreasonable or capricious. Otherwise, the body or committee whose adverse action occasioned the hearing shall have the initial burden to present evidence in support thereof. Thereafter, the burden shall shift to the Practitioner to support his/her challenge to the adverse action by a preponderance of the evidence that the grounds therefore lack any substantial factual basis or the conclusion drawn there from are either arbitrary, unreasonable or capricious. In all cases, the Hearing Committee shall rule against the Practitioner unless the Hearing Committee determines that the Practitioner has met his/her burden of proof.

The Medical Executive Committee or the Board, whichever body's action occasioned the hearing, shall either select legal counsel or appoint one of its members or another member of the active Medical Staff to represent it at the hearing, to present the evidence and arguments in support of its action, to examine and cross-examine witnesses.

H. Each of the parties shall have the following rights: to call and examine witnesses, to introduce written evidence, to cross-examine any witnesses on any matter relevant to the issue of the hearing, to challenge any witness and to rebut any evidence and to ask the Hearing Committee members questions which are directly related to determining whether they are impermissibly biased and to challenge such members. If the Practitioner does not testify in his/her own behalf, he/she may be called and examined as if under cross-examination.

I. The hearings provided for in these bylaws are for the purpose of resolving, on an intra-professional basis, matters bearing on professional competency and conduct. However, the foregoing shall not be deemed to deprive the Practitioner, the Medical Executive Committee of the Medical Staff, or the Board, of the right to legal counsel throughout the hearing process, including at the hearing itself.

ARTICLE VIX

HEARING AND APPELLATE REVIEW PROCEDURE

J. The Hearing Committee may, without special notice, recess the hearing and reconvene the same for the convenience of the participants or for the purpose of obtaining new or additional evidence or consultation. Upon conclusion of the presentation of oral and written evidence, the hearing may be closed. Each party shall have the right to submit a written statement within 10 days of the close of the hearing, providing arguments and authorities in support of its position. The Hearing Committee may thereupon, within thirty days after receiving post-hearing written submissions of the parties,

render a written decision in the matter, which shall include a written statement of the basis for the decision. The Hearing Committee may forward the written decision, together with the hearing record and all other documentation considered, to the Chief Executive Officer. The Hearing Committee's decision shall contain findings and facts, which shall be in sufficient detail to enable the parties, the Board or any other appellate review body to determine the basis for the Hearing Committee's decision on each matter contained in the notice of charges. The decision shall be supported by reference to the hearing record and all other documentation considered by the Hearing Committee.

K. BASIS OF DECISION: The decision of the Hearing Committee shall be based on the evidence produced at the hearing. This evidence may include, but shall not be limited to, oral testimony of witnesses, briefs or memoranda of points and authorities presented in connection with the hearing, any material contained in the Medical Staff's credential files regarding the person who requested the hearing, any and all applications, references and accompanying documents, all officially noticed matters, and any other relevant evidence considered by the Hearing Committee. The Hearing Committee shall also be entitled to consider all other information that may be considered, pursuant to the Medical Staff Bylaws, in connection with applications for membership to the Medical Staff and for Clinical Privileges.

L. NOTICE OF DECISION: The Chief Executive Officer shall promptly send by hand delivery or by registered or certified mail a copy of the Hearing Committee's recommendation to the Practitioner, the Chief of Staff, the Medical Executive Committee, and to the Board.

M. EFFECT OF DECISION: If the Hearing Committee's decision is adverse to the Practitioner in any of the respects listed in Section 1.A of this Article, the notice required by Section 5.L hereof shall inform the Practitioner of his/her right to request an appellate review by the Board as provided in Section 6 of this Article. If the Hearing Committee's decision is adverse to or modifies the Committee's decision action which occasioned the hearing, the notice required by Section 5.L hereof shall inform the Medical Executive Committee or the Board, as the case may be of the right to request an appellate review by the Board as provided in Section 6 of this Article. In the event that each party fails to request an appellate review within the time and in the manner specified in Section 6.A of this Article, the Hearing Committee's decision shall be deemed final and the matter shall be considered closed.

Section 5 - Appeal to Board

A. Within thirty days following receipt of the Hearing Committee's decision, either party may file a written request for an appellate review by the Board. Such request shall be delivered to the Chief Executive Officer either by hand delivery or by certified or registered mail, and it shall include a brief statement of the reasons for appellate review. The reasons for the appellate review shall be:

1. Substantial failure of any person to comply with the procedures required by these Bylaws or applicable law in the conduct of the hearing and the rendering of the recommendations or decision so as to deny the Practitioner a fair hearing; or
2. The action was taken arbitrarily, unreasonably, or capriciously.

B. A party who fails to request an appellate review within the time and in the manner specified in Section 6.A above waives any right to such review. Such waiver shall have the force and effect as provided in Section 1.E of this Article.

C. Upon receipt of a proper and timely request for appellate review, the Chief Executive Officer shall deliver such request to the Board. As soon as practicable, the Board shall schedule and arrange for an appellate review which shall be conducted not less than thirty days from the day of receipt of the appellate review request; provided, however, that the appellate review for a practitioner who is under a suspension then in effect shall be held as soon as arrangements for it may reasonably be made but not later than twenty days from the date of receipt of the request for appellate review. The Board, through the Chief Executive Officer, shall promptly deliver to the Practitioner notice of the time, place, and date of the appellate review.

D. The appellate review shall be conducted by the Board or by a duly appointed Appellate Review Committee of the Board of not less than five members. Knowledge of the matter involved shall not preclude any person from serving as a member of the Appellate Review Committee, so long as the person did not participate in a prior hearing on the same matter.

E. The Practitioner or the Medical Executive Committee or the Board, as the case may be, may submit a written statement detailing the findings of fact, conclusions, and procedural matters with which he/she disagrees, and the reasons for such disagreement. This written statement may cover any matters raised at any step in the hearing process and legal counsel may assist in its preparation. The statement shall be submitted to the Board through the Chief Executive Officer at least ten (10) days prior to the scheduled date of the appellate review, except if such time limit is expressly waived by the Board. A written statement in reply may be submitted by the Practitioner or the Medical Executive Committee or the Board, as the case may be, and if submitted, the Chief Executive Officer shall provide a copy thereof to the other party at least five (5) days prior to the scheduled date of the appellate review.

1. The Board or its designated Appellate Review Committee shall permit the parties or their representatives to appear personally and to make oral statements in favor of their positions at the designated time, place, and date of appellate review. Any party or representative who appears personally shall be required to answer questions put to him/her by any member of the appellate review body.

ARTICLE VIX

HEARING AND APPELLATE REVIEW PROCEDURE

2. The Board or its designated Appellate Review Committee shall have all the power granted to the Hearing Committee and such additional powers as it deems, in its sole discretion, to be reasonably appropriate to the discharge of its responsibilities.

3. A majority of the Board or its designated Appellate Review Committee must be present throughout the review and deliberations. If a member of the Board or Review Committee is absent from any part of the proceedings, said member shall not be permitted to participate in the deliberations or the decision.

F. The proceedings by the Board or its Appellate Review Committee shall be in the nature of an appellate review based upon the record of the hearing before the Hearing Committee, which committee's decision, and all other documentation considered by the Hearing Committee. The standard of review shall be the same as that provided in Section 5 of this Article. The Board shall also consider the written statements, if any, submitted pursuant to Section 6E of this Article and such other material as may be presented and accepted under this Section.

G. New or additional matters or evidence not raised or presented during the Hearing Committee hearing may be introduced if requested by the Board or its designated Appellate Review Committee in the exercise of its sole discretion or if accepted by the Board or its designated Appellate Review Committee after a foundation showing that such evidence could not have been made available to the Hearing Committee in the exercise of reasonable diligence and subject to the same rights to cross-examination or confrontation provided at the Hearing Committee hearing. The Board or its designated Appellate Review Committee alternatively may remand the matter to the Hearing Committee for the taking of further evidence and for decision.

H. The Board or its designated Appellate Review Committee may refer the matter back to the Hearing Committee for further review and recommendation to be returned to the Board within sixty days and in accordance with its instructions.

I. The appellate review shall not be deemed to be concluded until all of the procedural steps provided in this Section 6 have been completed or waived. Where permitted by the Hospital Bylaws, all action required of the Board may be taken by a committee of the Board duly authorized to act. The chairman of the Board or the chairman of the designated Appellate Review Committee shall permit postponements or extension of the appellate review only on good cause and upon request therefore made as soon as reasonably practicable. Such postponements and extensions shall automatically extend for an equal number of days the time set forth in this Section 6 for the appellate review. In all cases, such time period shall be extended until the transcript of the Hearing Committee hearing is completed.

J. The Chairman of the Board, or its designated Appellate Review Committee shall be the presiding officer, unless a hearing officer is appointed, in which case the hearing officer shall be the presiding officer. The presiding officer shall determine the order of procedure during the appellate review, make all required rulings, and maintain decorum.

K. The use of a hearing officer to preside at any appellate review hearing is optional. The use and appointment of a hearing officer shall be determined by the Board, in its sole discretion, after consultation with the Chief of Staff. If a hearing officer is used for the appellate review, the same standards set above for the hearing officer at the hearing will apply.

L. Notwithstanding any other provision of these Bylaws, no Practitioner shall be entitled to more than one evidentiary hearing and one appellate review with respect to each adverse action.

M. If at any time receipt of notice of an adverse action or decision, a Practitioner fails to make a required request or appearance or otherwise fails to comply with the provisions of this Article or to proceed with the matter, the Practitioner shall be deemed to have consented to such adverse action or decision and to have voluntarily waived all rights to which he/she might have otherwise been entitled to in these Bylaws with respect to the matter involved.

Section 6 - Final Decision by Board

A. If the Appellate Review Committee conducts the appellate review, within fifteen days after the conclusion of its review, it shall forward its proposed decision to the full Board. In rendering its final decision after review of the Appellate Review Committee's proposed decision, the Board shall either adopt the Appellate Review Committee's decision or modify that decision; in no case, however, shall the Board's modification result in the imposition of a greater penalty or restriction upon the effect of Practitioner than that which would have resulted from implementation of the initial adverse action. The Board must render its final decision in writing within thirty days after conclusion of the appellate review. The Board shall, through the Chief Executive Officer, deliver a copy of its final decision, by hand delivery or by certified or registered mail, to the Practitioner, the Chief of Staff, and the Medical Executive Committee. The final decision of the Board shall be effective immediately and shall not be subject to further review.

A. If an adverse ruling or recommendation is made with respect to a Practitioner's staff membership, staff status or Clinical Privileges at any time, regardless of whether he/she is an applicant or a Medical Staff member, he/she must exhaust the remedies afforded by these Bylaws before resorting to formal legal action challenging the decision, the procedures used to arrive at the decision, or any claim against the Hospital or participants in the decision process.

Section 7 - Reporting

The authorized representative shall report an adverse action to the National Practitioner Data Bank and any other state or federal agency as required by laws, but only upon its adoption as final action and only using the description set forth in the final action as adopted by the Board. The authorized representative shall report any and all revisions of an adverse action, including, but not limited to, any expiration of the final action consistent with the terms of that final action.

ARTICLE VIX

HEARING AND APPELLATE REVIEW PROCEDURE

Section 8 – Disputing Reported Language

A member who is the subject of a proposed adverse action report to state or federal agencies may request an informal meeting to dispute the text of the report filed. The report dispute meeting shall not constitute a hearing and shall be limited to the issue of whether the report filed is consistent with the final action issued. The meeting shall be attended by the subject of the report, the chief of staff, the chair of the subject's department, and the hospital's authorized representative, or their respective designees.

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Robert Randall, MD
MEC Surgical
1665 Herlong Court
Suite A
Rock Hill, SC 29732

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X Patricia Y Fedele ☐ Agent ☐ Addressee

B. Received by (Printed Name) PATRICIA Y FEDELE
C. Date of Delivery 11/1/10

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If YES, enter delivery address below: ☐ No

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PIEDMONT MEDICAL CENTER

Confidential: Protected from Disclosure Pursuant to S.C.Code Ann. § 40-71-20 and other applicable privileges

BY HAND AND U.S. Registered Mail, Return Receipt Requested

December 17, 2010

Robert D. Randall, Jr., M.D.
1665 Herlong Court
Suite A
Rock Hill, South Carolina 29732

Re: Notice of Hearing and Grounds

Dear Dr. Randall:

This letter will serve as the Notice of Hearing and Grounds relating to (i) the summary suspension of your abdominal surgery privileges, including herniorrhaphy, imposed October 15, 2010 and continued by the Medical Executive Committee on October 25, 2010; and (ii) the Medical Executive Committee recommendation to revoke your clinical privileges, issued on October 11, 2010 .

Prior to imposition of the summary suspension an ad hoc committee of the Medical Executive Committee had recommended to the Medical Executive Committee that your privileges for the performance of abdominal surgery, including herniorrhaphy, by either open or laparoscopic technique, be revoked. On October 11, 2010 the Medical Executive Committee accepted the adverse recommendation following consideration of internal peer review, review by external experts and the oral and written remarks you provided to the ad hoc committee. The Medical Executive Committee also took into account two more recent cases and an accounting of unplanned returns to the operating room by you as compared to all other general surgeons at the Hospital. The reason for the adverse recommendation was that the surgical judgment and technique you exhibited fell below the standards of the medical staff. This was communicated to you by letter, dated October 12, 2010 from Charles F. Miller.

Shortly thereafter, the Chief of Staff exercised his authority under the bylaws to summarily suspend your privileges because failure to take summary action may have resulted in imminent danger to the health or safety of any individual. The summary suspension was based on a third recent case. This was communicated to you by a separate letter, also dated October 15, 2010. The summary

suspension was continued by action of the Medical Executive Committee on October 25, 2010 after consideration of the totality of the information available, including your presentation to the Medical Executive Committee regarding each of the 10 cases in issue and the analysis of unplanned returns to the operating room. This was communicated to you by letter, dated October 28, 2010.

The summary suspension extends to the performance of abdominal surgery, including herniorrhaphy by either open or laparoscopic technique, including procedures detailed in your delineation of privileges: the alimentary tract, the adrenal glands and the pancreas, abdominal wall surgery to include hernia surgery, anal and rectal surgery, diagnostic laparoscopy, cholecystectomy, appendectomy, splenectomy, operative choledocholscopy, paracentesis, peritoneal lavage and surgery of the uterus, ovaries, kidney, bladder and adrenals. The suspension also extends to your providing general surgery coverage in the Emergency Department of Piedmont Medical Center and to your providing consultation at Piedmont Medical Center regarding any condition that may relate to the delineation of privileges.

The hearing will encompass the issues relating to both the recommendation for revocation of clinical privileges and the summary suspension. By agreement of the parties, the hearing will be conducted on January 5, 2011 and, if not concluded, will continue on January 6, 2011. The hearing will take place in the Womens' Tower Auditorium of the Hospital and begin at 5:30 p.m. each evening.

The hearing will be conducted before a Hearing Committee of the Medical Staff. The members of the Hearing Committee are E. Neal Powell, M.D., Robert Thomas, M.D., John Fassler, M.D. Richard Richter, M.D. and Craig McClelland, M.D. None of these physicians has acted as an accuser, investigator, fact-finder, initial decision-maker or otherwise actively participated in the formal consideration of this matter at any previous level. None is believed to be in direct economic competition with you or to gain direct financial benefit from the outcome. Please inform me in writing immediately if you object to the appointment of any of these individuals and state the basis for your objection. It is anticipated that there will be as many as three additional Hearing Committee members whose names will be made known to you as soon as possible.

Dawes Cooke, Esq. will serve as hearing officer. His contact information is as follows: Barnwell, Whaley, Paterson & Helms, LLC, Charleston, 885 Island Park Drive, South Carolina, 29492. His telephone number is (843) 577-7700. He may be reached by email at mdc@barnwell-whaley.com.

The grounds for the summary suspension and recommendation for revocation are based on a pattern of surgical care that does not meet generally accepted standards of professional competence or the standards of the medical staff as required by Article II, Section 1 of the Bylaws of the Medical Staff of Piedmont Medical Center. In particular:

1. Patient RC (MR 334851): The selection of the initial operative procedure was substandard or not indicated in that you performed procedures that subjected the patient to unnecessary complications. Specifically, it was not necessary to perform a left colectomy as the first operation, requiring you to operate on grossly distended bowel, when a simple diverting colostomy would have sufficed and subjected the patient to fewer complications and less risk.

Moreover, your technique in handling the colon and colostomy was questionable.

2. Patient WC (MR 214222): In the course of performing a laparoscopic cholecystectomy, you exercised substandard judgment in further dissecting previously operated upon bowel in the right lower quadrant, such bowel not apparently contributing to the primary indications for surgery, and in the course of that dissection created an unrecognized and therefore unremedied injury to the intestinal tract that led to patient's very serious decline due to consequent sepsis and then death.

3. Patient CE (MR 342876): You elected to operate on this man in the face of very high risk factors for indications that appear to be marginal. The patient suffered multiple complications of life-threatening dimensions due to repeated technical failures, raising concerns about your technical as well as cognitive processes.

4. Patient JP (MR 156580): In the course of a laparoscopic cholecystectomy, you encountered an inflammatory mass that by your description made identification of the anatomic structures impossible, yet you persisted in laparoscopic dissection, converting to open only after observing the spillage of either bile or feculent matter. You resolved the uncertainty by resecting both gallbladder and colon, characterizing the latter as necrotic, though pathologic examination does not support that conclusion.

5. Patient DS (MR 225223): You failed to appreciate and/or properly respond to the surgical urgency of the diagnosis of paraesophageal hernia; once in the operating room you neglected a fundamental part of the curative procedure, i.e. placement of a percutaneous tube gastrostomy which is important to the anchoring of the stomach and prevention of recurrent migration and torsion. Having initially neglected this, you returned the patient to the operating room to perform a tube gastrostomy, at a point at which a less invasive technique might have sufficed and for a reason (enteric nutrition) for which a tube gastrostomy is not likely to perform well in such a patient. Once the gastrostomy's failure in that regard was recognized, you yet again returned the patient to the operating room for a tube jejunostomy, from which there were several complications and repeat operations, the first of which was the unrecognized dislodgement of the tube with spillage into the peritoneal cavity.

6. Patient SW (MR 137911): You documented the significant co-morbidities in this case and proceeded with a non-emergency procedure despite them. The patient experienced multiple, life-threatening complications, due in part at least to substandard judgment and technique in the handling of the bowel, including at least one unintended injury, the repair of which failed.

7. Patient CW (MR 178902): This young man upon whom you performed an apparently uncomplicated appendectomy returned shortly after discharge with signs of sepsis. Upon re-exploration the patient was found to have a focal defect in the cecum at his appendectomy site and feculent soilage of the peritoneal cavity. The patient died.

8. Patient FM (MR 125214): You performed multiple procedures on this patient on two occasions, manifesting apparent confusion about the nature of the anatomic defects with which you were presented. In the course of performing the first surgery you apparently created a bladder injury that was not properly dealt with until the second operation.

9. Patient SJ (MR 137929). You operated upon this patient for gastric bleeding and performed a "sleeve gastrectomy", a procedure rarely or never employed for this indication. As a result of the performance of this procedure, the patient's stomach would not empty properly, and you returned the patient to the operating room and performed an extensive second operation, one more ordinarily utilized for the treatment of duodenal ulcer rather than for non-ulcer gastric outlet obstruction. This operation also failed to relieve the patient's gastric emptying dysfunction, and a tube jejunostomy was placed; the patient will be re-operated upon at an interval by another surgeon.

10. Patient JR (MR 135540). You persisted in a prolonged laparoscopic cholecystectomy for a gangrenous gallbladder. The patient required eleven (11) units of transfused blood in the first 48 postoperative hours, and manifested the consequences of hemorrhagic blood loss in her requirements for critical care and ventilatory support. A CT of the abdomen demonstrated a large hematoma beneath the liver at the site of surgery; such bleeding is extraordinary and indicative of a surgical misadventure, and the decision to observe rather than attempt control of the hemorrhage is an example of questionable judgment.

The Medical Executive Committee's recommendation for revocation of your clinical privileges was based on cases 1 through 9 above together with an analysis of unplanned returns to the operating room as compared to your peers. The summary suspension was imposed by the Chief of Staff when case # 10 was brought to his attention and then sustained by the Medical Executive Committee.

Under the Bylaws of the Medical Staff, it is the duty of the Executive Committee and the affected practitioner to exercise reasonable diligence in notifying the hearing officer of any pending or anticipated procedural irregularity or any objection to the hearing panel or to the hearing officer as far in advance of the scheduled hearing as possible in order that decisions concerning such matters may expeditiously be made. If you object to the appointment of any Hearing Committee member or the hearing officer please advise the hearing officer immediately and state the reason for your objection.

Your failure to appear at the hearing shall be deemed to constitute your voluntary acceptance of the adverse recommendation of the Medical Executive Committee and waiver of all hearing and appeal rights unless the Hearing Committee finds good cause for such failure, based upon written request by you or your representative.

At the hearing you will have the right to representation by counsel; to have a record made of the proceedings by a certified court reporter (copies of which shall be available for purchase by either party); to have a reasonable opportunity to question the Hearing Committee members and the hearing officer and to challenge their impartiality; to be provided with all the information made available to the Hearing Committee; to call, examine and cross-examine witnesses; to introduce relevant documents and evidence; to present written evidence that tends to impeach any witness on relevant matters; and to submit a written statement at the close of the presentation.

Under the bylaws of the Medical Staff the initial burden is on the Medical Executive Committee to present evidence in support of its adverse recommendation and action. Thereafter, the burden shifts to you to support your challenge to the adverse recommendation and action by a preponderance of the evidence that the grounds for the adverse action lack any substantial factual basis or that the conclusions drawn there from are either arbitrary, unreasonable or capricious.

At this time, the Medical Executive Committee expects to call as witnesses Nathaniel Edwards, M.D., and Gary Barone, M.D. A witness list and the addresses of the witnesses are attached hereto. The Medical Executive Committee will make available to you a disc containing the medical records referenced above. Please make arrangements with Ms. West if you wish to inspect the original records.

You will have a right to receive a copy of the written report and decision of the Hearing Committee including a statement of the basis for the decision, and the Hearing Committee's recommendation to the Governing Board. The Hearing Committee may recommend that the Board affirm, terminate or modify the recommendation that prompted the hearing. The Board will make the final determination after appellate rights as described in the Medical Staff Bylaws are waived or exhausted. You will receive the final written decision of the Board, including a statement of the basis for the decision.

This is a summary of your rights in the hearing process. Please refer to the Medical Staff Bylaws enclosed with this letter for a complete description of the hearing process.

Very truly yours,

Nathaniel Edwards, M.D.
Chief of Staff, Medical Executive Committee

Enclosures:

Medical Staff Bylaws
Witness List

Nathaniel Edwards, M.D.
197 Piedmont Boulevard, Suite 111
Rock Hill, South Carolina 29732

Gary Barone, M.D.
4301 W Markham St Ste 783
Little Rock, AR 72205

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Under the Bylaws of the Medical Staff, it is the duty of the Executive Committee and the affected practitioner to exercise reasonable diligence in notifying the hearing officer of any pending or anticipated procedural irregularity or any objection to the hearing panel or to the hearing officer as far in advance of the scheduled hearing as possible in order that decisions concerning such matters may expeditiously be made. If you object to the appointment of any Hearing Committee member or the hearing officer please advise the hearing officer immediately and state the reason for your objection.

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At the hearing you will have the right to representation by counsel; to have a record made of the proceedings by a certified court reporter (copies of which shall be available for purchase by either party); to have a reasonable opportunity to question the Hearing Committee members and the hearing officer and to challenge their impartiality; to be provided with all the information made available to the Hearing Committee; to call, examine and cross-examine witnesses; to introduce relevant documents and evidence; to present written evidence that tends to impeach any witness on relevant matters; and to submit a written statement at the close of the presentation.

Under the bylaws of the Medical Staff the initial burden is on the Medical Executive Committee to present evidence in support of its adverse recommendation and action. Thereafter, the burden shifts to you to support your challenge to the adverse recommendation and action by a preponderance of the evidence that the grounds for the adverse action lack any substantial factual basis or that the conclusions drawn there from are either arbitrary, unreasonable or capricious.

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This is a summary of your rights in the hearing process. Please refer to the Medical Staff Bylaws enclosed with this letter for a complete description of the hearing process.

Very truly yours,

Nathaniel Edwards, M.D.
Chief of Staff, Medical Executive Committee

Enclosures:

Medical Staff Bylaws
Witness List

Nathaniel Edwards, M.D.
197 Piedmont Boulevard, Suite 111
Rock Hill, South Carolina 29732

Gary Barone, M.D.
4301 W Markham St Ste 783
Little Rock, AR 72205

5/10/10 -

Piedmont Medical Center
Medical Staff Bylaws

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ARTICLE VIII

CORRECTIVE ACTION

Section 2 - Summary Suspension

A. Grounds; Authority. All or any portion of a practitioner's clinical privileges may be summarily suspended or restricted where the failure to take summary action may result in imminent danger to the health or safety of any individual. The following persons are authorized by the medical staff to take summary action: the Chief of Staff, the chairman of affected practitioner's clinical department, or any of its elected officers of the medical staff. Suspension or restriction pursuant to this paragraph shall be temporary and effective only until further action is taken by the Medical Executive Committee pursuant to Section 3 D of this Article. When no person referenced above is available to impose a summary suspension or restrict clinical privileges, the board, or its designee, may take such action if a failure to do so would be likely to result in an imminent danger to the health or safety of any individual. Prior to exercising this authority, the board, or its designee, must make reasonable attempts to contact the Chief of Staff, as the designee of the medical staff, another medical staff officer or the chairman or designee of the affected practitioner's clinical department or other elected officer of the medical staff. Summary action by the board which has not been ratified by the Chief of Staff, as the designee of the medical staff, or another elected officer of the medical staff within two (2) working days, excluding weekends and holidays, shall terminate automatically without prejudice to further summary or other corrective action as warranted by the circumstances.

B. Effective Date; Notice. A summary suspension or restriction shall become effective immediately upon imposition and the person or body imposing same shall promptly give written or oral notice of the suspension or restriction to the suspended practitioner, stating by whom it was imposed and the reasons for same. The notice shall be deemed to have been given on the date on which it is either personally delivered or mailed to the suspended practitioner, whichever occurs first. The notice, or a written confirmation of it, shall inform the suspended practitioner: (1) of his or her right to an informal interview upon his or her written request under Section 3 C of this Article; (2) whether the action is reportable pursuant to any State or Federal Statute; (3) if the suspension could be reportable to the National Practitioner Data Bank; and (4) that even if the suspension or restriction is terminated when the Medical Executive Committee takes further action under 3 D of this Article, the practitioner will be entitled to a hearing at which the sole issue will be whether there was probable cause for the summary suspension or restriction. A copy of the notice shall promptly be delivered to the Chief Executive Officer, the Medical Executive Committee, and the board.

C. Investigation. The Medical Executive Committee, before taking further action, shall conduct such investigation as it deems necessary, which shall include at least one (1) meeting of the Medical Executive Committee; and may include an informal interview with the suspending party. An informal interview with the affected practitioner may be held if the affected practitioner delivers a request for an informal interview in writing within seven (7) days after notice of the suspension was given to him. The Medical Executive Committee's investigation may include chart reviews, if applicable, and informal interviews with or reports from other persons or relevant departments or committees. Neither the investigation nor any other activities of the Medical Executive Committee in taking its further action shall constitute a hearing; they shall be informal, and none of the hearing and

appeal rights under these bylaws shall apply. In the event the affected practitioner resigns his of her medical staff membership or privileges during the course of an investigation pursuant to this section, such resignation shall be reported to the required agencies in accordance with State and Federal law.

ARTICLE VIII

CORRECTIVE ACTION

Section 2 - Summary Suspension

D. Further Action; Time. Within fourteen (14) days after the date of the suspension, the Medical Executive Committee shall take further action with respect to the suspension, and may modify, continue for a definite or indefinite period, or terminate the summary suspension or restriction. Such further action shall remain in effect unless and until altered or terminated pursuant to other provisions of these bylaws. If the Medical Executive Committee upholds a summary suspension, it shall also decide whether to recommend that the affected practitioner's medical staff membership and clinical privileges should be terminated. The Medical Executive Committee shall promptly give written notice of its further action to the suspended practitioner, the Chief Executive Officer and the person or body who imposed the suspension or restriction (if other than the Medical Executive Committee).

E. Rights to Hearing. Following the decision of the Medical Executive Committee regarding further action, the provisions of these Bylaws shall govern the hearing and appeal rights.

F. If the Medical Executive Committee's action pursuant to Section 2.B of this Article is to terminate the suspension and/or to cease all further corrective action, notice of such action shall be transmitted immediately, together with all supporting documentation, to the Board. Thereafter, the procedure to be followed shall be as provided in these Bylaws as applicable.

ARTICLE VIX

HEARING AND APPELLATE REVIEW PROCEDURE

Section 1 - Grounds for Hearing

A. Any of the following actions shall, if based on professional conduct or competence and deemed adverse pursuant to Section 1-B of this Article, entitle the Practitioner affected thereby to a hearing:

1. Denial of initial Staff membership.
2. Denial of Staff membership renewal.
3. Suspension of Staff membership.
4. Revocation of Staff membership.
5. Denial of requested advancement in Staff category.
6. Reduction in Staff category, except in accordance with the request of the Staff member.
7. Limitation or suspension of Privileges.
8. Denial of requested Department affiliation.
9. Denial of requested Clinical Privileges.
10. Reduction in Clinical Privileges.
11. Suspension of Clinical Privileges.
12. Revocation of Clinical Privileges.
13. Terms of probation.
14. Individual requirement of consultation.

B. When Deemed Adverse: An action enumerated in Section 1A of this Article shall be deemed adverse only when it has been:

1. Taken or recommended by the Medical Executive Committee; or
2. Taken by the Board contrary to a favorable recommendation by the Medical Executive Committee.

Unless otherwise provided in the Medical Staff Bylaws all adverse actions shall become final and effective in accordance with the provisions of this Article.

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HEARING AND APPELLATE REVIEW PROCEDURE

C. Notice of Adverse Action: A Practitioner against whom an adverse action has been taken or recommended which constitutes grounds for a hearing pursuant to Sections 1.A & 1.B of this Article shall promptly be given notice of such action by the Chief Executive Officer. Such notice shall be in writing and hand delivered or sent by certified or registered mail, return receipt requested, and shall

advise the Practitioner of his/her right to a hearing and shall include statements: (a) That an adverse action has been taken or recommended to be taken against the Practitioner; (b) Of the reasons for the action; (c) That the Practitioner has the right to request a hearing to challenge the adverse action or recommendation; (d) Of the time limit within which to request a hearing; (e) A general summary of the Practitioner's rights in the hearing; and (f) a copy of the Article on Hearing and Appeals Rights of these Bylaws.

D. Request for Hearing: A Practitioner shall have thirty days following the receipt of notice pursuant to Section 1.C of this article to file a written request for a hearing. Such request shall be delivered to the Chief Executive Officer either by hand delivery or by certified or registered mail, return receipt requested.

E. Waiver By Failure To Request A Hearing: A Practitioner who fails to request a hearing within the time and in the manner specified in Section 1.D hereof shall be deemed to have accepted the action and shall be deemed to have waived any right to such hearing and to any appellate review to which he/she might otherwise have been entitled.

Section 2 - Notice of Hearing

A. Upon receipt of a proper and timely request for a hearing, the Chief Executive Officer shall deliver such request to the Chief of Staff and shall notify the Medical Executive Committee of such request. Within fifteen (15) days after receipt of such request, the Chief of Staff shall schedule and arrange for a hearing by a Hearing Committee. The Chief Executive Officer shall send the Practitioner notice of the time, place and date of the hearing. The hearing date shall be not less than thirty (30) days nor more than ninety (90) days from the date of receipt of the request for hearing.

B. Notice of Grounds and Witness List: As a part of, or together with the notice of hearing required by Section 3.A above, the Chief of Staff, on behalf of the Medical Executive Committee, shall provide the affected Practitioner with written notice of the act(s) or omission(s) with which the Practitioner is charged, including a list of the specific or representative patient records being questioned, the grounds upon which the adverse action was taken or recommended, and/or the other reasons forming the basis for the adverse action which is the subject of the hearing. The affected Practitioner shall be provided a list of witnesses expected to testify at least fifteen (15) days before such hearing, including addresses of the individuals. The witness list shall be amended when additional witnesses are identified. The affected Practitioner shall provide and amend a list of witnesses expected to testify on the Practitioner's behalf on the same schedule.

Section 3 - Composition of Hearing Committee

A. When a hearing is properly requested, the Chief of Staff shall appoint a Hearing Committee composed of at least five members of the active Medical Staff and alternatives as appropriate. The members and alternatives to serve on the Hearing Committee shall not have actively participated in the formal consideration of the matter at any previously level and shall not be in direct economic competition with the Practitioner. Knowledge of the matter involved shall not preclude a member of the active Medical Staff from serving as a member of the Hearing Committee. In the event that it is not possible to appoint a fully qualified Hearing Committee from the active Medical Staff, the Chief of Staff may appoint qualified members of the Courtesy Staff or qualified Practitioners from outside the Staff. One of the members so appointed shall be designated as Chairman.

B. A majority of the members of the Hearing Committee may act for the Hearing Committee. No committee member may vote by proxy.

Section 4 - Conduct of Hearing

A. A court reporter shall record the proceedings to permit an informed and valid judgment to be made by any group that later may be requested to review the record and render a recommendation or decision in the matter. The Hospital shall bear the costs of the reporter's appearance and the parties shall share the cost of the transcript.

B. The personal presence of the Practitioner for whom the hearing has been scheduled shall be required. A Practitioner who fails without good cause to appear and proceed at such hearing shall be deemed to have waived his/her rights in the same manner as provided in Section 1.E of this Article and to have accepted the adverse recommendation or decision involved, and the same shall thereupon become and remain in effect as provided in said Section 1.E.

C. Postponement of hearing beyond the time set forth in these bylaws shall be made only with the approval of the Hearing Committee. Granting of such postponements shall only be for good cause shown and in the sole discretion of the Hearing Committee.

D. The affected Practitioner shall be entitled to be accompanied by and/or represented at the hearing by a member of the Medical Staff in good standing, by a member of his/her local professional society, by legal counsel, or other person of the practitioner's choice.

E. The CEO, in concurrence with the Chief of Staff of the Medical Staff, shall appoint a hearing officer on behalf of the Board. The hearing officer shall be an attorney at law qualified to preside over an administrative hearing such as this, but attorneys from a firm regularly utilized by the hospital, the medical staff or the involved medical staff member or applicant for membership for legal advice regarding their affairs and activities shall not be eligible to serve as hearing officer. The hearing officer shall gain no direct financial benefit from the outcome and must not act as a prosecuting officer or as an advocate. The hearing officer shall endeavor to assure that all participants in the hearing have a reasonable opportunity to be heard and to present relevant oral and documentary evidence in an efficient and expeditious manner, and that proper decorum is maintained. The hearing officer shall be entitled to

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HEARING AND APPELLATE REVIEW PROCEDURE

determine the order of or the procedure for presenting evidence and argument during the hearing and shall have the authority and discretion to make all rulings on questions which pertain to matters of law, procedure or the admissibility of evidence. If the hearing officer determines that either side in a

hearing is not proceeding in an efficient and expeditious manner, the hearing officer may take such discretionary action as seems warranted by the circumstances. If requested by the judicial review committee, the hearing officer may participate in the deliberations of such committee and be a legal advisor to it, but the hearing officer shall not be entitled to vote.

F. The hearing need not be conducted strictly according to rules of law relating to the examination of witnesses or presentation of evidence. Any relevant matter upon which responsible persons customarily rely in the conduct of serious affairs shall be considered, regardless of the existence of any common law or statutory rule which might make evidence inadmissible over objection in civil or criminal action. Either party shall, prior to or during the hearing, be entitled to submit memoranda concerning any issue or procedure or fact and such memoranda shall become a part of the hearing record.

G. When a hearing relates to a denial of initial Staff membership, a denial of requested advancement in Staff Category, a denial of requested Department affiliation, or a denial of requested Clinical Privileges, the Practitioner who requested the hearing shall have the burden of proving, by clear and convincing evidence, that the adverse action lacks any substantial factual basis or that such basis or the conclusions drawn there from are arbitrary, unreasonable or capricious. Otherwise, the body or committee whose adverse action occasioned the hearing shall have the initial burden to present evidence in support thereof. Thereafter, the burden shall shift to the Practitioner to support his/her challenge to the adverse action by a preponderance of the evidence that the grounds therefore lack any substantial factual basis or the conclusion drawn there from are either arbitrary, unreasonable or capricious. In all cases, the Hearing Committee shall rule against the Practitioner unless the Hearing Committee determines that the Practitioner has met his/her burden of proof.

The Medical Executive Committee or the Board, whichever body's action occasioned the hearing, shall either select legal counsel or appoint one of its members or another member of the active Medical Staff to represent it at the hearing, to present the evidence and arguments in support of its action, to examine and cross-examine witnesses.

H. Each of the parties shall have the following rights: to call and examine witnesses, to introduce written evidence, to cross-examine any witnesses on any matter relevant to the issue of the hearing, to challenge any witness and to rebut any evidence and to ask the Hearing Committee members questions which are directly related to determining whether they are impermissibly biased and to challenge such members. If the Practitioner does not testify in his/her own behalf, he/she may be called and examined as if under cross-examination.

I. The hearings provided for in these bylaws are for the purpose of resolving, on an intra-professional basis, matters bearing on professional competency and conduct. However, the foregoing shall not be deemed to deprive the Practitioner, the Medical Executive Committee of the Medical Staff, or the Board, of the right to legal counsel throughout the hearing process, including at the hearing itself.

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J. The Hearing Committee may, without special notice, recess the hearing and reconvene the same for the convenience of the participants or for the purpose of obtaining new or additional evidence or consultation. Upon conclusion of the presentation of oral and written evidence, the hearing may be closed. Each party shall have the right to submit a written statement within 10 days of the close of the hearing, providing arguments and authorities in support of its position. The Hearing Committee may thereupon, within thirty days after receiving post-hearing written submissions of the parties, render a written decision in the matter, which shall include a written statement of the basis for the decision. The Hearing Committee may forward the written decision, together with the hearing record and all other documentation considered, to the Chief Executive Officer. The Hearing

Committee's decision shall contain findings and facts, which shall be in sufficient detail to enable the parties, the Board or any other appellate review body to determine the basis for the Hearing Committee's decision on each matter contained in the notice of charges. The decision shall be supported by reference to the hearing record and all other documentation considered by the Hearing Committee.

K. BASIS OF DECISION: The decision of the Hearing Committee shall be based on the evidence produced at the hearing. This evidence may include, but shall not be limited to, oral testimony of witnesses, briefs or memoranda of points and authorities presented in connection with the hearing, any material contained in the Medical Staff's credential files regarding the person who requested the hearing, any and all applications, references and accompanying documents, all officially noticed matters, and any other relevant evidence considered by the Hearing Committee. The Hearing Committee shall also be entitled to consider all other information that may be considered, pursuant to the Medical Staff Bylaws, in connection with applications for membership to the Medical Staff and for Clinical Privileges.

L. NOTICE OF DECISION: The Chief Executive Officer shall promptly send by hand delivery or by registered or certified mail a copy of the Hearing Committee's recommendation to the Practitioner, the Chief of Staff, the Medical Executive Committee, and to the Board.

M. EFFECT OF DECISION: If the Hearing Committee's decision is adverse to the Practitioner in any of the respects listed in Section 1.A of this Article, the notice required by Section 5.L hereof shall inform the Practitioner of his/her right to request an appellate review by the Board as provided in Section 6 of this Article. If the Hearing Committee's decision is adverse to or modifies the Committee's decision action which occasioned the hearing, the notice required by Section 5.L hereof shall inform the Medical Executive Committee or the Board, as the case may be of the right to request an appellate review by the Board as provided in Section 6 of this Article. In the event that each party fails to request an appellate review within the time and in the manner specified in Section 6.A of this Article, the Hearing Committee's decision shall be deemed final and the matter shall be considered closed.

Section 5 - Appeal to Board

A. Within thirty days following receipt of the Hearing Committee's decision, either party may file a written request for an appellate review by the Board. Such request shall be delivered to the Chief Executive Officer either by hand delivery or by certified or registered mail, and it shall include a brief statement of the reasons for appellate review. The reasons for the appellate review shall be:

1. Substantial failure of any person to comply with the procedures required by these Bylaws or applicable law in the conduct of the hearing and the rendering of the recommendations or decision so as to deny the Practitioner a fair hearing; or
2. The action was taken arbitrarily, unreasonably, or capriciously.

B. A party who fails to request an appellate review within the time and in the manner specified in Section 6.A above waives any right to such review. Such waiver shall have the force and effect as provided in Section I.E of this Article.

C. Upon receipt of a proper and timely request for appellate review, the Chief Executive Officer shall deliver such request to the Board. As soon as practicable, the Board shall schedule and arrange for an appellate review which shall be conducted not less than thirty days from the day of receipt of the appellate review request; provided, however, that the appellate review for a practitioner who is under a suspension then in effect shall be held as soon as arrangements for it may reasonably be made but not later than twenty days from the date of receipt of the request for appellate review. The Board, through the Chief Executive Officer, shall promptly deliver to the Practitioner notice of the time, place, and date of the appellate review.

D. The appellate review shall be conducted by the Board or by a duly appointed Appellate Review Committee of the Board of not less than five members. Knowledge of the matter involved shall not preclude any person from serving as a member of the Appellate Review Committee, so long as the person did not participate in a prior hearing on the same matter.

E. The Practitioner or the Medical Executive Committee or the Board, as the case may be, may submit a written statement detailing the findings of fact, conclusions, and procedural matters with which he/she disagrees, and the reasons for such disagreement. This written statement may cover any matters raised at any step in the hearing process and legal counsel may assist in its preparation. The statement shall be submitted to the Board through the Chief Executive Officer at least ten (10) days prior to the scheduled date of the appellate review, except if such time limit is expressly waived by the Board. A written statement in reply may be submitted by the Practitioner or the Medical Executive Committee or the Board, as the case may be, and if submitted, the Chief Executive Officer shall provide a copy thereof to the other party at least five (5) days prior to the scheduled date of the appellate review.

1. The Board or its designated Appellate Review Committee shall permit the parties or their representatives to appear personally and to make oral statements in favor of their positions at the designated time, place, and date of appellate review. Any party or representative who appears personally shall be required to answer questions put to him/her by any member of the appellate review body.

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2. The Board or its designated Appellate Review Committee shall have all the power granted to the Hearing Committee and such additional powers as it deems, in its sole discretion, to be reasonably appropriate to the discharge of its responsibilities.

3. A majority of the Board or its designated Appellate Review Committee must be present throughout the review and deliberations. If a member of the Board or Review Committee is absent from any part of the proceedings, said member shall not be permitted to participate in the deliberations or the decision.

F. The proceedings by the Board or its Appellate Review Committee shall be in the nature of an appellate review based upon the record of the hearing before the Hearing Committee, which committee's decision, and all other documentation considered by the Hearing Committee. The standard of review shall be the same as that provided in Section 5 of this Article. The Board shall also consider the written statements, if any, submitted pursuant to Section 6E of this Article and such other material as may be presented and accepted under this Section.

G. New or additional matters or evidence not raised or presented during the Hearing Committee hearing may be introduced if requested by the Board or its designated Appellate Review Committee in the exercise of its sole discretion or if accepted by the Board or its designated Appellate Review Committee after a foundation showing that such evidence could not have been made available to the Hearing Committee in the exercise of reasonable diligence and subject to the same rights to cross-examination or confrontation provided at the Hearing Committee hearing. The Board or its designated Appellate Review Committee alternatively may remand the matter to the Hearing Committee for the taking of further evidence and for decision.

H. The Board or its designated Appellate Review Committee may refer the matter back to the Hearing Committee for further review and recommendation to be returned to the Board within sixty days and in accordance with its instructions.

I. The appellate review shall not be deemed to be concluded until all of the procedural steps provided in this Section 6 have been completed or waived. Where permitted by the Hospital Bylaws, all action required of the Board may be taken by a committee of the Board duly authorized to act. The chairman of the Board or the chairman of the designated Appellate Review Committee shall permit postponements or extension of the appellate review only on good cause and upon request therefore made as soon as reasonably practicable. Such postponements and extensions shall automatically extend for an equal number of days the time set forth in this Section 6 for the appellate review. In all cases, such time period shall be extended until the transcript of the Hearing Committee hearing is completed.

J. The Chairman of the Board, or its designated Appellate Review Committee shall be the presiding officer, unless a hearing officer is appointed, in which case the hearing officer shall be the presiding officer. The presiding officer shall determine the order of procedure during the appellate review, make all required rulings, and maintain decorum.

K. The use of a hearing officer to preside at any appellate review hearing is optional. The use and appointment of a hearing officer shall be determined by the Board, in its sole discretion, after consultation with the Chief of Staff. If a hearing officer is used for the appellate review, the same standards set above for the hearing officer at the hearing will apply.

L. Notwithstanding any other provision of these Bylaws, no Practitioner shall be entitled to more than one evidentiary hearing and one appellate review with respect to each adverse action.

M. If at any time receipt of notice of an adverse action or decision, a Practitioner fails to make a required request or appearance or otherwise fails to comply with the provisions of this Article or to proceed with the matter, the Practitioner shall be deemed to have consented to such adverse action or decision and to have voluntarily waived all rights to which he/she might have otherwise been entitled to in these Bylaws with respect to the matter involved.

Section 6 - Final Decision by Board

A. If the Appellate Review Committee conducts the appellate review, within fifteen days after the conclusion of its review, it shall forward its proposed decision to the full Board. In rendering its final decision after review of the Appellate Review Committee's proposed decision, the Board shall either adopt the Appellate Review Committee's decision or modify that decision; in no case, however, shall the Board's modification result in the imposition of a greater penalty or restriction upon the effect of Practitioner than that which would have resulted from implementation of the initial adverse action. The Board must render its final decision in writing within thirty days after conclusion of the appellate review. The Board shall, through the Chief Executive Officer, deliver a copy of its final decision, by hand delivery or by certified or registered mail, to the Practitioner, the Chief of Staff, and the Medical Executive Committee. The final decision of the Board shall be effective immediately and shall not be subject to further review.

A. If an adverse ruling or recommendation is made with respect to a Practitioner's staff membership, staff status or Clinical Privileges at any time, regardless of whether he/she is an applicant or a Medical Staff member, he/she must exhaust the remedies afforded by these Bylaws before resorting to formal legal action challenging the decision, the procedures used to arrive at the decision, or any claim against the Hospital or participants in the decision process.

Section 7 - Reporting

The authorized representative shall report an adverse action to the National Practitioner Data Bank and any other state or federal agency as required by laws, but only upon its adoption as final action and only using the description set forth in the final action as adopted by the Board. The authorized representative shall report any and all revisions of an adverse action, including, but not limited to, any expiration of the final action consistent with the terms of that final action.

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HEARING AND APPELLATE REVIEW PROCEDURE

Section 8 – Disputing Reported Language

A member who is the subject of a proposed adverse action report to state or federal agencies may request an informal meeting to dispute the text of the report filed. The report dispute meeting shall not constitute a hearing and shall be limited to the issue of whether the report filed is consistent with the final action issued. The meeting shall be attended by the subject of the report, the chief of staff, the chair of the subject's department, and the hospital's authorized representative, or their respective designees.

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January 5, 2011

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Ladies and Gentlemen:

The MEC Request for Postponement and Second Request for Postponement are granted for good cause shown. The parties are instructed to inform the hearing panel of a mutually agreeable date in February 2011.

For the Hearing Panel

By: _____
BY TELEPHONE POLL

PMC.00005230