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THE STATE OF SOUTH CAROLINA
In The Court of Appeals

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APPEAL FROM YORK COUNTY
Court of Common Pleas

SC Court of Appeals

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 TWO

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BEFORE THE PIEDMONT MEDICAL CENTER APPELLATE REVIEW COMMITTEE

In the Matter of

Robert D. Randall, Jr., M.D.

This matter came before this Appellate Review Committee pursuant to Article VIX (sic) of the Piedmont Medical Center Medical Staff Bylaws governing Appeals to the Board. Dr. Randall timely filed a Notice and Request for Appellate Review by the Board of an adverse Hearing Committee recommendation to uphold the Medical Executive Committee's recommendation for the revocation and summary suspension of Dr. Randall's clinical privileges to perform abdominal surgery, including herniorrhaphy privileges, whether by open or laparoscopic technique.

The Board appointed an Appellate Review Committee consisting of the following six Board members to hear the appeal and submit a proposed decision and recommendation to the full Board: Joe Robinson, M.D.; Karen Walto; Bill Alexander; Harold P. Tuttle; Clintley Boulter; and, John Hottelink, M.D. The Board also appointed Donna S. Tribble, Esquire, to serve as the hearing officer. The hearing for this appeal was scheduled for June 15, 2011. Prior to the scheduled hearing, written statements were timely submitted by representatives of both Dr. Randall and the Medical Executive Committee, and reviewed by each member of the Appellate Review Committee prior to the hearing. In addition, each member of the Appellate Review Committee was provided with a complete copy of the record of the hearing before the Hearing Committee, and each member independently reviewed that record prior to the scheduled hearing.

The hearing before the Appellate Review Committee took place on June 15, 2011 at which time representatives of Dr. Randall and the Medical Executive Committee presented oral arguments to the Appellate Review Committee. Dr. Randall was also present, and after the presentation of oral arguments, members of the Committee questioned Dr. Randall and the representatives of the parties about issues raised in the appeal and pertaining to the record of the hearing before the Hearing Committee. No new or additional matters or evidence not raised

or presented during the Hearing Committee hearing was presented or considered with the exception of a letter sent by counsel for the Medical Executive Committee in January of 2011 to counsel for Dr. Randall in which it was stated that there was no general surgeon on the active medical staff available to serve on the Hearing Committee. This letter was marked as Appellate Review Committee Exhibit 1.

The Appellate Review Committee then deliberated about the issues raised in the subject appeal for many hours before issuing the decision and recommendation set forth herein. The Committee notes and agrees with the finding of the Hearing Committee 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 for many years. The Committee also fully recognizes the gravity of the consequences to Dr. Randall of the recommendation for revocation and the summary suspension of his surgical privileges at Piedmont Medical Center, and the fact that Dr. Randall has vigorously and earnestly defended his conduct as a physician. Equally, the members of the Appellate Review Committee note and find that the members of the Medical Executive Committee and the Hearing Committee have diligently carried out their duties under the Bylaws to assure patients of Piedmont Medical Center are provided quality care by physicians granted clinical privileges through the Medical Staff. The Appellate Review Committee also notes and finds that in the appellate proceeding before them, and indeed in the proceedings before the Medical Executive Committee and the Hearing Committee, the parties are bound by the terms and provisions of the Medical Staff Bylaws.

Dr. Randall asserted two grounds on appeal as the basis for reversing the Decision of the Hearing Committee. He alleges he did not receive a fair hearing, and that both the summary suspension of his abdominal surgical privileges and the recommendation for revocation of abdominal surgical privileges, including herniorrhaphy, by either open or laparoscopic technique, was arbitrary, unreasonable, or capricious. The burden of proof under the Medical Staff Bylaws is upon Dr. Randall to prove his stated grounds for appeal by a preponderance of the evidence.

As to his allegation that he did not receive a fair hearing, he must prove by a preponderance of the evidence that the alleged errors he raised constituted a substantial failure to comply with the procedures required by the Bylaws or applicable law in the conduct of the hearing before the Hearing Committee and the rendering of the recommendations or decision.

by the Hearing Committee so as to deny him a fair hearing. Medical Staff Bylaws, Art XIX, Section 5.A

As to his allegation that the actions resulting in the summary suspension and the recommended revocation of his privileges to perform abdominal surgery were erroneous, he must prove by a preponderance of the evidence that said determinations lacked any substantial factual basis or the conclusions drawn therefrom were arbitrary, unreasonable, or capricious." Medical Staff Bylaws, Art XIX, Section 5.A; Section 5.F; and Section 4.G.

FAIR HEARING

With regards to Dr. Randall's assertion that he did not receive a fair hearing, he alleges there were substantial procedural errors in the conduct of the hearing before the Hearing Committee such that he was denied a fair hearing. The alleged procedural errors included the assertion that there was no general surgeon on the Hearing Committee; that he was prejudiced by the postponement of the hearing before the Hearing Committee until February 16 and 17, 2011, because the postponement allowed the Medical Executive Committee to replace its initial expert with Dr. Skudder; that he did not receive an "early hearing" as he requested, allegedly resulting in the mandatory reporting of the his summary suspension to the National Practitioner Data Bank; and, that a single reviewer did not review each of the 10 cases in question.

Having considered the arguments presented on these issues and having reviewed the record of the hearing before the Hearing Committee, a majority of the members of the Appellate Review Committee determined that Dr. Randall did not meet his burden of proof with regards to his assertion that did not receive a fair hearing under the terms and provisions of the Medical Staff Bylaws for the following reasons.

There is no requirement under the Bylaws that a member of the Hearing Committee be active in the same practice area as the affected practitioner, or that the Hearing Committee include particular medical or surgical specialties. The Medical Staff Bylaws indicate the Hearing Committee must be composed of at least five members of the active medical staff, none of whom shall have actively participated in the formal consideration of the matter at any previous level and none of whom is in direct competition with the affected practitioner. Medical Staff Bylaws, Art XIX, Section 3.A. The Hearing Committee in this matter met those requirements. Although there was no general surgeon on the Hearing Committee, all members of the Hearing Committee were licensed and trained medical doctors, and the members of the Hearing

Committee did include two physicians who practiced in surgical specialties as well as an anesthesiologist, all of whom had experience in the operating room. Additionally, the Hearing Committee did hear and consider the testimony from several experts in the specialty of general surgery, including Dr. Randall. Dr. Randall was afforded the opportunity to cross examine the expert testifying against him, to present expert testimony on his behalf, and to answer all charges asserted against him. Dr. Randall has not met his burden of proof in establishing that the members of the Hearing Committee were not capable of appreciating or understanding the experts who testified on behalf of the respective parties or the medical records and reports that were entered into evidence, nor has he met his burden of proof in establishing that the lack of a general surgeon on the Hearing Committee resulted in his being denied a fair hearing.

Dr. Randall has also not met his burden of proof in establishing that the remaining procedural issues he raised constituted any substantial failure to comply with the Bylaws so as to deny him a fair hearing.

A hearing before the Hearing Committee was scheduled within 90 days from the date of receipt of the request for a hearing. The date of the hearing was then rescheduled two times at the request of the Medical Executive Committee in order to accommodate the presentation of expert testimony by the Medical Executive Committee. The record reflects that both rescheduling requests were granted by the Hearing Committee for good cause shown. Article VIX, Section 4.C of the Medical Staff Bylaws indicates that postponement of a hearing beyond the times set forth in the Bylaws can be granted for good cause shown by the Hearing Committee in its sole discretion. Dr. Randall has failed to meet his burden of proof in establishing that these postponements resulted in the denial of a fair hearing. He has presented no evidence that the postponement denied him a meaningful opportunity to present his case or to cross examine the witnesses testifying against him. He seems to be arguing that the postponement denied him a fair hearing simply because the postponement allowed time for the Medical Executive Committee to substitute experts. However, the hearing before the Hearing Committee was for the purpose, "of resolving, on an intra-professional basis, matters bearing on professional competency and conduct." Medical Staff Bylaws, Art VIX, Section 4.I. As such, the Bylaws allow for postponement of hearings for good cause shown in furtherance of that purpose.

The report to the National Practitioner Data Bank in this matter came as a result of the summary suspension of Dr. Randall's abdominal surgical privileges by the Chief of Staff, which

summary suspension was later upheld by the Medical Executive Committee, and not as a result of the hearing before the Hearing Committee being re-scheduled for February 16 and 17, 2011. The Bylaws do not afford a practitioner an "early hearing" within 30 days before a Hearing Committee in the event of summary suspension. The Bylaws do indicate that once a summary suspension is imposed by the Chief of Staff, the Medical Executive Committee is required to make a determination within 14 days as to whether or not the suspension should be continued, modified, or terminated. Medical Staff Bylaws, Art VIII, Section 2.D. In addition, the practitioner who is the subject of the summary suspension is afforded the opportunity to meet with the Medical Executive Committee before it makes its determination to explain why the summary suspension should be rescinded. Medical Staff Bylaws, Art VIII, Section 2.C. All of this occurred in this case within the 14-day period required by the Bylaws. Once the Medical Executive Committee decided to uphold the summary suspension, Dr. Randall was given written notice of the decision and notified of his right to appeal under the provisions of the Bylaws governing hearing and appeal rights.

Lastly, Dr. Randall asserts that he was denied a fair hearing simply because a single reviewer did not review each of the 10 cases involved. There was no evidence presented that this fact violated the Medical Staff Bylaws or denied Dr. Randall a fair hearing. The record reflects Dr. Randall and his expert were afforded a full opportunity to review the charges presented in all 10 cases, to explain his treatment of all 10 of these patients, and to cross-examine the expert called to testify on behalf of the Medical Executive Committee. Moreover, a single reviewer, Dr. Skudder, did review each of the cases, rendered testimony during the hearing, and was available and subject to cross examination by Dr. Randall.

SUMMARY SUSPENSION AND RECOMMENDATION FOR REVOCATION OF PRIVILEGES

Dr. Randall asserts that both the summary suspension of his abdominal surgical privileges and the recommendation for revocation of abdominal surgical privileges, including herniorrhaphy, by either open or laparoscopic technique, were arbitrary, unreasonable, or capricious and therefore should be reversed.

Having considered the arguments presented on these issues and having reviewed the record of the hearing before the Hearing Committee, a majority of the members of the Appellate Review Committee determined that Dr. Randall did not meet his burden of proof with regards to his assertion that either the summary suspension or the recommendation for revocation of

abdominal surgical privileges, including herniorrhaphy, by either open or laparoscopic technique, lacked any substantial factual basis or the conclusions drawn therefrom were either arbitrary, unreasonable, or capricious for the following reasons.

The record reflects every member of the Hearing Committee independently reviewed the evidence concerning each case that formed a basis for the Medical Executive Committee's decisions which were under review as well as the overall circumstances concerning Dr. Randall. The Hearing Committee also had the opportunity to hear testimony from Dr. Randall, Dr. Edwards, and expert witnesses for both sides. It is evident to the Appellate Review Committee that the members of the Hearing Committee took their responsibilities seriously, and made a diligent effort to ensure there was a substantial factual basis for the actions taken and recommended by the Medical Executive Committee, and that the adverse actions were not arbitrary, unreasonable, or capricious. This is evident from the hearing transcript as well as from the detailed twenty-five (25) page opinion setting forth the Hearing Committee's reasons for upholding the Medical Executive Committee's adverse action and recommendation.

As acknowledged by the Hearing Committee, there was disagreement in some cases between the external reviews and the testimony of Dr. Skudder, and the Hearing Committee considered those differences of opinion as well as the testimony of Dr. Randall and his expert, Dr. Tribble. However, the Appellate Review Committee does not believe that these differences support Dr. Randall's contention that the findings of the Hearing Committee lacked any substantial factual basis or that the conclusions they drew were arbitrary, unreasonable, or capricious. The question before the Appellate Review Committee is not to weigh the evidence presented before the Hearing Committee, but rather to determine whether or not Dr. Randall met his burden of proof in establishing by a preponderance of the evidence that the determinations of the Hearing Committee lacked any substantial factual basis or the conclusion drawn therefrom were either arbitrary, unreasonable, or capricious.

Dr. Randall has not met this burden of proof in this regard as the Appellate Review Committee finds there was sufficient evidence and testimony in the record to support the findings of the Hearing Committee. The Hearing Committee in their order set forth in detail the testimony and evidence they believed supported their conclusions, and there is no evidence before this Appellate Review Committee that his testimony relied upon lacked a factual basis or that the conclusions drawn from it were arbitrary, unreasonable or capricious. Dr. Randall is, in

essence, arguing that the testimony he presented was more credible and should have been accepted; but that is not the standard for this appellate review.

DECISION AND RECOMMENDATION

Having considered the arguments presented in this appeal and having reviewed the record of the hearing before the Hearing Committee, a majority of the members of the Appellate Review Committee determined that Dr. Randall did not meet his burden of proof with regards to his assertion that he did not receive a fair hearing or with regards to his assertion that the summary suspension or the recommendation for revocation of abdominal surgical privileges, including herniorrhaphy, by either open or laparoscopic technique, lacked any substantial factual basis or the conclusions drawn therefrom were either arbitrary, unreasonable, or capricious. As such, it is found and recommended that the Decision and Order of the Hearing Committee be upheld by the Board.

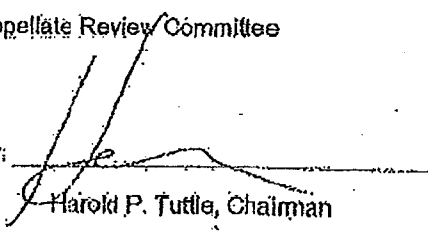
The Appellate Review Committee consisting of Joe Robinson, M.D.; Karen Walto; Bill Alexander; Harold P. Tuttle; Chantey Boulter; and, John Hotfink, M.D. voted to appoint Harold P. Tuttle as Chairman of the Appellate Review Committee and authorized him to sign this Decision and Recommendation on its behalf for consideration by the Board.

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Respectfully submitted,

Appellate Review Committee

By:


Harold P. Tuttle, Chairman

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BEFORE THE GOVERNING BOARD OF PIEDMONT MEDICAL CENTER
FINAL DECISION OF THE GOVERNING BOARD

In the Matter of

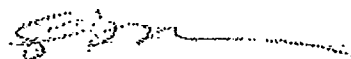
Robert D. Randall, Jr., M.D.

This matter came before the Governing Board of Piedmont Medical Center (hereinafter at times referred to as the "Board") pursuant to Article VIX (sic), of the Piedmont Medical Center Medical Staff Bylaws governing Appeals to the Governing Board. Dr. Randall timely filed a Notice and Request for Appellate Review by the Board of an adverse Hearing Committee recommendation to uphold the Medical Executive Committee's recommendation for the revocation and summary suspension of Dr. Randall's clinical privileges to perform abdominal surgery, including herniorrhaphy privileges, whether by open or laparoscopic technique.

The Governing Board appointed an Appellate Review Committee consisting of six Board members to hear the appeal and submit a proposed decision and recommendation to the full Board. The Appellate Review Committee held a hearing on June 15, 2011 and thereafter submitted its Final Decision and Recommendation, a copy of which is attached hereto as Exhibit A.

The Governing Board thereafter scheduled a special meeting of the Board on July 7, 2011 to consider the appeal and the Appellate Review Committee's decision and recommendations. A quorum was present for the Board's meeting on July 7, 2011. Dr. Alex Espinal recused himself from participation in this appeal and the Board appointed Charles F. Miller to serve as Acting Chairman of the Board for the purposes of this appeal, and authorized him to sign this Final Decision on behalf of the Board. After due deliberation and consideration of the issues presented, the Board voted to accept and adopt in its entirety the Final Decision and Recommendation of the Appellate Review Committee, attached as Exhibit A, and incorporates those findings and recommendations into this Final Decision as if set forth herein verbatim.

NOW, THEREFORE, the Governing Board hereby provides its final decision that the reports by the Medical Executive Committee and the Hearing Committee be affirmed. Pursuant to the Medical Staff Bylaws, Rules and Regulations of Piedmont Medical Center, this final decision shall be effective immediately and not subject to further hearing or appeal. A copy of this Final Decision shall be delivered to Dr. Randall by certified mail at his address on file with the Medical Staff Office and by certified mail to his attorney, Julius W. McKay, II. Copies shall also be provided to the hospital administrator, the Chief of Staff, and the Medical Executive Committee via hand delivery.



Charles F. Miller
Acting Chairman of the Board

Rock Hill, South Carolina
July 12, 2011

Page 2 of 2

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CERTIFICATE OF SERVICE

A copy of the foregoing FINAL DECISION OF THE GOVERNING BOARD was served on the following individuals by U.S. Mail on July 12, 2011:

Cynthia b. Hutto, Esquire
Nelson Mullins Riley & Scarborough, LLP
151 Meeting Street, 6th Floor
Charleston, SC 29401-2239

Julia Krebs-Markrich, Esquire
Reed Smith, LLP
3110 Fairview Park Drive
Falls Church, VA 22042

A handwritten signature in dark ink, appearing to read 'Tara Caswell', is written over a horizontal line.

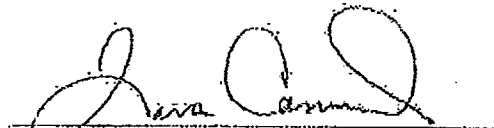
Tara Caswell, for
E. Douglas Pratt-Thomas
Pratt-Thomas Walker, PA
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P.O. Drawer 22247
Charleston, SC 29413-2247

CERTIFICATE OF SERVICE

A copy of the foregoing FINAL DECISION OF THE GOVERNING BOARD was served on the following individuals by U.S. Mail (Certified/Return Receipt Requested) on July 12, 2011:

Julius W. McKay, II, Esquire
McKay, Cauthen, Settana, & Stubbley, P.A.
1303 Blanding Street
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Robert D. Randall, Jr., M.D.
1964 Rosehaven Lane
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Tara Caswell, for
E. Douglas Pratt-Thomas
Pratt-Thomas Walker, PA
16 Charlotte Street (29403)
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Charleston, SC 29413-2247

State of South Carolina	)	
	)	
County of York	)	
Robert Randall, M.D.,	)	2012-CP-46-167
	)	
Plaintiff,	)	
	)	
vs.	)	Deposition
	)	
Amisub of South	)	of
Carolina, Inc. d/b/a/	)	
Piedmont Medical Center,	)	Carlos Gilberto
Nathaniel Edwards, M.D.,	)	Paxtor, MD
and Richard Patterson,	)	
M.D.,	)	
	)	
Defendants.	)	
	)	
	)	
	)	

Deposition of Carlos Gilberto Paxtor, MD, taken before Susan A. Wyant, a notary public in and for the State of South Carolina, commencing at the hour of 4:41 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

1 only certain of his surgical privileges were
2 recommended to be revoked and then ultimately
3 suspended?

4 A Yes.

5 Q All right. So what -- what privileges did he
6 retain?

7 A Everything except for abdominal surgery.

8 Q All right. You mentioned that it was difficult for
9 you, difficult for others on the committee --

10 A Yes.

11 Q -- difficult for Dr. Edwards to summarily suspend?

12 A I believe so.

13 Q Okay. And you mentioned there was some sentiment,
14 "Gosh, why can't we just pass this on to others?"

15 A Yes.

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

17 A You're asking me personally?

18 Q Yeah.

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

21 MR. DAYHUFF: No further questions. Jim?

22 MR. GRIFFIN: No. I don't have any questions.

23 MR. DAYHUFF: Thank you, Doctor, for your
24 time.

25 FURTHER DEPONENT SAITH NOT.

State of South Carolina	)	
	)	
County of York	)	
	)	
Robert Randall, M.D.,	)	C/A no.
	)	2012-CP-46-167
	)	
Plaintiff,	)	
	)	CONFIDENTIAL
vs.	)	
	)	Deposition of
Amisub of South Carolina, Inc.,	)	
d/b/a Piedmont Medical Center,	)	
Nathaniel Edwards, M.D., and	)	Sushil K.
Richard Patterson, M.D.,	)	Singhi, M.D.
	)	
Defendants.	)	
	)	
	)	

****C O N F I D E N T I A L****

CONTAINS CONFIDENTIAL PEER REVIEW INFORMATION

Deposition of SUSHIL K. SINGHI, M.D., taken before Joy R. Dawson, a notary public in and for the State of South Carolina, commencing at the hour of 4:49 p.m., Wednesday, August 14th, 2013, at Piedmont Medical Center, Women's Center, Room D 222 South Herlong Avenue, Rock Hill, South Carolina.

Reported by
Joy R. Dawson

1 A Yes.

2 Q You observed Dr. Randall's presentation?

3 A Yes.

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

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

15 MR. DAYHUFF: No further questions.

16 (Deposition concluded at 5:24 p.m.)

17 (*This transcript may contain quoted
18 material. Such material is reproduced as read
19 or quoted by the speaker. **Certificate
20 accompanies only sealed original.)
21
22
23
24
25

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,	)	Christopher B. Benson,
Inc. d/b/a Piedmont Medical	)	M.D.
Center, Nathaniel Edwards,	)	
M.D., and Richard	)	
Patterson, M.D.,	)	
	)	
Defendants.	)	
	)	
	)	

CONFIDENTIAL

Deposition of Christopher B. Benson M.D.,
 taken before Carolyn M. Beam, a notary public in and
 for the State of South Carolina, commencing at the
 hour of 4:57 p.m., Wednesday, July 24, 2013, at
 Piedmont Medical Center, 222 South Herlong Avenue,
 Rock Hill, South Carolina.

Reported by
 Carolyn M. Beam

1 MR. GRIFFIN: Dr. Benson, I do not have
2 any further questions.

3 EXAMINATION

4 BY MR. DAYHUFF:

5 Q Dr. Benson, a couple quick questions. For the
6 record, my name is Travis Dayhuff. I
7 represent the Defendants that have been sued
8 in this matter, Piedmont Medical Center,
9 Dr. Edwards, your former chief of staff, and
10 Dr. Patterson, the former chief medical
11 officer at this facility. I want to ask you a
12 little bit about your recollections at the MEC
13 meetings. That seems to be where you -- you
14 had the most recollection, was at the MEC as
15 opposed to the peer review is that --

16 A Correct.

17 Q -- right?

18 A Yes.

19 Q When you were in the MEC meetings, did you --
20 well, let -- let me represent this to you:
21 Dr. Patterson and Dr. Edwards have been sued
22 for engaging in a conspiracy to harm
23 Dr. Randall through the peer review action of
24 which you were a part. So this is my
25 question: Did you observe, when you were in

1 your peer review process in the MEC, making
2 the decisions you guys made, did you observe
3 either Dr. Patterson or Dr. Edwards do
4 anything that you thought was inappropriate?

5 A No.

6 Q Unfair to Dr. Randall?

7 A No.

8 Q Anything that appeared to you to be in
9 furtherance of a conspiracy?

10 A No.

11 Q Did you hear any discussion, from either of
12 those two or anyone else, that this peer
13 review action was being undertaken to
14 retaliate against Dr. Randall for the sale of
15 his practice to Novant?

16 A No.

17 Q Did you hear anything about this -- in the MEC
18 setting, this peer review action being
19 undertaken to retaliate against Dr. Randall
20 for testimony he may or may not have given in
21 a medical malpractice case?

22 A No.

23 MR. DAYHUFF: I have no further
24 questions. Follow-up?

25 MR. GRIFFIN: Briefly. Very, briefly.

STATE OF SOUTH CAROLINA
COUNTY OF YORK

) IN THE COURT OF COMMON PLEAS
) THIRTEENTH JUDICIAL CIRCUIT
)

Robert Randall, M.D.

Civil Case No.: 2012-CP-46-167

Plaintiff,

v.

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

Defendants.

**MEMORANDUM IN OPPOSITION TO
DEFENDANTS' MOTION FOR
SUMMARY JUDGMENT**

FACTUAL STATEMENT

Plaintiff, Dr. Robert Randall ("hereinafter Dr. Randall") is a board certified general surgeon. Until his privileges were revoked in summer of 2009, Dr. Randall had been performing abdominal surgeries at the Defendant Piedmont Medical Center for more than 25 years. Randall CV, Exhibit 1. As part of a periodic peer review process, the peer review committee of Piedmont Medical Center reviewed all of Dr. Randall's surgeries in 2007 and concluded that the procedures were all appropriately done and there was no need to monitor Dr. Randall's surgical procedures going forward. Peer Review Minutes 5/7/08 Exhibit 2.

In 2008 Dr. Randall's surgical practice, Rock Hill Surgical Associates, was purchased by Novant Health. Randall Depo. p. 33, ll. 13-22. Novant Health also owns Carolinas Medical Center in Charlotte, North Carolina. During this period of time, Novant was also seeking a certificate of need to construct a new hospital in Fort Mill, South Carolina. Novant was competing with Piedmont and a third hospital for the right to build this new hospital. Charles Miller Depo. p. 13, ll12-24, pp.14-15, ll 1-4.

In addition, Piedmont was also actively recruiting surgeons to become employed by Piedmont. Piedmont eventually created its own hospital surgeon practice through recruiting and hiring other local surgeons in the Rock Hill area. Charles Miller Depo. p. 12-11, 7-24, p. 13 11.1-3. Thus, during 2008 through 2010, Piedmont was actively competing with Dr. Randall's employer for the construction of a new hospital in Fort Mill and was preparing to compete with Dr. Randall and other surgeons in the Rock Hill area.

In 2010, Dr. Nathaniel Edwards ("Dr. Edwards"), a cardiologist, became chairman of the medical executive committee (MEC) at Piedmont. Dr. Edwards Depo., p. 13, 11. 11-22. As chairman of the MEC, Dr. Edwards also served on the peer review committee. Id at p. 16, 11 4-13. Prior to his becoming chairman of the MEC, Dr. Edwards had never served on the peer review committee. Id. at p. 19, 11.24-25, p. 20, 11. 1-20.

Dr. Edwards held a personal animosity toward Dr. Randall. Dr. Randall Depo. p. 98, 11. 5-25, p. 99-103 11. 1-13. Dr. Randall had previously treated a patient who is a close family friend of Dr. Edwards and his wife. Dr. Edwards' wife is also a medical doctor. She complained about Dr. Randall's care of this close family friend to Dr. Edwards. Dr. Edwards Depo. at p. 88, 11. 16-25, pp. 89-90 11. 1-4. During Dr. Edwards' tenure as chairman of the MEC, the hospital chief medical officer (CMO) Dr. Patterson, began pulling medical files of patients of Dr. Randall to submit to the peer review committee for review and action. See, Exhibit 3 Email correspondence (Diane West Depo. Exhibits 1-11, 14, 16, 18, 21, 23, 27 and 28) Dr. Patterson is not licensed to practice medicine in South Carolina and he is not on the medical staff. Rather, he is simply a hospital employee. However, Dr. Patterson as the CMO attends peer review committee, credentials committee and the MEC on behalf of the hospital.

The hospital by-laws provide for the peer review committee to review files submitted to it and if the peer review committee believes corrective action needs to be taken, then the peer

review committee is tasked with recommending the action to the medical executive committee. The MEC is then required to vote on a recommendation and then submit proposed action to the hospital board for their consideration. Piedmont Medical Center By-Laws, Exhibit 4. Here, the peer review committee never made any recommendation to the MEC for corrective action to be taken against Dr. Randall.

Moreover, in the summer of 2010, Dr. Randall's credentials on the surgical medical staff were up for renewal. Dr. Edwards, in his capacity as chairman of MEC and a designated member of the peer review committee appeared before the credentials committee opposing Dr. Randall's renewal. Dr. Edwards presented a series of cases that had previously been reviewed by the peer review committee. Minutes of Credentials Committee 6/10/2010, Exhibit 5.

The credentials committee consists of more experienced members of the medical staff. Dr. Patterson Depo. p. 29 ll. 13-19. Dr. Edwards has never served on the credentials committee. After hearing from Dr. Edwards, the members of the credential committee invited Dr. Randall to address the series of cases presented by Dr. Edwards. The physician members of the credentials committee concluded that "Dr. Randall was safe to continue performing surgery." Minutes of the Credentials Committee, 7/13/2010, Exhibit 6. Thereafter, the full MEC considered the credentials committee's recommendation that Dr. Randall be reappointed and did in fact reappoint Dr. Randall for another year. MEC Minutes 8/9/10, Exhibit 7, Medical Staff Appointment 8/19/10 Exhibit 8

Dr. Edwards, having his views rejected by both the peer review and the credentials committee as well as the full MEC, acting in conjunction with Dr. Patterson, created a brand new committee formed solely for purposes of sanctioning Dr. Randall. Dr. Edwards Depo. p. 17, ll 22-25, p. 18 ll.1-25. This new committee was called the "ADHOC" committee and was hand-picked by Dr. Edwards. Dr Edwards did not select any general surgeons with experience

performing abdominal laparoscopic surgery to serve on his committee. The members of this ADHOC committee requested that a general surgeon serve and further requested that Dr. Patterson on behalf of the hospital provide one. These requests went unanswered and there was never a board certified general surgeon to sit in judgment of Dr. Randall. MEC Committee Minutes 9/13/10, Exhibit 9; Dr. Edwards Depo. p. 39, ll.16-25, p. 40, ll. 1-22.

Dr. Edwards' ADHOC committee met and considered the files previously reviewed and considered by the credentials committee and the peer review committee. The Edwards' ADHOC committee ultimately voted to recommend to the MEC that Dr. Randall's abdominal surgical privileges be revoked. During this process, Dr. Randall was invited to appear and made a presentation about his care of a number of patients whom he had been notified were being considered by the ADHOC committee. During this meeting, Dr. Edwards questioned Dr. Randall on two additional cases that Dr. Randall had never been notified were under consideration. Dr. Randall Depo. p. 91, ll. 9-25; p. 92, ll.1-13.

Although the ADHOC recommended to the MEC that Randall's abdominal surgical privileges be revoked, their recommendation was conditioned upon allowing Dr. Randall to continue performing surgical procedures while he exhausted the peer review hearing process provided in the hospital by-laws. Dr. Baker Depo. p. 50, ll. 23-25, p. 51, ll. 1-17. Subsequently, the MEC to voted accept the recommendation of this ADHOC committee, provided that Dr. Randall's privileges would not be restricted until he was given an opportunity for a formal hearing. MEC Minutes 10/10/2010, Exhibit 10.

Days later, Dr. Edwards, contrary to decisions of his hand-picked ADHOC committee and of the MEC, unilaterally suspended Dr. Randall's privileges without notice or hearing. Letter of Dr. Edwards to Dr. Randall, 10/15/2010, Exhibit 11. Dr. Edwards made this decision after Dr. Patterson presented him with information regarding patient JR, who had been treated and

released in July, almost three months earlier. There was a question regarding Dr. Randall's treatment of JR and the amount of blood that she was transfused over numerous days. Interestingly, the hospital external reviewer subsequently determined that he could not argue with Dr. Randall's successful outcome in the treatment of patient JR and did not conclude that Dr. Randall's care of this patient was substandard. Furthermore, Dr. Edwards testified that he did not consult with anyone other than Dr. Patterson regarding Dr. Randall's treatment of patient JR. Dr. Edwards Depo. p. 53 ll 13-25, pp. 54-70 ll. 1-19.

Dr. Edwards also testified that he made the decision to suspend Dr. Randall because the general consensus in the ADHOC committee meeting was that Dr. Randall's privileges should have been suspended but that he was one of only a few holdouts who thought Dr. Randall should have been given his "due process" rights of review. Dr. Edwards' testimony of the sentiments of the ADHOC committee is contradict the testimony of other MEC members. Dr. Baker for example testified that Dr. Edwards actions came as a surprise and contrary to the decision of the MEC. Dr. Baker Depo. p. 55 ll. 12-17, p. 59 ll. 2-12. No member of the ADHOC committee testified that the majority of the members wished to deny Dr. Randall his full hearing rights before imposition of such a career ending sanction. Dr. Edwards' actions were totally at odds with the decision with the ADHOC that Dr. Randall's privileges should not be summarily suspended without having formal review hearing prior to the sanction going into effect. Id.

Dr. Randall received written notice of the summary suspension and immediately requested a hearing before the medical executive committee. At this hearing Dr. Randall appeared with an attorney. However, Dr. Randall's attorney was not permitted to participant in the hearing. Dr. Patterson Depo. p. 58, ll. 14-25, p. 59 ll. 1-10; Jay McKay Depo. p. 5 ll. 19-25, pp. 6-8 ll. 1-3. Once again Dr. Randall gave a presentation on the cases he believed were under consideration by the MEC and no one asked any questions of Dr. Randall. Furthermore, there

was no investigation undertaken by the MEC prior to Dr. Randall's appearance before the committee. Dr. Patterson Depo. p. 54 ll. 21-25, p. 55 ll. 1-8; Dr. Edwards Depo. p. 59 ll. 21-25, p. 60 ll. 1-25. At this hearing, Dr. Patterson, who is not a voting member of the MEC, falsely represented that a reviewer determined that patient JR's injury occurred as a result of Dr. Randall's procedure. Notes of MEC Meeting 10/25/10, Exhibit 12. This was not correct as the external reviewer's report was not even available at the time of the MEC meeting. Once the external review's report was made available, the reviewer could not determine that Dr. Randall's treatment of patient was substandard. Dr. Edwards Depo. p. 62, ll. 10-25, pp. 63-64.

In addition, Dr. Patterson also misinformed the MEC of their options. He advised MEC that they could either uphold the summary suspension in its entirety or modify it. Dr. Patterson did not inform the MEC that they could have vacated the summary suspension. Notes of MED Meeting 10/25/10, Exhibit 12.

The summary suspension, once it was in effect, was required to be reported to the South Carolina Medical Board and to the National Practitioner Data Bank. Dr. Randall through his attorney, attempted to negotiate a resignation without the report being submitted to the medical board but could not because of the reporting obligations. Jay McKay Depo. p. 18 ll. 12-17. The Defendant Piedmont had previously negotiated such a resolution with another physician in the past. This no doubt was no longer an option because of Dr. Edwards' unilateral decision to suspend Dr. Randall prior to the appellant process taking place.

Dr. Randall requested that a general surgeon serve on the hearing panel that was to be convened to consider the appeal of the summary suspension sanction and the recommendation by the MEC to revoke Dr. Randall's abdominal surgical privileges. Once again, the hospital refused to appoint a member from the medical staff who had experience with performing laparoscopic abdominal surgery to the hearing panel. This is because the hospital by-laws prohibit anyone

serving on a committee considering sanctions of another physician if the proposed member of the hearing panel has an economic interest with or against the doctor who is being reviewed. All witnesses who were asked testified that it is essentially impossible for someone's conduct to be judge by a physician who practices within the same specialty under the hospital's policy. At Piedmont Medical Center, all physicians in the same specialty either compete against with each other or are in the same practice. Thus, Dr. Randall was deprived of the opportunity to have a board certified general surgeon to serve on the hearing panel. However, there were other surgeons available on the medical staff that in fact perform abdominal surgery, yet none of the other surgical specialties who have experience performing the same type surgeries that were under review for Dr. Randall. Jay McKay Depo. p. 31, ll. 5-25, pp. 32-34 ll. 1-22.

Also, under the hospital by-laws, Dr. Randall had a right to a hearing to consider his summary suspension and revocation within 90 days from the date the sanctions went into effect. However, just two days before the scheduled hearing within the time frame provided under the by-laws, the hospital's surgical expert who had reviewed Dr. Randall's files refused to come testify before the hearing panel. The hospital through its attorney first claimed that there was a scheduling conflict and then later notified the hearing panel representative that the surgical expert would not be available at all. Id. at p. 22, ll. 15-25, p. 23 ll. 1-26, p. 27 ll. 1-22. At the hospital's request the hearing was postponed in violation of the hospital by-laws and was rescheduled only once when the hospital found another expert to testify against Dr. Randall. This expert was not a general surgeon but a vascular surgeon.

Dr. Randall's attorney who attempted to appear with him before the MEC to consider the summary suspension and who participated before the hearing panel testified that Dr. Randall was denied a fair hearing based upon a number of facts. First, Dr. Randall was prohibited from having attorney representation at the hearing before the MEC to consider his summary

suspension. Second, Dr. Randall was not given adequate notice of all of the cases that were to be reviewed by the MEC prior to his suspension and hearing. Third, Dr. Randall was not given a timely hearing under the by-laws before the review panel. Had the hearing gone forward as required under the by-laws, Dr. Randall no doubt would have prevailed before the hearing panel. Fourth, Dr. Randall did have a board certified general surgeon appear before the panel to testify on his behalf that Dr. Randall's conduct was within the standard of care and that he was competent to prepare abdominal surgical procedures. See, Testimony of Dr. Ben Tribble, Transcript of Hearing, Exhibit 13 If the hearing had gone forward as scheduled, the hospital would not have had any competent expert to contradict Dr. Randall's well qualified expert. Jay McKay Depo. at p. 57 ll. 22-25, p. 28 ll. 1-22.

ARGUMENT¹

I. *DEFENDANTS ARE NOT IMMUNE FROM LIABILITY UNDER HCQIA*

Defendants are not entitled to immunity under the Health Care Quality Improvement Act. (HCQIA) because Dr. Randall was not afforded adequate notice of the charges levied against him and a fair hearing prior to the imposition of the summary revocation of his surgical privileges. Furthermore, Dr. Randall was not provided a fair hearing to address the summary revocation because he was denied the right to counsel before the MEC, was not provided notice that the summary suspension was the result of Dr. Edward's review of Dr. Randall's care of patient JR and because Dr. Patterson misrepresented the procedural options available to the MEC. Dr. Patterson also misrepresented the facts concerning Dr. Randall's treatment of patient JR to the MEC. In addition, Dr. Randall was not provided a hearing within the 90 day period as required under the hospital by-laws to review the decision of the MEC. Lastly, there were not

¹ In cases applying the preponderance of the evidence burden of proof, the non-moving party is only required to submit a mere scintilla of evidence in order to withstand a motion for summary judgment. Hancock v. Mid-S. Mgmt. Co., Inc., 381 S.C. 326, 673 S.E.2d 801 (2009)

any physicians who had experience with laparoscopic adnominal surgery on the hearing panel that ultimately reviewed the decision of the MEC.

A. Immunity Under HCQIA

Congress enacted HCQIA "to improve the quality of medical care by encouraging physicians to identify and discipline physicians who are incompetent or who engage in unprofessional behavior." *Matthews v. Lancaster General Hosp.*, 87 F.3d 624, 632 (3'd Cir. 1996)(quoting H.R. Rep. No. 903, 99th Cong., 2d Sess. 2 (1986)). An entity qualifying for HCQIA immunity "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). Specifically, HCQIA provides a "professional review body"² with immunity from damages whenever a "professional review action"³ is taken in accordance with the requirements of the statute.

In order for HCQIA immunity to apply, a professional review action must have been taken:

- (1) in the reasonable belief that the action was in 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

² The term "professional review body" means a health care entity and the governing body or any committee of a health care entity which conducts professional review activity, and includes any committee of the medical staff of such an entity when assisting the governing body in a professional review activity. 42 U.S.C. § 11151(11)

³ The statute defines "professional review action" as an action or recommendation of a professional review body which is taken or made in the conduct of professional review activity, which is based on the competence or professional conduct of an individual physician (which conduct affects or could affect adversely the health or welfare of a patient or patients), and which affects (or may affect) adversely the clinical privileges, or membership in a professional society, of the physician. Such term includes a formal decision of a professional review body not to take an action or make a recommendation described in the previous sentence and also includes professional review activities relating to a professional review action. 42 U.S.C. § 11151(9).

physician involved or after such other procedures as are fair to the physician under the circumstances, and
(4) in the reasonable belief that the action was warranted by the facts known after such reasonable effort to obtain facts and after meeting the requirement of paragraph (3).

42 U.S.C. §11112(a).

The evidence establishes a question of fact as to whether the Defendants can meet the third and fourth provisions of the statute.

Defendants Did Not Provide Adequate Notice and Hearing Procedures or Other Procedures Fair Under the Circumstances

Dr. Randall clearly was not provided "adequate notice and hearing procedures" prior to the imposition of the summary suspension. A suspension of a physician's clinical and admitting privileges is a significant action. There are consequences that flow from a suspension. All suspensions of doctors, regardless of the term, must be reported to the South Carolina Board of Medical Examiners pursuant to the South Carolina Hospital Reporting Act. Guanciale v. McLeod Regional Health, C/A No. 4:02-3001 (USDC-SC March 8, 2004)(attached). Congress recognized the importance of procedural safeguards by including a "due process" component requiring "adequate notice and hearing procedures" in the statutory framework. Congress intended to ensure that physicians facing disciplinary action have an opportunity to present a response to such action.

The United States District Court in Guanciale explained:

The statute requires that "adequate notice and hearing procedures" are afforded to the physician" facing disciplinary action. Use of the terms "notice" and "hearing procedures" are significant. Congress chose these terms for good reason and the use of these terms indicate the hospital must meet at least a minimal "due process" requirement if the hospital gets the benefit of the shield of immunity. Inherent in basic due process is the right to be heard. "The right to be heard, which is so essential to due process in an adversary system of adjudication, [can] be vindicated only by affording a defendant an opportunity to testify before the fact-finder." *Sexton v. French*, 163 F.3d 874, 881 (4th Cir. 1998).

In this case, Randall did not receive any advanced notice of his suspension or the grounds for it. In addition, Randall was not provided any opportunity for a hearing prior to his summary suspension took effect. This cannot be disputed.

Congress was very specific when it drafted into the statute what rights it believed a physician should be afforded under the "adequate notice and hearing procedures" section. Regarding a hearing procedure, the statute specifically states:

(C) in the hearing the physician involved has the right-

- (i) to representation by an attorney or other person of the physician's choice,
- (ii) to have a record made of the proceedings, copies of which may be obtained by the physician upon payment of any reasonable charges associated with the preparation thereof,
- (iii) to call, examine, and cross-examine witnesses,
- (iv) to present evidence determined to be relevant by the hearing officer, regardless of its admissibility in a court of law, and
- (v) to submit a written statement at the close of the hearing; and

(D) upon completion of the hearing, the physician involved has the right-

- (i) to receive the written recommendation of the arbitrator, officer, or panel, including a statement of the basis for the recommendations, and
- (ii) to receive a written decision of the health care entity, including a statement of the basis for the decision.

42 U.S.C. § 11112 (b)(3)(C)&(D).

While the statute also states that a professional review body's failure to meet the conditions described in this subsection shall not, in itself, constitute failure to meet the standards of subsection (a) (3), it does clearly indicate what type of hearing procedure should be afforded to a physician facing disciplinary action. Guancia.

As noted, Dr. Randall was not given notice of the charge that led to his summary suspension, nor was he provided an opportunity to be heard ahead of time. Furthermore, Dr. Patterson prevented Dr. Randall's attorney from appearing

before the MEC to address the summary suspension. Thus, even the post-sanction meeting before the MEC does not qualify as a hearing under HCQIA.

Defendants Do Not Meet the Exception to the Due Process Requirement

Additionally, Defendants do not meet the exceptions to the notice and hearing requirements outlined in 42 U.S.C. §11112(c)(1) and (2). Section §11112(c) states:

For purposes of section 11111 (a) of this title, nothing in this section shall be construed as--

(1) requiring the procedures referred to in subsection (a)(3) of this section--

(A) where there is no adverse professional review action taken, or

(B) in the case of a suspension or restriction of clinical privileges, for a period of not longer than 14 days, during which an investigation is being conducted to determine the need for a professional review action; or

(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)

Clearly, the exception cited in §11112(c)(1) (A) is not appropriate because the summary suspension was an adverse professional review action. The exception cited in §11112(c)(1) (B) applies only if the suspension or restriction of clinical privileges does not exceed 14 days "during which" an investigation is "being conducted" to determine the "need for" a professional review action. There are two primary components to the (c)(1)(B) subsection: (1) a suspension must not exceed 14 days; and (2) the suspension is imposed while an investigation is being conducted to determine the need for a professional review action.

The facts in the record do not support application of this special exception to the notice and fair hearing procedures required by §11112(a) (3). First, Randall's summary suspension was not limited to 14 days. Second, there was no investigation

undertaken to determine the need for professional review action during the period of summary suspension. Both Dr. Patterson and Dr. Edwards denied that any investigation was undertaken following the imposition of the summary suspension. Dr. Patterson Depo. p. 54 ll. 21-25, p. 55 ll. 1-8; Dr. Edwards Depo. p. 59 ll. 21-25, p. 60 ll. 1-25. Furthermore, the letter to Dr. Randall from Dr. Edwards does not indicate that an investigation will be undertaken. Rather, the letter states that Dr. Edwards has "determined that summary restriction of your privileges is warranted to ensure there will be no imminent danger to the persons for whom you might provide services under those privileges."

Dr. Edwards' conclusion that Dr. Randall posed an imminent danger is contradicted by the actions of the MEC just days before which concluded that Dr. Randall would be permitted to retain his surgical privileges while the proposed corrective action was under review. The patient JR who Dr. Edwards cited as the basis for his decision to impose a summary suspension was discharged in July from the hospital, had not been readmitted and, as far as the record indicates, did not suffer any adverse outcome. In addition, upon recommendation of the Credentials Committee, the MEC renewed Dr. Randall's privileges for another year as of August, 2010, a month after patient JR had been discharged. Lastly, when patient JR's chart was reviewed by an external reviewer, the reviewer did not assess fault with Dr. Randall's care and treatment.

Therefore, while a finding of imminent danger is an exception to the notice and hearing due process requirements under HCQIA, here there is sufficient evidence from which a jury could conclude that Dr. Randall was not an imminent danger. As a result, summary judgment must be denied upon the Defendants'

claim of HCQIA immunity.

II. The Intracorporate Conspiracy Doctrine Does Not Shield the Defendants' From Liability Under South Carolina Law

The Defendants Dr. Patterson and Dr. Edwards have also moved for summary judgment under the intracorporate conspiracy doctrine claiming that because each is an agent of the hospital. Under South Carolina law, the intracorporate conspiracy doctrine does not shield the defendants from liability for agent to agent conspiracies, particularly where one of the co-conspirators is acting through self-interest and malice.

In *Anthony v. Ward*, 336 Fed.Appx. 311 (4th Cir. 2009) (unpublished opinion attached as Exhibit A), the Fourth Circuit Court of Appeals affirmed a jury verdict against employees of the South Carolina Department of Corrections for civil conspiracy. The employees were accused of conspiring "for personal and malicious reasons" to force the plaintiff's termination from the Department. *Id.* at 312. On appeal, the Defendants argued that the trial court erred by refusing the charge the jury on the issue of whether the Defendants were acting in the course and scope of their employment and were therefore incapable of conspiring with each other. *Id.* at 315. The trial court ruled that the intracorporate conspiracy doctrine was only applicable to principal-agent conspiracies and since the plaintiff alleged an agent-agent conspiracy the requested charge was rejected. *Id.* at 315-16. The Fourth Circuit Court of Appeals affirmed the judgment of the District Court concluding that since the jury specifically found on the jury verdict form that the Defendants had conspired "for the purpose of injuring" the plaintiff, the Defendants were not prejudiced "even if the district court erred in failing to give the requested instruction..." *Id.* at 316.

Here, the evidence clearly creates a jury question regarding Dr. Edwards motives for summarily suspending Dr. Randall. As Dr. Randall explained, Dr. Edwards harbored personal

animosity towards Dr. Randall. Dr. Edwards admitted that his wife complained about Dr. Randall's care for a friend's child. Subsequently, Dr. Edwards confronted Dr. Randall more than once in the hospital over mundane issues, such as complaining that Dr. Randall parked his car too close to Dr. Edwards. Dr. Edwards stubbornness refusal to accept the decision of the Credentials Committee, the Peer Review Committee and the MEC to allow Dr. Randall to continue with surgical privileges is also circumstantial evidence of the ill will Dr. Edwards harbored toward Dr. Randall.

Furthermore, the evidence is overwhelming that Dr. Patterson conspired with Dr. Edwards to summarily suspend and ultimately convince the MEC to revoke Dr. Randall's surgical privileges. At Dr. Edwards request, Dr. Patterson pulled patient records to present to the Peer Review Committee and then to the Credentials Committee. Dr. Patterson also met with Dr. Edwards after the MEC refused to summarily suspend Dr. Randall and drafted the letter for Dr. Edwards that suspended Dr. Randall, in direct conflict with the decision of the MEC. Dr. Patterson falsely represented the facts of patient JR's care before the MEC and misrepresented the MEC's options with regard to the summary suspension. Moreover, Dr. Patterson was the only physician who had training in general surgery that attended the ADHOC committee and MEC committee meetings where Dr. Randall's surgical skills were being considered.

Under South Carolina law, a claim for civil conspiracy includes the following elements: (1) a combination of two or more persons; (2) joining for the purpose of injuring the plaintiff; and (3) which causes special damage to the plaintiff. *Pye v. Estate of Fox*, 369 S.C. 555, 566-67, 633 S.E.2d 505, 511 (2006). Clearly there is more than a scintilla of evidence in the record to create a question of fact for the jury as to whether the Defendants Edwards and Patterson conspired for the purpose of injuring Dr. Randall, causing him special damages.

III. The Premise Underlying Dr. Randall's Suspension was False and Therefore the Report of that Suspension to the S.C. Medical Board and the National Practitioner's Databank Gives Rise to a Claim for Defamation

Defendants argue that the claim for defamation must fail because the statements submitted to the NPDB were factually accurate. Defendants miss the point. South Carolina law recognizes that defamation may be actionable if the insinuation of the statement is false. Eubanks v. Smith, 292 S.C. 57, 63, 354 S.E.2d 898, 901 (1987)(A mere insinuation is actionable as a positive assertion if it is false and malicious and its meaning is plain.). The clear insinuation of the Defendants report of suspension to both the South Carolina Medical Board and the NPDB is that Dr. Randall is so incompetent that allowing him to practice medicine poses an imminent danger to patients.

In Wuchenich v. Shenandoah Memorial Hospital, 215 F.3d 1324 (4th Cir. 2000), the Court of Appeals concluded that the hospital's accurate reporting to the State Medical Board and the NPDB of a summary suspension based upon incompetence "constitutes defamation per se because each statement falsely imputed unfitness on the part of Dr. Wuchenich to perform his duties as an anesthesiologist and prejudiced him in his profession." Similarly, in Guanciale, the District Court also permitted the plaintiff to pursue a claim for defamation for reporting a summary suspension to the South Carolina Medical Board.⁴

In a footnote, the Defendants also claim that any report to the NPDB is privileged and cannot form the basis for a defamation claim, citing Swinton Creek Nursery v. Edisto Farm Credit 334 SC 469, 514 S.E.2d 126 (1999). Swinton Creek merely stands for the proposition that certain communications are conditionally privileged and when the conditional privilege applies, the plaintiff must prove actual malice. To prove actual malice, "plaintiff must show that the

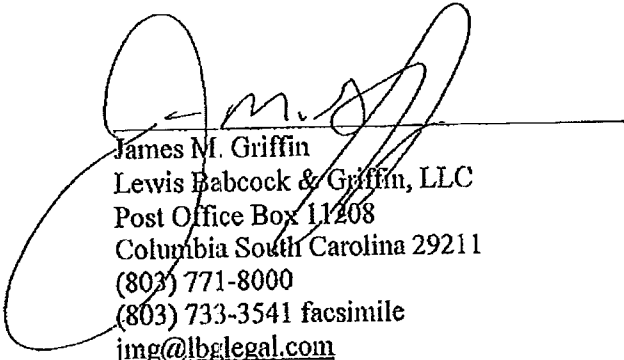
⁴ The undersigned counsel was also counsel for Dr. Guanciale. In Guanciale, the case was ultimately remanded back to the Court of Common Pleas, Dillon County where a jury trial was held and Plaintiff obtained a verdict on the defamation claim.

defendant was activated by ill will in what he did, with the design to causelessly and wantonly injure the plaintiff; or that the statements were published with such recklessness as to show a conscious disregard for plaintiff's rights." 334 S.C. 469, 485, 514 S.E.2d 126, 134 (1999).

The evidence in the record discussed above clearly is sufficient to create a jury question regarding whether the Defendants acted with ill will and/or recklessness by causing the report of Dr. Randall's summary suspension to be submitted to the NPDB. In addition, Dr. Randall also alleges that the report of his suspension to the South Carolina Medical Board likewise was defamatory. In order to be immune from liability for making reports to the Medical Board, the Defendants must make the report "in good faith and without malice." S.C. Code Ann. § 44-7-70. Once again, whether the Defendants' actions were in good faith and without malice are questions of fact to be decided by the jury.

CONCLUSION

Based upon the foregoing, Plaintiff respectfully requests that this Court deny Defendants' motion for summary judgment.



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October 23, 2013
Columbia, SC

) IN THE COURT OF COMMON PLEAS

) FOR THE

) THIRTEENTH JUDICIAL CIRCUIT

)

)

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) Case No.: 2012-CP-46-167

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) CERTIFICATE OF SERVICE

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Monteith P. Todd
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Columbia, SC 29201

Jenny K. Bakley
Jenny K. Bakley

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EXHIBIT 1

Robert D. Randall, Jr. MD
1964 Rosehaven Lane
Rock Hill, South Carolina 29732
rdrandall@comporium.net
803.323.7370

EDUCATION

Wake Forest University- Bowman Gray School of Medicine, Winston-Salem, North Carolina
Medical Doctorate, May 1976

Davidson College, Davidson, North Carolina
Bachelor of Science, May 1972

INTERNSHIP AND RESIDENCY

North Carolina Baptist Hospital/Wake Forest University, Winston-Salem, North Carolina
General Surgery Intern and Resident, July, 1976 to June, 1982

- Responsible for trauma call and performing multiple surgeries.
- Worked in a 800 bed Level I Trauma Center.
- Taught and managed medical students, interns and residents.
- Bradshaw Fellow in Surgery from June 1979 to July 1980.

EXPERIENCE

Piedmont Medical Center, Rock Hill, South Carolina
Attending Physician/Staff Surgeon, 1982 to present

- Performed multiple surgeries and attended to acutely and chronically ill patients.
- Worked in a 272 bed Level II Trauma Center.
- Director of Vascular Lab from 1988 to present.
- Trauma Director from 2004 to present.
- Served as Chief of Surgery from 1988 to 1989.

Carolinas Medical Center Pineville, Charlotte, North Carolina
Courtesy Staff, 1988 to present

- Performed outpatient and occasional inpatient surgery.

Rock Hill Surgical Associates, Rock Hill, South Carolina
Partner, 1982 to 2008

- Attended to 35-40 patients daily.
- Partner in five surgeon general surgery practice.
- Grew practice from 4 to 6 surgeons during tenure.
- Supervised and grew staff from 9 to 18 employees.
- Performed a variety of office and hospital procedures.
- On call two to three times weekly, including emergency room and Level II trauma coverage.



RANDALL 0158

Surgical Specialists of the Carolinas, Rock Hill, South Carolina

Partner, July 1, 2008 to July 24, 2009

- On call two to three times weekly, including emergency room and Level II trauma coverage.
- Partner in four surgeon general surgery practice.

LICENSURE

North Carolina, June 1976 (License #20949)

South Carolin, June 1982 (License #10864)

CERTIFICATION

Board Certified by the American Board of Surgery, 1983 (Certificate #29289)

Recertified in 1992 and 2003 (Valid to July 1, 2014)

PROFESSIONAL MEMBERSHIPS

American College of Surgeons, member since 1983

Southeastern Surgical, member since 1975

South Carolina Surgical Society, member since 1990

South Carolina Medical Associates, member since 1982

American Medical Association, member since 1986

York County Medical Society, member since 1982 (President 1989-1990)

EXHIBIT 2

Agenda	Findings/Discussion	Conclusions/ Recommendations	Actions/Follow- Up																								
Practitioner 4018 4 th 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 <table> <tr> <td>MR: 294179</td><td>MR: 320089</td><td>MR: 242504</td><td>MR: 22461</td></tr> <tr> <td>MR: 297999</td><td>MR: 174747</td><td>MR: 320883</td><td>MR: 27709</td></tr> <tr> <td>MR: 8966</td><td>MR: 320480</td><td>MR: 321282</td><td>MR: 178250</td></tr> <tr> <td>MR: 259218</td><td>MR: 195215</td><td>MR: 246958</td><td>MR: 141049</td></tr> <tr> <td>MR: 322328</td><td>MR: 82256</td><td>MR: 12975</td><td>MR: 267686</td></tr> <tr> <td>MR: 137826</td><td>MR: 323069</td><td>MR: 279724</td><td>MR: 324163</td></tr> </table> <u>Carotid Endarterectomies - None</u>	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	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. QI - Outcome acceptable or not unexpected. UI - Utilization acceptable or not unexpected. MI - Management appropriate or not routine, but not unacceptable. BI - 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.
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																								
REDACTED	REDACTED →	→																									
Adjournment	There being no further business, the meeting was adjourned.																										

PLAINTIFF'S
EXHIBIT
2

EXHIBIT 3

From: West, Dianne
Sent: Tuesday, January 06, 2009 9:44 AM
To: PattersonMD, Richard
Subject: RE: Incident on 12/24/08 (Endoscopy)

Will do.

From: PattersonMD, Richard
Sent: Monday, January 05, 2009 4:44 PM
To: West, Dianne
Subject: RE: Incident on 12/24/08 (Endoscopy)

I do agree that it is physician only and it should be peer review for Dr. Randall. I think this should go outside.

Thanks.

C. Richard Patterson, M.D.

Chief Medical Officer

Piedmont Medical Center

Rock Hill, South Carolina 29732

(803) 323-2894

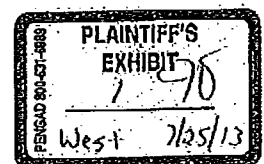
From: West, Dianne
Sent: Monday, January 05, 2009 3:49 PM
To: PattersonMD, Richard
Subject: RE: Incident on 12/24/08 (Endoscopy)

Is this a peer review for Dr. Randall?

I would think that this would not be a RCA since it was physician only?
Do you agree?

Thanks

CONFIDENTIAL



PMC.00004846

From: PattersonMD, Richard
Sent: Monday, January 05, 2009 8:45 AM
To: Halterman, Mary Kaye; Miller, Charles
Cc: West, Dianne
Subject: RE: Incident on 12/24/08 (Endoscopy)

The patient underwent laparoscopic cholecystectomy and sustained an injury to the duodenum, resulting in a leak of bile and stomach contents into the peritoneal cavity and the subsequent ERCP findings as described below. The "white foreign body" referred to below is the drain left in the abdomen at the time of surgery, a drain that would not ordinarily be seen during endoscopy absent a substantial rent in the bowel.

The duodenal injury was repaired surgically, but subsequent nuclear imaging demonstrated a continued bile leak, whether from the duodenal injury or from the bile duct or both. Given the difficulty of the ERCP by our physician, arrangements were made to transfer the patient to MUSC for ERCP and delineation of the site of the leak.

C. Richard Patterson, M.D.

Chief Medical Officer

Piedmont Medical Center

Rock Hill, South Carolina 29732

(803) 323-2894

From: Halterman, Mary Kaye
Sent: Monday, January 05, 2009 8:29 AM
To: PattersonMD, Richard; Miller, Charles
Cc: West, Dianne
Subject: FW: Incident on 12/24/08 (Endoscopy)

FYI

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

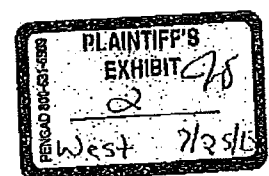
From: Wylie, Anita
Sent: Wed 12/24/2008 5:38 PM
To: West, Dianne
Cc: Halterman, Mary Kaye; HAUSSLING, LYNETTE; Henrion, Mary;
Green, Holly; Beaty, Beth

CONFIDENTIAL

PMC.00004847

From: West, Dianne
Sent: Tuesday, January 06, 2009 1:12 PM
To: Sealey, Christine
Subject: Peer Review Case - [REDACTED]
Attachments: Peer Review Worksheet.doc

Per Dr. Patterson, he would like this to be an external peer review for Dr. Randall.
Thanks



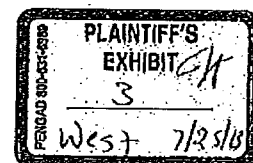
CONFIDENTIAL

PMC.00004849

From: West, Dianne
Sent: Tuesday, January 06, 2009 1:37 PM
To: Smith, Sandy; Marten, Lisa
Subject: SIN1886237

This one needs to go to Dr. Randall (for followup) and the new 2009 Surgery Chairman.

Lisa, this one has gone to Christine for peer review at the direction of Dr. Patterson in case you need to share that with the new chairman.



CONFIDENTIAL

PMC.00004853

Sealey, Christine

From: West, Dianne
Sent: Tuesday, May 19, 2009 9:04 AM
To: PattersonMD, Richard; Sealey, Christine
Subject: RE: Dr. Randall

Christine, please add this to this week's peer review information. Dr. Patterson will provide a summary for the committee.

From: PattersonMD, Richard
Sent: Tuesday, May 19, 2009 7:29 AM
To: West, Dianne
Subject: RE: Dr. Randall

Ask Christine to add it to the list that peer review committee will consider this week. I'll provide a summary for the committee.

From: West, Dianne
Sent: Tuesday, May 19, 2009 6:50 AM
To: PattersonMD, Richard
Subject: RE: Dr. Randall

Is this one that I will need to send to peer review when the patient is discharged?

From: PattersonMD, Richard
Sent: Monday, May 18, 2009 5:26 PM
To: West, Dianne
Subject: RE: Dr. Randall

It is the same patient.

From: West, Dianne
Sent: Monday, May 18, 2009 11:46 AM
To: PattersonMD, Richard
Subject: RE: Dr. Randall

After you get your other info on the young female, if it isn't this patient will you let me know whether I should proceed with anything on this one? Thanks

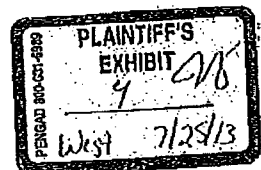
From: PattersonMD, Richard
Sent: Monday, May 18, 2009 10:37 AM
To: West, Dianne
Subject: RE: Dr. Randall

I agree with you.

I do not know the patient's name, but I heard this morning of another case of Dr. Randall's in which there is concern about quality and communication. I expect to receive something more detailed some time today. I do know that this patient is a young female.

From: West, Dianne

1



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PMC.00005605

From: West, Dianne
Sent: Tuesday, June 02, 2009 6:53 AM
To: EVERETT, NANCY
Subject: RE: Report on Dr. Randall

yes

From: EVERETT, NANCY
Sent: Monday, June 01, 2009 6:59 PM
To: West, Dianne
Subject: RE: Report on Dr. Randall

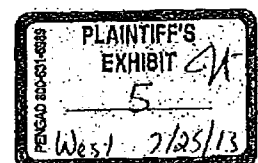
Is this the one on the perforation?
Thanks

Nancy

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

From: West, Dianne
Sent: Mon 6/1/2009 3:29 PM
To: EVERETT, NANCY
Cc: Sealey, Christine
Subject: Report on Dr. Randall

Dr. Patterson asked that this one go to peer review. I gave Christine the written info, but I didn't have the patient name and date of event. Please provide to her and she can send out to peer review. Go ahead and send to Dr. Abrams and Randall to review. thanks

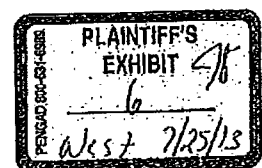


CONFIDENTIAL

PMC.Q0004869

From: West, Dianne
Sent: Monday, June 08, 2009 3:23 PM
To: PattersonMD, Richard
Subject: Peer Review Charts of Dr. Randall

Christine and I are trying to get the cases that are going to external peer review and we have 3 patients who are still in-house. In the past we haven't sent the charts until they are complete. We know that these are all suppose to be reviewed by the same reviewer. Should we send the record as it is complete now, or wait and send all of the charts when all of the patients are discharged? Thanks



CONFIDENTIAL

PMC.00004870

From: Sealey, Christine
Sent: Friday, June 12, 2009 10:16 AM
To: West, Dianne
Subject: RE: External Peer Review for Dr. Randall

AllMed - they are the one we like....

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

From: West, Dianne
Sent: Friday, June 12, 2009 10:08 AM
To: Sealey, Christine
Subject: RE: External Peer Review for Dr. Randall

Who did his other one?

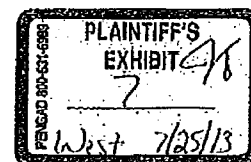
From: Sealey, Christine
Sent: Friday, June 12, 2009 9:54 AM
To: West, Dianne
Subject: External Peer Review for Dr. Randall

Dianne, and you ask Dr. Patterson if he wants me to utilize Allmed or AMR (the cheaper one) for Dr. Randall's cases?

Thanks,

Christine Sealey
Medical Staff Coordinator
Piedmont Medical Center
222 S Herlong Avenue
Rock Hill, SC 29732
803-329-6772 (phone)
803-328-1785 (fax)
e-mail: christine.sealey@tenethealth.com <<mailto:christine.sealey@tenethealth.com>>

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CONFIDENTIAL

PMC.00004834

From: West, Dianne
Sent: Friday, June 12, 2009 11:16 AM
To: Sealey, Christine
Subject: FW: External Peer Review - Dr. Randall

AMR

>
>From: PattersonMD, Richard
>Sent: Friday, June 12, 2009 10:47 AM
>To: West, Dianne
>Subject: RE: External Peer Review - Dr. Randall
>
>Let's use AMR. Their reviews have been good, despite their not using
>our scoring system, and the savings may be substantial with so many
>cases. I kind of like the fact that they don't use the scoring,
>because that engages our committee members in arriving at an unaffected
>score.

>
>
>From: West, Dianne
>Sent: Friday, June 12, 2009 10:33 AM
>To: PattersonMD, Richard
>Subject: External Peer Review - Dr. Randall

>
>We have received all the medical records now and are ready to send out.
>Just wanted to check with you to see if you want us to use Allmed (this
>is the original company we used and they did his other review for us)
>or AMR (they are the company that was a little cheaper)? Thanks

>
>Dianne West
>Director, Medical Staff & Risk Management Services Piedmont Medical
>Center
>222 S Herlong Avenue
>Rock Hill, SC 29732

>
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>only to the intended recipient. Please do not forward this
>communication without my permission. If you have received this
>communication in error, please notify me immediately and delete/destroy
>this communication. Thank you.
>Telephone: 803-329-6868
>Fax: 803-328-1785

>

From: West, Dianne
Sent: Tuesday, June 23, 2009 3:13 PM
To: Sealey, Christine; PattersonMD, Richard
Subject: RE: External Peer Review Cases - FYI

I would think that Allmed's review would be sufficient; however, if Dr. Patterson wanted all of them to be reviewed by the same company, we may need to have AMR do so. I understand that when we have a focused review that all are usually done by the one group. [REDACTED] W [REDACTED] was done a long time ago and when I gave you C [REDACTED], I did not realize that the focus review was in progress. Let's wait for Dr. Patterson to advise us.
Thanks

Dianne West
Director, Medical Staff & Risk Management Services Piedmont Medical Center
222 S Herlong Avenue
Rock Hill, SC 29732

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Telephone: 803-329-6868
Fax: 803-328-1785

From: Sealey, Christine
Sent: Tuesday, June 23, 2009 1:12 PM
To: PattersonMD, Richard; West, Dianne
Subject: External Peer Review Cases - FYI

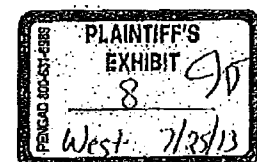
This is just FYI:

We sent a total of 11 cases out for external review to AMR today.

Six of these cases are Dr. Randall's. Two of the cases that were referred had already been sent to Allmed and I did not send those to AMR again unless you advise that you want AMR to review them as well. These were W [REDACTED] and C [REDACTED] W [REDACTED]. We just received Allmed's responses last week. Do you want to go ahead and review these or wait and review all cases at one time?

The others were for [REDACTED]
[REDACTED] as recommended either at the ESRM meetings or Peer Review Committee.

Please advise your thoughts about Dr. Randall's cases.



CONFIDENTIAL

PMC.00004875

West, Dianne

From: PattersonMD, Richard
Sent: Tuesday, February 16, 2010 10:04 AM
To: West, Dianne
Subject: RE: D [REDACTED] S [REDACTED] - Peer Review

C. Richard Patterson, M.D.
Chief Medical Officer
Piedmont Medical Center
Rock Hill, South Carolina 29732
(803) 323-2894

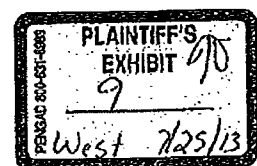
From: West, Dianne
Sent: Tuesday, February 16, 2010 9:49 AM
To: PattersonMD, Richard
Subject: D [REDACTED] S [REDACTED] - Peer Review

[REDACTED]

This is Dr. Randall's case and this was sent out for external review. We have received it back and it is in the stack of reports that Christine gave you previously to review for Dr. Randall. It has not gone to our Peer Review Committee yet. Have you completed the review of the external reports? [Richard Patterson] Yes, and this one will cause Billy heartburn. Can they go to the Peer Review Committee in March? [Richard Patterson] Please ask Dr. Pillai to review them as chair. He was party to the preliminary reviews as vice-chair, and I think he should review and discuss with Dr. Edwards the entire series of cases along with Dr. Kessler, the current PR rep. Thanks

Dianne West
Director, Medical Staff Services
Piedmont Medical Center
222 S Herlong Avenue
Rock Hill, SC 29732
Telephone: 803-329-6868
Fax: 803-328-1785

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Fax: 803-328-1785



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PMC.00001733

From: PattersonMD, Richard
Sent: Thursday, March 04, 2010 8:38 AM
To: West, Dianne
Subject: RE: Dr. Randall's Peer Review

2008 forward will be fine.

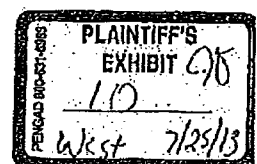
C. Richard Patterson, M.D.
Chief Medical Officer
Piedmont Medical Center
Rock Hill, South Carolina 29732
(803) 323-2894

From: West, Dianne
Sent: Wednesday, March 03, 2010 4:08 PM
To: PattersonMD, Richard
Subject: Dr. Randall's Peer Review
Importance: High

How far back should we go -- Is 2008, 2009 and 2010 enough or should we go back further? thanks

Dianne West
Director, Medical Staff Services
Piedmont Medical Center
222 S Herlong Avenue
Rock Hill, SC 29732
Telephone: 803-329-6868
Fax: 803-328-1785

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Fax: 803-328-1785



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PMC.00004905

From: Sealey, Christine
Sent: Wednesday, March 03, 2010 1:07 PM
To: West, Dianne
Subject: RE: Dr. Randall's review - URGENT REQUEST

When he says - all previous reviews - how far back is he wanting us to go?

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

From: West, Dianne
Sent: Wednesday, March 03, 2010 11:58 AM
To: PattersonMD, Richard; Sealey, Christine
Subject: RE: Dr. Randall's review - URGENT REQUEST
Importance: High

Christine,
Please see note below and proceed to prepare copies for each peer review committee member to have on 3-8-10 for the Peer Review Committee on 3-15-10. I believe that it would be best to have these ready so that we could hand them to the member at the Medical Staff meeting if they are in attendance and then to hand-deliver the others to them on Tuesday 3/9.

Please give to Natalie so that she can make the copies by Friday afternoon. I will let her know that this will be a priority when you give to her.

Let me know if you have any questions. Thanks

Dianne West
Director, Medical Staff Services
Piedmont Medical Center
222 S Herlong Avenue
Rock Hill, SC 29732
Telephone: 803-329-6868
Fax: 803-328-1785

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Telephone: 803-329-6868
Fax: 803-328-1785

From: PattersonMD, Richard
Sent: Tuesday, March 02, 2010 4:23 PM
To: West, Dianne

CONFIDENTIAL

PMC.00004906

Subject: Dr. Randall's review

Dr. Edwards would like for each member of peer review to have copies of the current external reviews and all previous reviews for Dr. Randall, including his professional conduct meetings. Thanks.

C. Richard Patterson, M.D.

Chief Medical Officer

Piedmont Medical Center

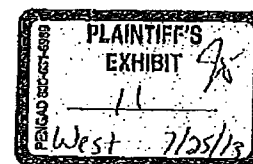
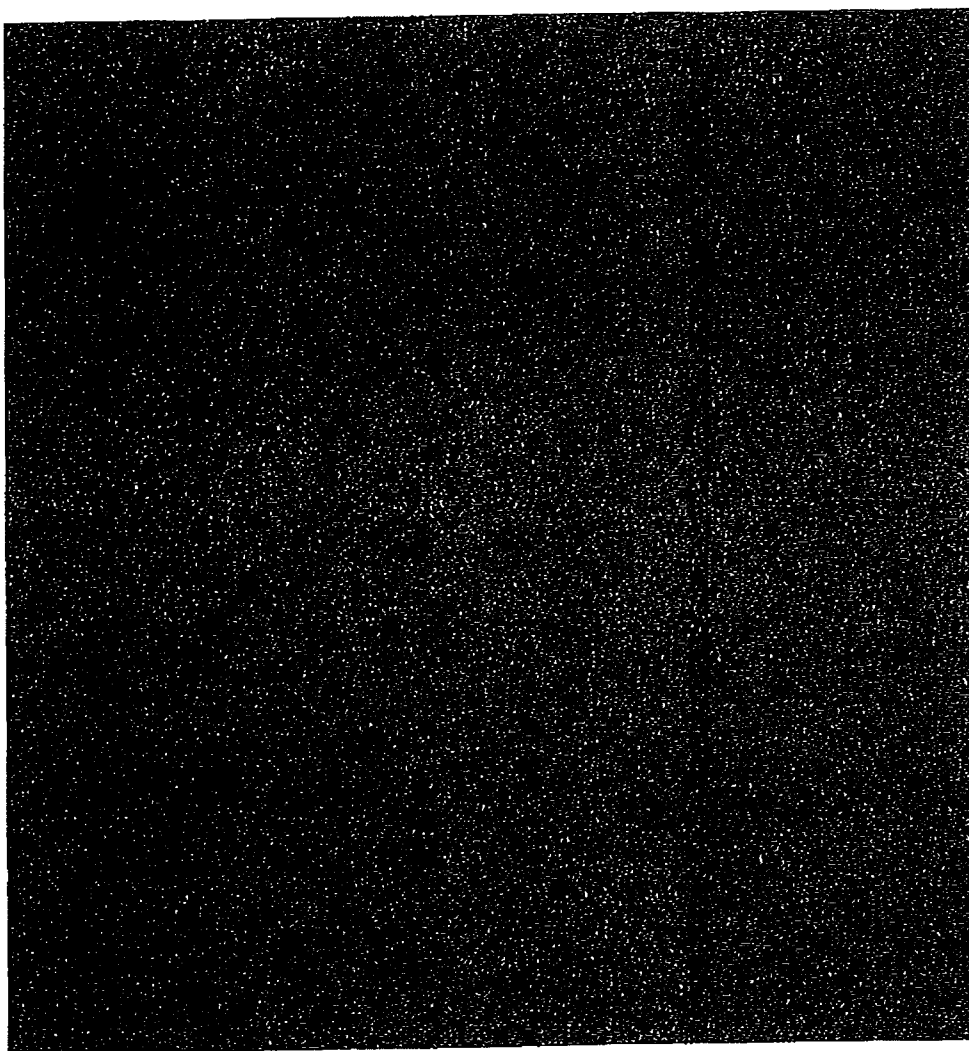
Rock Hill, South Carolina 29732

(803) 323-2894

From: PattersonMD, Richard
Sent: Wednesday, June 09, 2010 2:48 PM
To: West, Dianne
Subject: RE: Admissions to WT4

Is Dr. Edwards on the Credentials agenda? He was going to discuss the peer review committee's views regarding Dr. Randall.

C. Richard Patterson, M.D.
Chief Medical Officer
Piedmont Medical Center
222 South Herlong Avenue
Rock Hill, South Carolina 29732
(803) 329-6868



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PMC.00004920

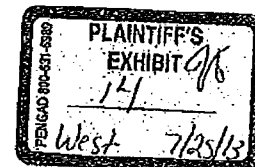
From: West, Dianne
Sent: Monday, August 30, 2010 4:43 PM
To: PattersonMD, Richard
Subject: External Peer Review - Dr. Randall

When the MEC was talking about any of the cases that are determined to need external peer review from the cases that you are reviewing for abdominal and herniorrhaphy, there was a comment made that they should go to the same group that did his cases before.

If we get cases that do not come out of the on-going review for external peer review, do I use the same reviewer or can it go to AllMed? Thanks

Dianne West
Director, Medical Staff Services
Piedmont Medical Center
222 S Herlong Avenue
Rock Hill, SC 29732
Telephone: 803-329-6868
Fax: 803-328-1785

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Telephone: 803-329-6868
Fax: 803-328-1785



CONFIDENTIAL

PMC.00005017

From: West, Dianne
Sent: Thursday, September 02, 2010 9:43 AM
To: PattersonMD, Richard; Miller, Charles
Subject: Agenda for MEC Meeting
Attachments: Executive Committee Agenda September 13, 2010.doc

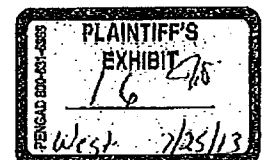
Dr. Edwards and I reviewed the agenda today and this is what is being suggested for the MEC meeting on 9/13/10. I am preparing copies of the
1) summary of peer review activities for Dr. Randall since July 2006, 2)
9 case summary that was prepared by Dr. Edwards when he presented to the Credentials Committee (he will go over these tonight), and 3) I will have copies of the Credentials minutes at the meeting which Dr. Jenkins will report from, and
4) Dr. Edwards asked that I have several copies of the external peer review of the 9 cases he will talk about but not to include them in the packet that goes to their office. I will have the Bylaws with me. Can you think of anything else that we should have at the meeting?

If you can respond today, I would like to get them copied and hand delivered to the physicians' offices since I will not be here tomorrow and Monday. Thanks

Dianne West
Director, Medical Staff Services
Piedmont Medical Center
222 S Herlong Avenue
Rock Hill, SC 29732
Telephone: 803-329-6868
Fax: 803-328-1785

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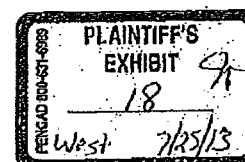
PMC.00005015

From: PattersonMD, Richard
Sent: Thursday, September 02, 2010 1:30 PM
To: West, Dianne; Miller, Charles
Subject: RE: Agenda for MEC Meeting

The content appears fine to me. I believe the items should be re-ordered so that the peer review segment is last. In order to maintain confidentiality, non-physicians will need to be excused at that time, so the other business items need to be concluded prior to that.

C. Richard Patterson, M.D.
Chief Medical Officer
Piedmont Medical Center
222 South Herlong Avenue
Rock Hill, South Carolina 29732
(803) 329-6868

>
>From: West, Dianne
>Sent: Thursday, September 02, 2010 9:43 AM
>To: PattersonMD, Richard; Miller, Charles
>Subject: Agenda for MEC Meeting
>
>Dr. Edwards and I reviewed the agenda today and this is what is being
>suggested for the MEC meeting on 9/13/10. I am preparing copies of the
>1) summary of peer review activities for Dr. Randall since July 2006,
>2) 9 case summary that was prepared by Dr. Edwards when he presented to
>the Credentials Committee (he will go over these tonight), and 3) I
>will have copies of the Credentials minutes at the meeting which Dr.
>Jenkins will report from, and 4) Dr. Edwards asked that I have several
>copies of the external peer review of the 9 cases he will talk about
>but not to include them in the packet that goes to their office. I
>will have the Bylaws with me. Can you think of anything else that we
>should have at the meeting?
>
>If you can respond today, I would like to get them copied and hand
>delivered to the physicians' offices since I will not be here tomorrow
>and Monday. Thanks
>
><< File: Executive Committee Agenda September 13, 2010.doc >> Dianne
>West Director, Medical Staff Services Piedmont Medical Center
>222 S Herlong Avenue
>Rock Hill, SC 29732
>Telephone: 803-329-6868
>Fax: 803-328-1785
>
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>communication without my permission. If you have received this



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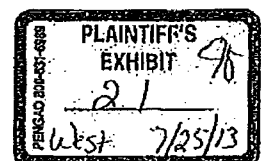
PMC.00004934

From: West, Dianne
Sent: Tuesday, September 14, 2010 5:00 PM
To: PattersonMD, Richard
Subject: Dr. Randall's Case - Mr. Jones

Dr. Edwards agreed that it should go to external peer review. I will keep check to see when he is discharged, and prepare it as soon as he is discharged.

Dianne West
Director, Medical Staff Services
Piedmont Medical Center
222 S Herlong Avenue
Rock Hill, SC 29732
Telephone: 803-329-6868
Fax: 803-328-1785

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Fax: 803-328-1785



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PMC.00005011

From: West, Dianne
Sent: Wednesday, September 29, 2010 1:42 PM
To: PattersonMD, Richard
Subject: New Case Review Results - Dr. Randall
Attachments: new case randall.PDF

This came back today on Mr. M [REDACTED]'s review. It was reviewed by the same general surgeon that reviewed the others according to AMR.

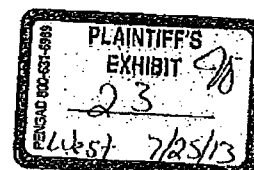
Should I make copies to have at the meeting for everyone on 10-4-10?
I'll show Dr. Edwards when he comes by.

In regards to the S [REDACTED] case, since he is still in-house, do you want me to have the chart copied from admission to today and go ahead and get it sent off? Or wait until he is discharged? Thanks

Dianne West
Director, Medical Staff Services
Piedmont Medical Center
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Rock Hill, SC 29732
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PMC.00005020

From: West, Dianne
Sent: Wednesday, October 27, 2010 1:57 PM
To: PattersonMD, Richard
Subject: MEC Minutes 10/25/10
Attachments: Medical Executive Committee Minutes 10-25-10.doc

Please review and revise as you deem necessary.

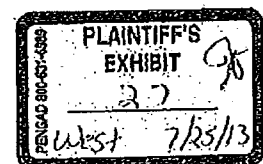
Do I need to ask AMR or AllMed about whether they have a general surgeon that would be able to serve on the hearing panel? If so, is there anything else such as their cost, etc. that I would need to ask?

I did give Charlie a copy of all the letters yesterday.

Dianne West
Director, Medical Staff Services
Piedmont Medical Center
222 S Herlong Avenue
Rock Hill, SC 29732
Telephone: 803-329-6868
Fax: 803-328-1785

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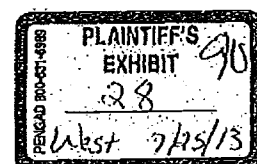
PMC.00005023

From: West, Dianne
Sent: Thursday, November 04, 2010 1:38 PM
To: PattersonMD, Richard
Subject: Final Review from AMR - J [REDACTED]
Attachments: AMR FINAL REPORT - J [REDACTED].doc

This was the last case that was sent to AMR for Dr. Randall. I will add this to the Peer Review Committee agenda for November 15th. Should a copy be shared with Dr. Randall now or wait until the Peer Review Committee has received it? I don't see that she has been readmitted since she was discharged.

Dianne West
Director, Medical Staff Services
Piedmont Medical Center
222 S Herlong Avenue
Rock Hill, SC 29732
Telephone: 803-329-6868
Fax: 803-328-1785

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PMC.00005030

EXHIBIT 4

Piedmont Medical Center
Medical Staff Bylaws

ARTICLE X

OFFICERS

Section 6 - Duties of Officers

- A. Chief of Staff: The Chief of Staff shall serve as the chief administrative officer of the Medical Staff to:
1. act in coordination and cooperation with the Chief Executive Officer in all matters of mutual concern within the Hospital;
 2. call, preside at, and be responsible for the agenda of all general meetings of the Medical Staff;
 3. serve on the Medical Staff Executive Committee as its Chairman;
 4. serve as a member of the Medical Staff committees as assigned (a designee, may fulfill this requirement);
 5. be responsible for the enforcement of Medical Staff Bylaws, Rules & Regulations, for implementation of sanctions where these are indicated, and for the Medical Staff's compliance with procedural safeguards in all instances where corrective action has been requested against a Practitioner;
 6. appoint committee members to all standing, special, and multi-disciplinary Medical Staff committees except the Medical Executive Committee and Credentials Committee
 7. represent the views, policies, needs, and grievances of the Medical Staff to the Board and to the Chief Executive Officer;
 8. be responsible for the educational activities of the Medical Staff;
 9. be the spokesman for the Medical Staff in its external professional and public relations; and
 10. serve as an Ex-Officio on the Board.
- B. Vice Chief: In the absence of the Chief, the Vice-Chief shall assume all the duties and authority of the Chief, until the return of the Chief from the absence. The Vice-Chief shall be a member of the Medical Executive Committee and the Clinical Quality Improvement Committee, which he/she will chair. The Vice-Chief shall automatically succeed the Chief when the latter fails to serve for any reason.
- C. Immediate Past Chief: The duty of the Immediate Past Chief is to function in an advisory capacity to the Staff Officers and to the Medical Executive Committee, of which he/she is a member.
- D. Secretary-Treasurer: The Secretary-Treasurer shall be a member of the Medical Executive Committee of the Medical Staff. The Secretary-Treasurer shall see that accurate and complete minutes of all Medical Staff meetings are kept, call Medical Staff meetings on order of the Chief, attend to all correspondence as needed, collect Medical Staff dues and submit timely financial reports to the Chief of Staff as requested, and perform such other duties for any Ad-Hoc Committee whenever it convenes, should his/her attendance be requested. The secretary-treasurer shall chair the Utilization Review Committee.



Piedmont Medical Center
Medical Staff Bylaws

ARTICLE X

OFFICERS

Section 7 - Removal of Officers

- A. Removal of a Medical Staff officer for cause may be initiated by a two-thirds majority vote of the active Medical Staff. Removal shall also require approval of the Medical Executive Committee.
- B. Each of the following conditions in itself constitutes cause for removal of a staff officer from office:
 - 1. Suspension from the Medical Staff.
 - 2. Having Medical Staff Privileges suspended if a license is suspended.
 - 3. Failure to adhere to professional ethics.
 - 4. Failure to comply with or support enforcement of the Hospital and Medical Staff Bylaws, Rules, and Regulations and Hospital policies.
 - 5. Failure to maintain Active Staff membership.

Section 8 - Compensation

A stipend may be provided annually to the Officers, Department Chairs and others at amounts as may be approved by the medical staff at a regular meeting of the medical staff.

EXHIBIT 5

CONFIDENTIAL

Piedmont Medical Center

Date: June 10, 2010

Committee: Credentials

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

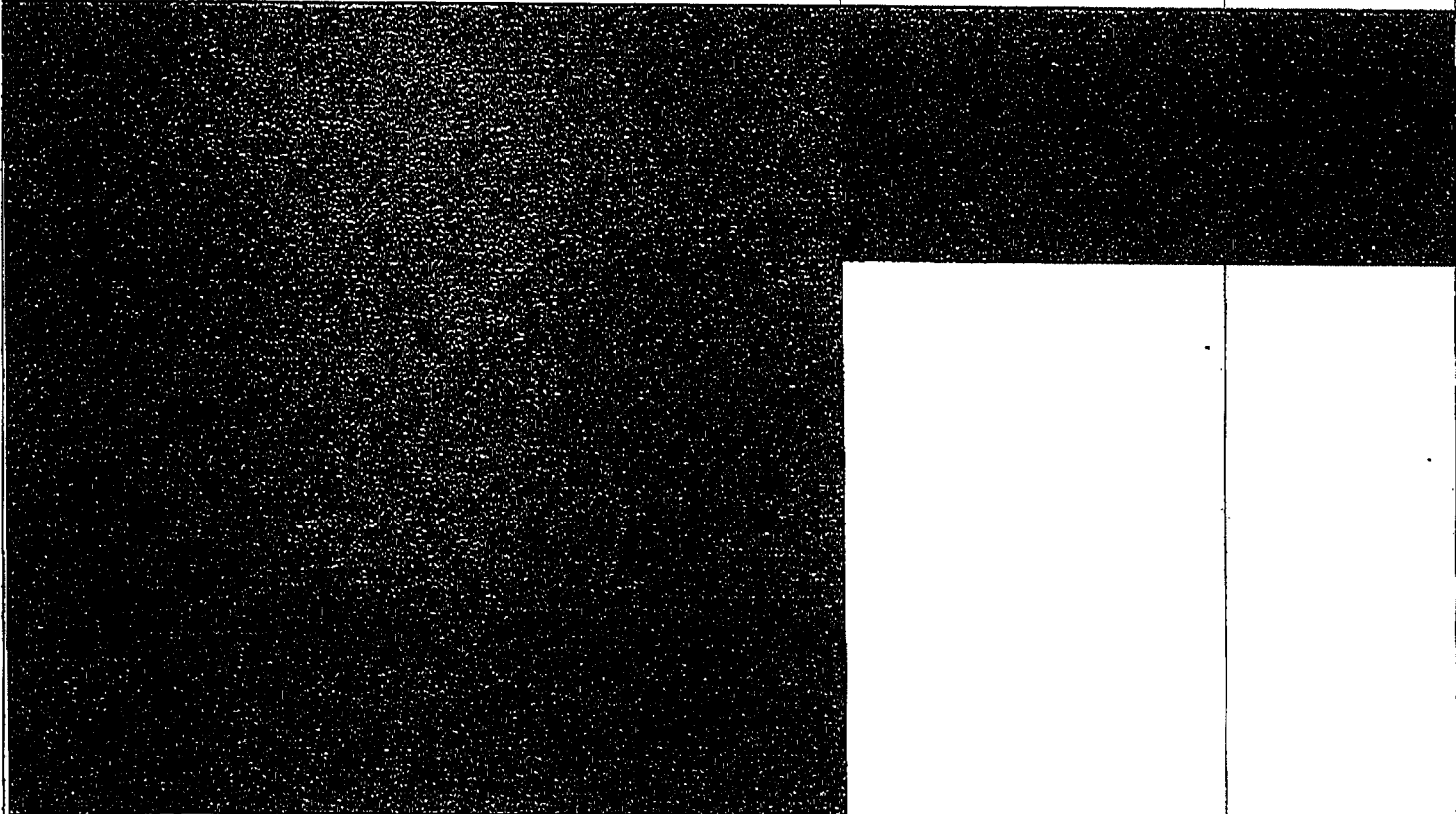
Earl Jenkins
Chairman

Agenda	Discussions/Findings	Conclusions/Recommendations	Action/Follow-up
Meeting Called to Order	The meeting was called to order by Dr. Jenkins, Chairman.		
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.

PLAINTIFF'S
EXHIBIT
5

CONFIDENTIAL

Credentials Committee
Page Two
June 10, 2010

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.		
			

PMC.00002995

EXHIBIT 6

Committee: Credentials

Members Present: Drs. Jenkins, Taylor and Patterson; Ms. Martin,
and Ms. West

Guests Present: Dr. Robert Randall

Date: July 13, 2010

Chairman

Agenda	Discussion/Findings	Conclusions/Recommendations	Action/Follow-up
Call the Meeting to Order	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 Presentations by Dr. Randall	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		



Credentials Committee
Page Six
July 13, 2010

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.	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.
Review of Medical Staff Appointment	Department of OB-GYN Paul Pietro, MD, Courtesy A	This request for medical staff will be recommended to the MEC.	Director of Medical Staff Services will forward recommendation to MEC in August

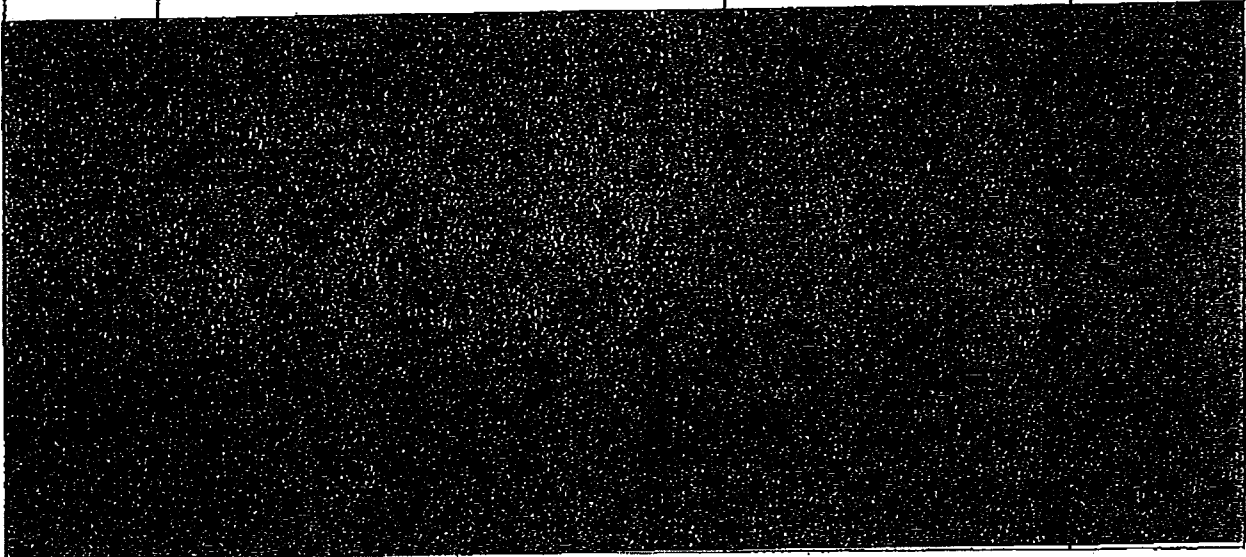
EXHIBIT 7

Committee: Medical Executive Committee

Date: August 9, 2010

Members Present: Dr. Baker, Benson, Billman, Edwards, Eller,
Grawal, Maynard, Paxton, and Pihls; Mr. Cline,
Mr. Douglass, Mr. Miller, and Mr. Permisson *and West*

[Signature]
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.
			



CONFIDENTIAL

PMC.00005364

Agenda	Discussions/Findings	Conclusions/Recommendations	Action/Follow-up
Credentials Committee Activities	The Credentials Committee recommended the following appointments, reappointments, OPPII, additional privileges and deletions for the Medical Staff and AHPs:	All appointments, reappointments, OPPII, additional privileges and deletions for the Medical Staff and AHPs will be recommended to the Governing Body, with the exception of:	CBO will present these appointments, reappointments, OPPII, additional privileges and deletions to the Governing Body at their August meeting.
		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	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.

Agenda	Discussions/Findings	Conclusions/Recommendations	Action/Follow-up
Credentials Committee Report Cont....	• Review of Medical Staff, On-Going Performance Practice Evaluation A. Robert D. Randall, Jr., MD, Department of Surgery, Sub-specialty of General Surgery, Active	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.	

EXHIBIT 8

ONE
Medical Staff ~~Two~~-Year Reappointment
Practitioner Name: Robert D. Raudall, Jr., MD

Credentials Committee Review

I have reviewed evidence of relevant training and experience; current competence (including information on Medical Staff Reappointment Profile for this time period), the application is:

☒ Recommended ☐ Not Recommended ☐ Deferred

Comments: _____

E. Jenkins, MD
Chairman, Credentials Committee

7-6-10
Date

Executive Committee Review

Based on the recommendation of the Credentials Committee and evidence of current competence (including information on Medical Staff Reappointment Profile for this time period), the application is:

☒ Recommended ☐ Conditionally Recommended ☐ Deferred

Comments: _____

[Signature]
Chief of Staff

8/18/10
Date

Governing Body Review

Based on the recommendation of the Executive Committee and evidence of relevant training and experience; current competence (including information on Medical Staff Reappointment Profile for this time period), the application is:

☒ Approved ☐ Not approved ☐ Denied

Comments: _____

[Signature]
Secretary, Governing Board

8-18-10
Date



CONFIDENTIAL

PMC.00001224

EXHIBIT 9

Date: September 13, 2010

Committee: Executive Committee

Members Present: Drs. Baker, Benson, Billman, Edwards, Eiler, Hubbard, Kessler, Maynard, McKinney, and Paxton, Ms. Douglass, Ms. Halterman, Mr. Miller, Dr. Patterson, and Mr. West

Guests Present: Drs. B. Jenkins from the Credentials Committee; Drs. Kessler, Ramos, and Raymond from Peer Review Committee

[Handwritten signature]

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.



PMC.00005359

Agenda	Discussion/Findings	Conclusions/Recommendations	Action/Follow-up
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 #018. 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 #018 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	

Executive Committee
Page 5
September 13, 2010

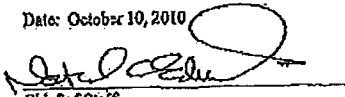
Agenda	Discussion/Findings	Conclusions/Recommendations	Action/Follow-up
MEC, Peer Review & Credentials Committee Review Continued....	As Chairman of the Credentials Committee, Dr. Jenkins advised that a letter had been prepared and submitted to the physician regarding the Committee's concerns with the 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.		

EXHIBIT 10

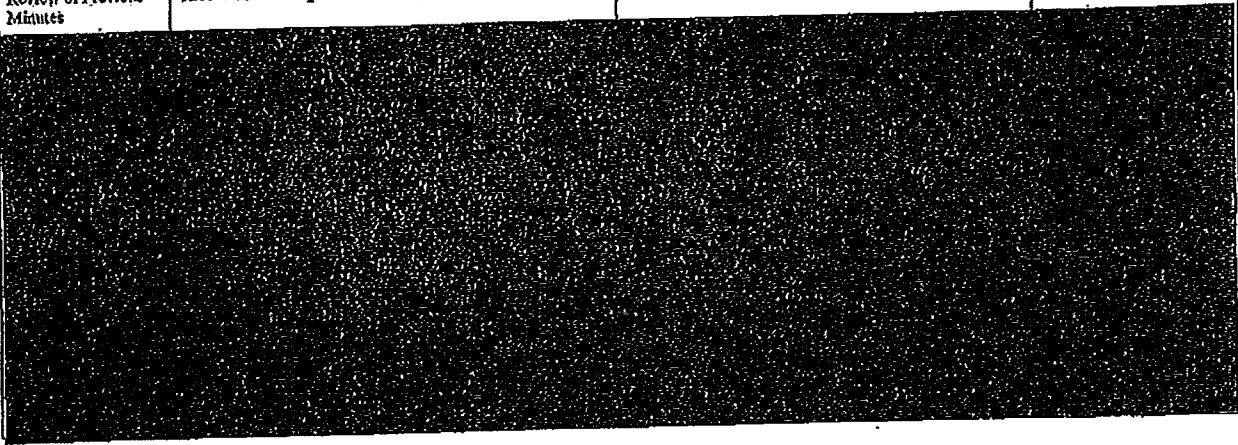
Committee: Medical Executive Committee

Date: October 10, 2010

Members Present: Drs. Benson, Billman, Edwards, Blitt, Grawal, Hubbard, Maynard, McKinney, Patterson, and Paxton, Ms. Cline, Ms. Douglass, Mr. Miller, Mr. Pennington, 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.
			



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PMC.00005346

Medical Executive Committee

Page 13 of 13

October 11, 2010

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 herniorrhaphy, 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.		

EXHIBIT 11



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.

EX 111



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PMC.00000588

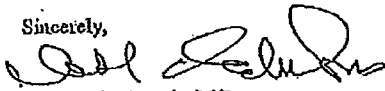
Robert D. Randall, Jr., M.D.

Page 2

October 15, 2010

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

EXHIBIT 12

26

10-25-10

MCC w/ Kandace

BAKER, Randall, Edwards, Singh, Jenkins, Pillai, Pastor, Benson, Patterson,

Call to Order 5:45 pm

Address Summary 10/15/10 Restriction of Privileges

I. R.

Only about Summary Suspension

Wants to take

Wants to Sustain Summ

Kandace

- Restriction Gen. Surgeon can't practice
- Report to Data Bank - Keep from practicing anywhere.

R.

12 yr. old - last necrotic gallbladder
Septic Sick from gallbladder
Bleeding

Obs - Recovered to go to Heaven South
Went to Heaven South due to



U.

Problems began 3 yrs by another surgeon
Family not involved
Nursing Home - debilitated condition

Chester considers in yr.
valley (ball size) hernia
All of bladder in hernia sac (sac) by
Dr. Livingston - mid line incision
Treated on back side of bladder from
front.

Dangerous w/ pyloroplasty not done
CT scan hard to do on N/H pts - for cancer

Back to pre-surgical baseline

Mouth plugs are std to close

5. [redacted] J. [redacted]

7/10 Massive vomit of blood, looked like
went to ICU - upper GI saw tumor mass w/
vessel in it - took to OR - open stomach
did not find anything.
Atx/

taking out some stomach - came back to his
office dehydrated

Complete Gastric Ect.

3 wks later back to surgery.

One pile butt stomach did not empty.
Back to OR.

Then went home.

Not completely eating now -

Taken to Dr. [redacted] at MUSC. [redacted] he
will improve.

After 3-4 hrs. one night [redacted] [redacted] [redacted]
[redacted] [redacted] - portions of needle broken
off - Have to go to OR w/ [redacted] copy. [redacted]
[redacted] & [redacted] - They are OK w/ [redacted]

Other Cases [redacted] about

① Toothpaste Pt

② 4 Recruits - Bone Resection - [redacted] - radial
Asteroidis - [redacted] Assist - [redacted] pt -
28 yrs of doing this - no other [redacted]
[redacted]

③ J. [redacted] - She [redacted] [redacted] [redacted]
[redacted] [redacted] [redacted] [redacted] [redacted] [redacted]

D. [redacted] cont

Back to group home

Why not please take 1st surg. With it he d

J. [redacted] [redacted]

Mass removed gallbladder — removed + also colon

Mike Cowan — Not a problem

Base like status

J. [redacted] W. [redacted]

Abd. pain — incarcerated hernia — Tachycardia ⁱⁿ Rk

Dense fluid

Back to OR — Colectomy

Homeless stayed 6-8 wks.

Back to OR

Went to MUSC.

C. [redacted]

Mass + Cholelithiasis

Next day to creative to (care)

Turned over to C. Crain Concern of Bowel Injury

CT SCAN — Corey believed CT instead of pt

Sam — Angry — told him could not operate — no procedure.

Mailed by him + Corey

Pt Expired

W. [redacted]

Appendectomy — 2 days J/c — Back to ED

Picked up by Schroeder — never told — Revel

Picked up — pt arrested. Chest x-ray — free

air — Call Schroeder — not ans. bandage — not

on case — He took to surgery — Dead cecum

12 days after 1st surg. Autopsy —

Don't know what he would do differently

B. Cont. since 1983

Memorial Mission — No problems in Ashville

Pathologists + Anesthesiologist know who can
operate.

He stated he can only operate - if goes to
NPD13 - he will not be able to practice -

Don't feel res. me. equitable w/ my
local record - the last 3 cases - nothing
wrong.

Dr. Randall was appeared at 6¹⁵ pm.

~~9-11-68~~ Lap Chole. 11 units blood
Intubated 1st 48 hrs
Large collection of blood under the pancreas

Did not take back to surgery.

Not recognized & treated timely.

Dr. Patterson (Bladder Case)

Reviewed & chart indicates there
was an injury.

to uphold, modify, or Cont (See
letter)

Parlor - ^{Appears} Everyone is wrong
He is right } Dr. Randall
Appears

B

Technical Skills nothing
Judgment change
Skill need
free to
uphold

Jenkins - Told him that Randace did not see anything wrong w/ those 3 cases -

Benson - His #s compared to other Surgeons

Equal Case - not more better than other surgeons

Significant about Nova

Upheld restrictions

Unanimous

He requested a formal hearing - Name of your ~~name~~ can be involved.

5 members

MEC agreed to let ^{Randace cover} Törnqvist - need triage would put (H) - not his prob but not

It came to ED - he can't be ~~let~~

Only 1 Vascular Surgeon

Benson left
6:45 PM

Dr. P. to talk to Dr. Törn

Covering Practice (give list to ED)

need to identify - Prosecutor

General Eng. or Hearing Committee
outside

Could ask AMR or AllMed

PMC
Office
Hear
Atty &
G. Surg.

hard del.
Notified by letter that NEC to
restrain the sum. restriction
(privileges).

Thanked for coming

EXHIBIT 13

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BEFORE THE PIEDMONT MEDICAL CENTER
HEARING COMMITTEE

IN THE MATTER OF
ROBERT D. RANDALL, JR., M.D.

VOLUME II

DATE: February 17, 2011

TIME: 5:44 p.m.

LOCATION: Piedmont Medical Center
222 South Herlong Avenue
Rock Hill, South Carolina

REPORTED BY: YVONNE R. BOHANNON
Registered Merit Reporter,
Certified Realtime Reporter

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RANDALL 0659



1 Q. But you're -- you're not aware of any
2 specific communication that has been made?

3 A. I am not aware of any other specific
4 information or communication. I am just making my
5 statement for the record.

6 MS. KREBS: Okay. Thank you, sir.

7 THE WITNESS: Thank you.

8 MR. COOKE: Any -- panel have any
9 questions?

10 THE WITNESS: Thank you for your time.

11 MR. COOKE: Thanks.

12 MR. McKAY: Thank you.

13 THE WITNESS: Am I dismissed?

14 MR. McKAY: Yes. Appreciate it.

15 We'd call Dr. Benjamin Tribble.

16 JAMES BENJAMIN TRIBBLE, M.D.,
17 being first duly sworn, testified as follows:

18 EXAMINATION

19 BY MR. McKAY:

20 Q. Would you state your full name and your
21 medical address, please.

22 A. James Benjamin Tribble, M.D. Medical
23 address, 1850 Laurel Street, Columbia, South
24 Carolina.

25 Q. And what is your surgical specialty?

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RANDALL 0671

1 A. General and vascular surgery.

2 Q. Do you practice both general and
3 vascular surgery?

4 A. I do.

5 Q. And where -- where -- where did you go
6 to medical school?

7 A. Vanderbilt.

8 Q. And where did you go -- and when did
9 you finish?

10 A. 1983.

11 Q. And where did you do your residency and
12 fellowship?

13 A. I did my residency at Wake Forest
14 University.

15 Q. Generically called Bowman Gray?

16 A. It -- it was Bowman Gray at the time,
17 that's right.

18 Q. And how about your vascular surgery?

19 A. At that time there was no vascular
20 surgery boards, and so I have no -- no fellowship
21 in that.

22 Q. All right, sir. You were trained in
23 both at the time?

24 A. I was.

25 Q. And you're board certified?

1 A. I am board certified in surgery.

2 Q. Okay. And -- and have you recertified?

3 A. A couple of times.

4 Q. All right, sir. And what hospitals do
5 you have privileges in?

6 A. Palmetto Health Baptist, Palmetto
7 Health Richland, Providence Hospital, and
8 Providence Northeast Hospital.

9 Q. Those are the four hospitals in the
10 greater Columbia area?

11 A. They are. Yes, sir.

12 Q. And how many surgeons are in your
13 group?

14 A. There are nine.

15 Q. Nine.

16 And have you had -- you have been chief
17 of surgery or had positions within various hospital
18 staffs?

19 A. I have.

20 Q. And what positions have you held?

21 A. I've been chief of surgery at Palmetto
22 Baptist and chief of staff at Palmetto Baptist.

23 Q. So you are familiar with these types of
24 issues, peer review, that type of thing?

25 A. Yes, I am.

1 Q. I assume you had to be a part of these
2 types of hearings before?

3 A. Yes, sir.

4 Q. All right, sir. Now, I -- I asked you
5 to review ten cases that have come up for the --
6 Dr. Randall has been criticized for exercising
7 surgical care that's beneath standards -- the
8 standard of care. Do you understand that?

9 A. Yes, sir.

10 Q. And are you familiar with standards of
11 care for surgeons?

12 A. Yes, I am.

13 Q. And do you have -- do you work with
14 residents in your practice?

15 A. I -- I do. Not on a daily basis, but
16 certainly from time to time and I have been
17 recently.

18 Q. Would that be Palmetto Richland
19 primarily or --

20 A. Yeah, from -- those from the Palmetto
21 Health Richland and Dorn VA Hospital.

22 Q. The USC School of Medicine?

23 A. Yes, that training program.

24 Q. All right, sir. And what medical
25 societies are you a member of?

1 A. American Medical Association, the
2 American College of Surgeons, and the Columbia
3 Medical Society, the South Carolina Medical
4 Society -- Association. I think that's -- American
5 Society for Bariatric and Metabolic Surgery [sic].

6 Q. All right, sir. And your dad was a
7 surgeon; is that correct?

8 A. That's correct. Uh-huh.

9 Q. And your brother -- you have a brother
10 that's a surgeon?

11 A. Well, two brothers who are surgeons,
12 uh-huh.

13 Q. All right, sir. Now -- excuse me.
14 The -- generally -- and you reviewed
15 ten cases; is that correct?

16 A. Yes.

17 Q. And it's -- I mean, I'm not going to
18 ask you on page 4,000 of --

19 A. That -- that might be difficult.

20 Q. -- read what was said on the seventh
21 line. That would just be impossible to do; is that
22 correct?

23 A. I -- I think so. That's a lot of cases
24 to look at.

25 Q. We've got 40,000 pages of records; is

1 that correct?

2 A. Yes, sir.

3 Q. You primarily reviewed the surgical
4 care, whether there were complications, the
5 surgical techniques, things of that nature?

6 A. As -- as best I could as represented in
7 the operative note and discharge summary and
8 progress notes.

9 Q. All right, sir. Do you have an opinion
10 based upon a reasonable degree of medical certainty
11 whether Dr. Randall complied with accepted
12 standards of surgical care with respect to these
13 ten patients? And I'm going to break them down a
14 little bit.

15 A. Yeah. I -- I think as a general rule,
16 though there were complications, for the most part
17 that the care was -- was meeting the standard of
18 care.

19 Q. All right, sir. How about general
20 surgery itself? It's a difficult field, is it not?

21 A. It is. And I'm sure the other fields
22 are difficult as well.

23 Q. And some patients are much more
24 difficult than others?

25 A. No question.

1 Q. And some of these patients were very
2 complex patients, were they not?

3 A. Some -- some of them were very complex,
4 yes.

5 Q. You had a few people who were morbidly
6 obese, a lady who had cerebral palsy and lots of
7 complicated problems?

8 A. That's true.

9 Q. The first case I'd like you to talk
10 about is the R [REDACTED] C [REDACTED] case. Do you have
11 that one in front of you?

12 A. Yes, I have that one.

13 Q. All right, sir.

14 MR. McKAY: And I hope I'm going in the
15 right order. I know Dr. Hicklin jumped around.

16 MR. COOKE: Yeah, we'll figure it out.

17 MR. McKAY: And -- but I think on the
18 letter to Dr. Randall of December 17th I'm going to
19 go in that order if that's okay --

20 MR. COOKE: Sure.

21 MR. McKAY: -- the best I can.

22 MR. COOKE: What exhibit number is that
23 again just in case we want to follow it?

24 MR. McKAY: Mine does not have a number
25 on it. It's the December 17th letter to

1 Dr. Randall, It's in that stack --

2 MR. COOKE: Yeah.

3 MR. McKAY: -- from Dr. Edwards.

4 MS. KREBS: It's Exhibit 4 of the MEC
5 exhibits.

6 MR. COOKE: Exhibit 4?

7 MS. KREBS: Yes.

8 MR. McKAY: Unless the Board wants to
9 go in some other order -- and it's kind of --
10 yesterday the expert for the hospital jumped around
11 and it wasn't in the order that the doctors got
12 them in. I really don't care which order we go in.

13 MR. COOKE: Anybody have a preference?

14 MR. McKAY: Okay.

15 MR. COOKE: Just do whatever makes more
16 sense for you.

17 MR. McKAY: All right, sir.

18 BY MR. McKAY:

19 Q. Well, the first case is R [REDACTED]

20 C [REDACTED] is that correct?

21 A. Yes.

22 Q. Okay. And the initial complaint was
23 that the -- the operative procedure was substandard
24 or shouldn't be done and that it subjected the
25 patient to unnecessary complications.

1 A. That's right.

2 Q. Okay. Now, Mr. C [REDACTED], what were
3 his problems? He had an obstruction and a dilated
4 colon?

5 A. That's correct, uh-huh.

6 Q. And there was a criticism that
7 Dr. Randall took him to surgery rather than just
8 observed him. What -- what's your feeling on that?

9 A. I --

10 Q. What's your opinion?

11 A. As I read the criticism, I think the
12 criticism was that the first procedure was maybe
13 not the right procedure, and that is that at least
14 in this document where -- anyway, and according to
15 this document which I think came from the Piedmont
16 Medical Center, I guess the Medical Exec
17 Committee -- I don't know exactly -- maybe the
18 initial procedure was not the right one, but
19 instead it should have been a colostomy.

20 Q. All right. And what is your opinion on
21 that?

22 A. I -- I think that's a judgment that
23 really needs to be made by the surgeon at the
24 table. It's a bit hard for me to second guess
25 that.

1 But I will say this, that in the end
2 when he took out colon and especially additional
3 colon tissue, there were ischemic and necrotic
4 areas. Not -- not just ischemic, but necrotic skip
5 areas in the colon making me think that -- that his
6 initial thought of taking out at least some of the
7 colon was a better option than doing a colostomy.

8 Certainly anyone that's -- that's
9 trained in surgery or gastroenterology would know
10 that a full thickness necrotic area in the bowel
11 is -- is not a good thing to leave in somebody
12 because it will ultimately perforate and -- and
13 lead to peritonitis.

14 And ultimately the pathology report did
15 show skip areas of necrosis which is admittedly
16 difficult sometimes for a surgeon to see grossly at
17 the -- in the operating room, but is not difficult
18 for a pathologist to see. And it is for that
19 reason that sometimes surgeons take people back to
20 the operating room to second look them to look
21 again to see whether something that may have looked
22 suspicious is now frankly necrotic.

23 And the best I can tell from read --
24 looking at this record, that's precisely what took
25 place here was second look type procedures to see

1 if there were areas of necrosis in the bowel.

2 Q. And this patient in fact had three
3 planned procedures, did he not?

4 A. I think that's right.

5 Q. It was not one procedure, then two
6 additional emergency procedures; it was -- all
7 three of these procedures were planned because of
8 the --

9 A. That's -- that's my recollection
10 from -- from reading the record.

11 Q. And the -- the necrotic -- the ischemic
12 necrotic areas, were those most likely caused by
13 this stool that was impacted in there and swelled
14 his bowel up?

15 A. Yes. The -- the mechanism of that is
16 there -- the bowel will be obstructed and will
17 swell, develop tension on the wall to the point
18 that -- that arterial blood flow can't always get
19 into all parts of it, and some parts may be at more
20 risk than others because of the -- of the
21 distribution of the arterial system, and so you may
22 have skip areas of necrosis.

23 Now, it's easy for a surgeon when you
24 look in there and you see something that's frankly
25 black and dead and smells bad, we know that has to

1 come out, but if -- if the bowel looks kind of
2 normal but there's some areas that look a little
3 suspicious, it's hard to tell, and it's a judgment
4 a surgeon has to make at the operating table about
5 is this best managed by taking this out.

6 And another issue is, my understanding
7 on Mr. O [REDACTED] was that he had a history of
8 chronic constipation, and that being the case,
9 it's -- it's not a bad move to remove some of the
10 colon at the time of -- of the initial procedure
11 and the initial colostomy.

12 Q. So --

13 A. He did get a colostomy at the first
14 operation.

15 Q. Yes. So talk about short bowel
16 syndrome where you have to go to the bathroom more
17 often, but in his case it would probably be better
18 for his health if he were able to go to the
19 bathroom?

20 A. Yes. But I -- I would not be thinking
21 in terms of short bowel syndrome because that's
22 something we -- we talk about when we're talking
23 about small intestine issues. But a person who is
24 suffering with -- with chronic constipation not
25 uncommonly will do much better with -- with less

1 colon.

2 Q. Okay. All right, sir. And do you
3 believe the surgical care was appropriate in that
4 case?

5 A. From my review of the record, yes, I
6 believe it was.

7 Q. Now, there was a criticism that
8 Dr. Randall mishandled the colon and that caused
9 the vascular problem. Do you see any evidence of
10 that there?

11 A. I -- I don't. I don't know how I would
12 see evidence of that, though. I don't know how
13 anyone would unless there was somebody there with
14 him in the operating room that -- that knew
15 something about surgery. And I do understand that
16 the colostomy ultimately became necrotic, but based
17 on what I saw in the pathology report, there's a --
18 there's a ready explanation for that, and that is
19 that this man had skip areas of necrosis, and one
20 of those areas very likely was the colostomy.

21 Many of you in the panel know that the
22 colostomy is going to be in a little bit of a
23 compromised situation in the best of circumstances
24 because you've already divided the mesentery right
25 there at it to get it to come to the skin. And

1 when you do that, that's -- that area is going to
2 be at more risk than others.

3 So let's say it was a bit compromised
4 to start with, then it's going to be more
5 compromised when a colostomy is created, something
6 any surgeon understands.

7 Q. All right, sir. And you believe the
8 care was within the accepted standard of care of
9 this patient?

10 A. From my review of the record. Of
11 course I wasn't there and I have the papers to look
12 at, and it looks like -- looks like good care to
13 me.

14 Q. Okay. Now, the second patient I wanted
15 to talk about was W███████ C███████. That was an
16 appendectomy with a bowel injury that was missed;
17 is that correct? No. I'm sorry. I'm sorry.

18 That was -- that was a laparoscopic
19 cholecystectomy and lysis of adhesions.

20 A. Yes, sir.

21 Q. In that case a criticism was made that
22 Dr. Randall should have just done the
23 cholecystectomy and should not have gone to further
24 dissect some areas in the lower bowel. I believe
25 there may have been a suspicion that it could have

1 been a tumor or cancer.

2 A. As best I can tell from the -- from the
3 one paragraph allegation that it is something like
4 that. It says -- addressed to Dr. Randall, "You
5 exercised substandard judgment in further
6 dissecting previously operated upon bowel in the
7 right lower quadrant. Such bowel not apparently
8 contributing to the primary indications for the
9 surgery."

10 My understanding was that CT scan
11 had -- had suggested there was a cystic mass in
12 the --- in the right lower quadrant that was not --
13 did not have a clear etiology as to what it was,
14 and certainly in my practice and I think in -- in
15 many surgeons' practice, it's not uncommon when you
16 have laparoscope in somebody to look at that
17 situation to try to determine what is the cause of
18 the cystic mass that has been identified on CT
19 scan.

20 So based on that, I -- I don't find
21 that alarming that he would choose to look at the
22 right lower quadrant and dissect that bowel.

23 Q. In retrospect in this case apparently
24 there was an injury to the bowel, was -- was there
25 not, or an injury of some sort?

1 A. I -- I think that's right.

2 Q. And it was not recognized by
3 Dr. Randall at the time; is that correct?

4 A. It was certainly not recognized at the
5 time of the -- of that operation because I'm sure
6 he would have -- would have addressed it by fixing
7 it.

8 Q. The patient got sicker and sicker with
9 other people caring for him, and then ultimately he
10 had a second surgery and then -- and dies?

11 A. Yeah, frankly I can't remember
12 precisely the -- the course of events, but I
13 believe that -- that there was a transfer in -- in
14 call maybe on the weekend or something, and others
15 in the group were -- were involved in -- in making
16 the rounds and assessing his situation and were
17 involved.

18 But I do -- my understanding is that
19 the peritonitis and sepsis that resulted from
20 the -- the bowel perforation ultimately led to his
21 death.

22 Q. Thank you, sir.

23 Now, the next patient, C[REDACTED]

24 E[REDACTED] --

25 A. Yes, sir.

1 Q. -- you got that one?

2 Now, this one was a 320-pound man with
3 hernias and bowel obstruction.

4 A. That's -- that is my understanding.

5 Q. Okay.

6 A. I understand he had a CT scan that
7 showed an incarcerated hernia that was causing him
8 pain.

9 Q. Now, there was a criticism of
10 Dr. Randall even operating on this patient and not
11 just having him observed. Do you have an opinion
12 based upon a reasonable degree of medical certainty
13 whether that's proper to go ahead and do surgery on
14 him?

15 A. Well, the -- the allegation is that he
16 elected to operate on a man in spite of high risk
17 factors. But the best I can tell from looking at
18 this case, you know, you don't always have a --
19 have a choice of -- of who your patient is going to
20 be. You have to look at -- at the whole process
21 and make a decision as to whether it's better to --
22 to leave the -- the hernia as-is, possibly
23 subjecting him to complications of -- of eventual
24 hernia which might be bowel infarction, for
25 example, or -- and/or continued pain and/or

1 continued expansion of a hernia.

2 There's certainly not much you're going
3 to be able to do about the substantial risk factor
4 of a man being -- being 320 pounds. It's -- it's
5 highly unlikely that you're going to be able to
6 change that in preparation for an operation.

7 So I -- I have not seen, you know, what
8 it is that would cause a surgeon to say that this
9 man doesn't need an operation.

10 Q. All right. This man had had a bowel
11 obstruction and had had a previous anastomosis at
12 some other surgeon's hands earlier?

13 A. I -- I do recall that having been the
14 case, and I think he'd had ventral hernia repairs
15 in the past. So it was -- I'm sure Dr. Randall or
16 anyone else going into that case didn't think this
17 was going to be easy.

18 Q. It wasn't?

19 A. It obviously was not.

20 Q. All right, sir. Do you have an opinion
21 based upon a reasonable degree of medical certainty
22 that Dr. Randall most probably complied with the
23 standard of care for surgeons in his treatment of
24 Mr. Erickson?

25 A. You know what, I mean, this -- this

1 case became very complicated as you know. There
2 was a -- a small bowel fistula that -- that
3 occurred and repeat expiration, the bringing out of
4 either ileostomy or jejunostomies to the skin. I
5 mean, that's -- that's a nightmare for a surgeon.
6 It's a very difficult situation for the surgeon and
7 for the patient.

8 Now, you know, the -- if the question
9 is did he repair the bowel properly or -- or do a
10 proper anastomosis. I mean, clearly I -- I was not
11 there to make a judgment about that. But what I do
12 know is that -- is that all surgeons have that
13 complication from time to time, that is, two things
14 that you've sewn together don't stay together quite
15 right. Something leaks, and once it starts
16 leaking, it often leads to an entire rupture of it.

17 And I can't know from -- from looking
18 at a record whether it was because of -- of
19 inattention to detail in -- in the course of
20 operating or whether it was a complication of
21 anastomotic breakdown that -- that any surgeon has
22 been around for very long has -- has experienced.

23 Q. And small bowel fistula -- fistulas,
24 are they rare?

25 A. No. They're -- I don't have one in the

1 hospital right now, but they're not rare.
2 Q. Is it something you deal with ---
3 A. I deal with --
4 Q. -- pretty frequently?
5 A. -- pretty regularly.
6 Q. Okay. I think there was some testimony
7 that they were extremely rare or something like
8 that?
9 A. They -- they're -- they're not rare for
10 general surgeons and -- but I'm not saying that --
11 that they're all caused by a surgeon's anastomosis
12 that failed. I mean, sometimes it's from -- from
13 Crohn's disease. It can be from other -- other
14 things. But small bowel fistula is something
15 that -- that all general surgeons are accustomed
16 to -- to dealing with in trying to -- in trying to
17 manage. And -- and they often have to be managed
18 for a considerable period of time before they can
19 be definitively -- definitively repaired.
20 Q. And -- and this man had --- is it two
21 surgeries or three surgeries? Three? Three
22 surgeries. I'm sorry.
23 A. I -- two or three. I can't testify to
24 that exactly right now.
25 Q. One of the surgery -- later surgeries I

1 think Dr. Randall had Dr. Crain also look at it and
2 make sure -- get his input on the repair?

3 A. I think that's right, as an assistant
4 and maybe an advisor, and I believe the -- the
5 patient was ultimately referred to Duke to -- to
6 remedy the problem.

7 Q. All right. And you believe that the
8 care of this complicated patient was within the
9 surgical standard of care?

10 A. You know, again, from -- from looking
11 at the record, I -- unless there's something else
12 that I don't know, I -- I don't see a deviation
13 from the standard of care.

14 Q. Thank you.

15 Now, the next patient is a very -- it's
16 a sad case. It's D [REDACTED] S [REDACTED]. It's case number
17 five. She's the lady with cerebral palsy.

18 A. Yes, sir.

19 Q. That's a very long record. This --
20 this lady was taken back to surgery maybe 20 times.
21 It's hard to even know how many times. Is that
22 correct?

23 A. It -- it was a number of times. I -- I
24 don't remember how many either.

25 Q. These were planned -- most of these

1 were planned surgeries for washouts because she's
2 both retarded and schizophrenic and also retorted
3 because of her medical condition of being bedridden
4 her entire life.

5 So this is not a patient you can clean
6 at the bedside basically, is it?

7 A. No. No.

8 Q. Okay. There was some criticism of
9 Dr. Randall --

10 A. Let me clarify --

11 Q. I'm sorry.

12 A. I'd just like to clarify one. My
13 understanding was -- I -- I don't think it was
14 cerebral palsy. I believe she had a posterior
15 fossa tumor.

16 Q. This was the cerebral palsy --

17 A. Who are we on?

18 Q. D██████ S██████

19 A. Oh, okay. I'm sorry.

20 Q. I'm sorry, we got -- might have got
21 them --

22 A. I think we skipped over one in this
23 or -- anyway.

24 Q. Yeah, I'm sorry, J██████ P██████. I did.
25 Let's -- let's -- number five. I apologize.

1 A. Number four on my list is -- is P [REDACTED]
2 and number five is S [REDACTED].

3 Q. Okay. Well, J [REDACTED] P [REDACTED]. I
4 apologize. This is a lady who had the shunt in
5 the -- brain shunt?

6 DR. RANDALL: Uh-huh.

7 A. Yeah, she did have a shunt and she had
8 had a posterior fossa tumor. I think -- I think it
9 was resected by a neurosurgeon, if I'm not
10 mistaken, and it's left her with disability,
11 dysarthria, left hemiparesis, permanent --
12 permanent PEG tube if I'm not mistaken and a -- and
13 a ventriculoperitoneal shunt.

14 BY MR. MCKAY:

15 Q. And Dr. -- Dr. Randall started with a
16 laparoscopic cholecystectomy on this patient, did
17 he not?

18 A. That's correct.

19 Q. And she had -- she had gallbladder
20 disease and needed a -- needed surgery; is that
21 correct?

22 A. She did. She had a lot of pain, CT
23 scan showing a thickened gallbladder, and a white
24 count of 20,000.

25 Q. All right, sir. And that -- does that

1 indicate surgery?

2 A. I mean, it -- unless there's something
3 else causing those things, then, yes, I see no --
4 no criticism of his -- of his indications there.

5 Q. Okay. How about the decision to do
6 it -- to start laparoscopically as opposed to open
7 procedure?

8 A. I -- I think that's appropriate.

9 Q. That's probably more laparoscopic now
10 than maybe, --

11 A. Yeah, I'd say that's actually the
12 standard.

13 Q. Okay. All right, sir.

14 And then during the surgery I think
15 there was a -- in opening her up I think the tube
16 with the shunt got some type of injury to it; is
17 that correct?

18 A. That's correct. What I understand is
19 that the -- the tubing was coming down from the --
20 from the brain on her left side, but presumably
21 because of a PEG tube in place there, the
22 neurosurgeon tunneled it and diverted it over to
23 the right side. And that was unexpected and the
24 tube was encountered and divided.

25 And also my understanding is that

1 didn't create a big problem in that there was a
2 handy repair kit that the neurosurgeons told
3 Dr. Randall about and allowed him to fix the tubing
4 and proceed on with the operation.

5 Q. And was the -- now, there was some
6 criticism that he called the -- some of the
7 material necrotic. Is that -- did you ever see
8 that?

9 A. Yeah, I think there was a question of
10 his calling the gallbladder necrotic and the -- and
11 the colon necrotic by gross examination.

12 Q. Do you see a problem with that?

13 A. Well, not -- not particularly. I mean,
14 it's -- you know, I guess we wouldn't need
15 pathologists if -- if we could every time make the
16 call precisely ourselves by grossly looking at
17 things.

18 There is a notation made in the
19 complaint that in fact turned out the colon was not
20 necrotic, that -- that the gallbladder was but the
21 colon wasn't. But when -- when there's one
22 necrotic organ in proximity to another one that may
23 be inflamed or -- or disturbed in other ways, it
24 can -- it can make other things look necrotic by
25 staining of tissues and so on. It's not a -- it's

1 not a leap of faith at all to -- to think that it
2 may have appeared necrotic and appeared possibly
3 unsafe to leave in place.

4 You know, we actually have been over
5 this on the other case that had skip areas of
6 necrosis. This patient did have a white count of
7 20,000 which is really a bit higher than you
8 usually see with gallbladder problems. You do see
9 it sometimes.

10 But, you know, I -- I certainly have
11 found myself in situations where I'm looking at the
12 colon in particular more -- more likely than small
13 intestine and -- and finding that it's hard to tell
14 whether it's viable or not. The colon is -- is a
15 bit different than the small intestine in that it's
16 got a lot of camouflage on top of it, and by that I
17 mean fat. A lot of -- even in normal size people
18 there's a lot of fatty tissue over it making it
19 hard to -- sometimes to make a determination about
20 viability.

21 Q. And you believe that Dr. Randall
22 complied with accepted standards of care in his
23 care and treatment of J█████ P█████ll?

24 A. You know, again, from -- from the
25 record I have and comparing the -- the allegations

1 to the record, I -- I don't see where these
2 allegations hold water.

3 Q. Thank you.

4 Then the next patient, I'm sorry, I
5 skipped was D [REDACTED] S [REDACTED]. Tell -- tell the panel
6 about D [REDACTED] S [REDACTED]

7 A. My understanding is that she was a --
8 or is in her 20s, suffers from mental retardation
9 from cerebral palsy and also has schizophrenia.
10 That's the one we were alluding to earlier.

11 Like a lot of patients with cerebral
12 palsy she had developed a large hiatal hernia even
13 at a young age, a very large paraesophageal hernia.
14 And the problem at her rest home was that she was
15 vomiting everything. And these -- these patients
16 not uncommonly are -- are brought to the operating
17 room for repair of the large hiatal hernia to
18 basically try to remedy the problem.

19 So she did have that done.

20 Q. And the criticism --

21 A. From my --

22 Q. I'm sorry.

23 A. From my review of the record I think it
24 was a -- I know it was a laparoscopic operation,
25 but I think largely because of her contractures

1 and -- and the limited space in her abdomen because
2 of her contractures and -- and maybe legs being in
3 the way -- I've been there before. I know how that
4 can be. It was converted to an open operation to
5 bring the -- bring the stomach down out of the
6 chest and -- and fix the hiatal hernia.

7 Q. Is that a complicated surgery on a
8 patient like this?

9 A. It's a -- it's a pretty big deal, I
10 guess. Yes.

11 Q. And there was some criticism that he
12 didn't put a PEG tube in. Does that hold any
13 water?

14 A. Well, I saw the criticism of -- of no
15 gastrostomy tube being placed, and, you know,
16 sometimes a -- it had mentioned that a
17 percutaneous -- it says percutaneous tube
18 gastrostomy which is not really what it is. It
19 would be a surgical gastrostomy.

20 That can be placed in these situations
21 to anchor the stomach in place, that is, to fixate
22 it to the abdominal wall thus prohibiting it from
23 sliding back up into the chest. And -- and
24 sometimes people do that, and from time to time I
25 have, but it's not a situation where I routinely do

1 it -- or I don't think it's the standard of care to
2 routinely do it if the -- if the stomach comes down
3 and can stay in the abdominal cavity without
4 tension and -- and often it does.

5 Q. And this patient I think after the
6 surgery -- and I don't know if I got my words
7 right -- developed some apnea of her stomach and --
8 and bowel. Is that -- it just wasn't -- wasn't
9 pumping the food in; is that --

10 A. Yeah, essentially it was not -- the
11 stomach wouldn't empty basically is --

12 Q. And that's just a complication that can
13 occur from these types of procedures?

14 A. It can. I mean, I can -- I can -- I
15 would say that you would expect it to ordinarily
16 resolve its ileus and -- and start emptying, but in
17 this case it did not and -- and certainly that can
18 happen sometimes.

19 Q. Now, the patient was not eating, and so
20 Dr. Randall had to go back in surgically and put in
21 another feeding tube, did he not?

22 A. Well, he did. I -- I think he first
23 went back because the stomach was not emptying, and
24 we all know what happens when a stomach won't
25 empty. It dilates and becomes a problem. So he

1 decompressed it with a gastrostomy tube.

2 Q. All right.

3 A. I think that even with decompression my
4 understanding, the -- the stomach still wouldn't
5 work later on as a -- as an organ to feed into, so
6 he ultimately placed a jejunostomy feeding tube.

7 Q. And that's sewn in -- or placed in the
8 bowel?

9 A. It's placed directly into the small
10 intestine and -- and sutured in place. As I
11 recall, he did a so-called Witzel tunnel; that is,
12 he fixated it to the wall of the bowel and fixated
13 it to the abdominal wall, sutured it to the -- to
14 the abdominal wall as well.

15 And even when the stomach is exhibiting
16 an ileus, that is, it's not working, then the small
17 intestine more commonly will work and then you can
18 feed a person that way.

19 Q. Now, in this patient apparently she
20 somehow dislodged this tube out of her small
21 intestine. Can you --

22 A. Yes.

23 Q. Pulled it out. And there's evidence
24 that she pulled some other tubes out --

25 A. That's --

1 Q. -- is that correct?

2 A. The record does document that.

3 Q. So the -- maybe not enough nursing care
4 or something watching her?

5 A. You know, these -- these things happen
6 in -- in hospitals.

7 Q. Okay.

8 A. I think anybody that's -- that's
9 practiced in -- in this hospital or Columbia or any
10 place I've ever been or seen knows that tubes
11 either get pulled out by patients sometimes or by
12 staff that are well meaning but transferring
13 patients and so on. It happens.

14 Q. Okay. Now -- and this -- after that it
15 was a while before anyone recognized that something
16 was going on with this patient; is that correct?

17 A. Yes. I -- I think what happened
18 with -- with her jejunostomy tube was it got pulled
19 partially out. And it's unusual for one to get
20 pulled partially out and to remain in the
21 peritoneal cavity but not in the small intestine,
22 and that's what happened in her, and so
23 consequently as the feedings were ongoing tube
24 feeds were going directly into her peritoneal
25 cavity.

1 Q. All right, sir. And her inability to
2 communicate, those type of things would affect --

3 A. No -- no question. Some -- somebody
4 who is more alert, maybe not retarded -- I -- I
5 don't know how she communicated her pain to
6 individuals, but one of the things we're looking
7 for when somebody is having an abdominal problem
8 like peritonitis would be a complaint of pain. And
9 I don't know how she would be able to relate that
10 to the staff.

11 But I do understand that -- that, you
12 know, tube feedings did go into the abdominal
13 cavity and that will cause peritonitis. It can
14 cause a lot of irritation of all the organs inside.

15 You know, my -- I -- I have no
16 criticism of Dr. Randall for having that happen.
17 That's -- that's something that -- that can happen.
18 Whenever you do a -- whenever a surgeon is asked to
19 do a procedure on somebody, whether it be a
20 jejunostomy tube, whether it be a central line,
21 there's -- there are potential untoward effects
22 that can happen, complications, and none of those
23 invasive procedures are without potential risks
24 like that.

25 And so certainly a tube getting pulled

1 back like that, that -- that can be a problem. My
2 reading of the operative note and the technique
3 that he describes using and placing the tube is --
4 is proper. I mean, that's a good way to put in
5 a -- a feeding tube by what I saw in the
6 description of the operative note.

7 I -- one thing that I think could have
8 been improved upon in that particular case was
9 frankly I think I would have been inclined to
10 operate on her a little sooner than -- than he did
11 when I knew that she had had some tube feedings
12 going into her abdominal cavity. But I think it
13 could be argued -- and he probably will argue that,
14 "Yeah, but she was dehydrated. We needed to
15 resuscitate her some. She -- needs to get some
16 antibiotics on board, IV fluids because of the
17 dehydration."

18 So that would be I think a legitimate
19 counter to -- to my thought that maybe operating
20 sooner rather than -- than whatever it was, eight
21 hours later, might would have been better.

22 Q. All right, sir. But as far as you
23 know, the -- the delay in taking her back to
24 surgery, she would have had peritonitis anyway; is
25 that --

1 A. She would have had peritonitis anyway,
2 and -- and she ultimately did recover. And it's --
3 it's not -- I don't see it as being as big a
4 problem as having the usual causes of peritonitis
5 in the peritoneal cavity. The usual causes would
6 be colon perforation or small bowel perforation in
7 which there's a lot of bacteria and sepsis is more
8 likely to intervene in those situations.

9 You know, this in my mind would be
10 more -- more like something like bile peritonitis
11 where they're --

12 Q. A chemical type?

13 A. Chemical peritonitis, yes.

14 And we --- we certainly do treat bile
15 peritonitis quite a bit differently than we do
16 colon perforation or stomach perforation. It
17 seemed to be more of a chemical peritonitis and --
18 and the urgency is not the same, and there's
19 some -- some time to -- to prepare the patient is
20 certainly justified.

21 Q. So it's a judgment call basically of
22 what to do?

23 A. It -- it is a judgment call.

24 Q. And either way the injury to the
25 patient was not caused by Dr. Randall's surgery; is

1 that correct?

2 A. No, I don't think the injury was caused
3 by that. I think it was from the -- the tube --
4 tube being pulled back. It would have been a lot
5 better if it had been pulled all the way out,
6 but -- but it wasn't and so it wasn't recognized.

7 And, you know, certainly it's -- it's
8 not like I've never seen something like that happen
9 before. As a surgeon who has been around for a few
10 decades, I've seen those kind of things, including
11 tubes that are in somebody's stomach through their
12 nose being pulled back and in feeding too high in
13 the esophagus and leading to aspiration.

14 In -- in those situations you -- you
15 hope that you're going to get a little help from
16 the nursing staff by recognizing that -- that maybe
17 the tube is further out than it used to be. The --
18 the doctor can't always be there looking at the
19 patient and seeing the -- the changes, the fact
20 that the tube is now hanging out 12 inches instead
21 of where it was coming out just four inches.

22 Q. Now, on Ms. S█████, she was returned to
23 the OR, and I'm not sure how many times, 15, 16
24 times.

25 A. No, I -- I have no criticism of that

1 part of it because it was -- it was a necessary --
2 it became a necessary thing to get her sufficiently
3 debrided and -- and eventually closed up in some
4 way.

5 Q. And these were things that in some
6 patients some of the procedures could be done at
7 the bedside but not with her because of her mental
8 condition; is that -- some of the cleanings and
9 all?

10 A. Possibly so, yes.

11 Q. Okay. All right, sir.

12 The -- excuse me a moment. I'm sorry.

13 The next patient I think is number six
14 is -- is St██████ Wa██████. Do you have that one in
15 front of you?

16 A. I do.

17 Q. What -- what is -- brief -- briefly
18 describe that patient to the panel.

19 A. My understanding is he is a man about
20 42 years old on some steroids for reasons that
21 weren't entirely clear to me, although I think it
22 may have been because of asthma -- the treatment of
23 asthma. He had open gastric bypass sometime in the
24 past and had lost a lot of weight, from about 440
25 pounds maybe down to 220. And he -- he'd had --

1 had had multiple ventral hernias. And then he was
2 taken to the operating room for repair of a ventral
3 hernia or ventral hernias. And that was done
4 laparoscopically.

5 My understanding is that he had some
6 bleeding postoperatively as evidenced by some
7 tachycardia in the recovery room and drop in
8 hemoglobin that at first was not very impressive,
9 maybe -- I've got in my notes, 10.5 down to 9.2
10 which as a general surgeon that's -- that's not
11 alarming to me. I mean, that's almost within the
12 lab variation. We see that all the time with --
13 with the hydration that may go on during surgery
14 and the -- and also the -- the blood loss that
15 might be expected. But the next morning his
16 hemoglobin was down some more to 6.7, so clearly
17 there had been some blood loss, and he's having
18 more tachycardia.

19 The -- the very unusual thing that
20 occurred here was that I think it may have been
21 somebody, one of the clinicians, a nurse or
22 somebody detected a bad smell from one of his
23 trocar sites. Since his operation was
24 laparoscopic, all he had was -- was the little
25 small incisions, the trocar sites. And one of them

1 was -- was draining and smelled bad.

2 And if I understand correctly, that --
3 that resulted in a suspicion of -- of infection
4 there and he was taken back to the operating room
5 for laparotomy and debridement of that area. And a
6 very unusual occurrence happened, and that was he
7 had developed a necrotizing infection in one of the
8 trocar sites, and I think in less than 24 hours
9 after the operation necrotizing fasciitis -- I know
10 all the panel knows basically what that is, but it
11 can happen in the first 24 hours after an
12 operation, but that's exceedingly rare.

13 And I'm not sure, you know, what --
14 what may have caused that to be the case, but
15 that's -- that -- that was what started this
16 unfortunate man's difficulties, and that was
17 that -- that -- it wasn't the bleeding. He did
18 have some bleeding, but that wasn't the -- the
19 thing that really put him in -- in harm's way
20 and -- and caused him great difficulty. It was the
21 necrotizing fasciitis that started off on one of
22 the trocar sites on his abdominal wall.

23 Q. Is there any evidence of any surgical
24 misadventure or error causing that necrotizing
25 fasciitis?

1 A. Well, nothing that I can tell from the
2 record. I mean, you know, I guess when somebody
3 has a necrotizing fasciitis, within 24 hours you --
4 you -- as an institution and as a surgeon and as a
5 surgical team, you have to wonder, you know, what
6 is it that contaminated the site because something
7 did. It didn't just happen from -- from, you know,
8 no bacterial involvement. I haven't heard of that.

9 So somewhere -- it could have been a --
10 an instrument or a cannula that was thought to be
11 sterile but actually wasn't, some break in
12 technique in the operating room. It could be that
13 it was -- was colonized from -- from his bed
14 from -- after he was out of the operating room.
15 Something got into the incision.

16 It's just exceedingly rare, but it did
17 result in his having to have a substantial portion
18 of his abdominal wall debrided. I don't remember
19 exactly how big it was. It seems like it was --
20 from my review is as big around as a grapefruit or
21 a cantaloupe or something like that. When I say
22 abdominal wall, I'm referring to the skin and
23 subcutaneous layer.

24 So I -- my -- my understanding from
25 reviewing the record is that Dr. -- Dr. Randall

1 felt like he better take a look inside because
2 there could be something inside that's leading to a
3 necrotizing fasciitis, that is, something that
4 started from the inside, went to the trocar site,
5 which would be a rational thing to think. So he
6 did a laparotomy on the patient as well.

7 There was infection in the field, so
8 the mesh was appropriately taken out. You don't
9 want to leave a foreign body in an infected field.
10 And there were -- he -- he needed to close the --
11 the -- the abdomen back after the mesh was taken
12 out, and he chose to use a Prolene suture.

13 That's -- for the non-surgeons, it's
14 a -- it's a permanent suture that -- that commonly
15 is used in abdominal wall closures, especially if
16 there's a hernia involved. So there was a hernia
17 here, so I think that's why he chose that. But
18 it's like fishing line. It's kind of a -- it's
19 kind of a monofilament-type suture.

20 And review of the records suggests that
21 since the man was -- was ill and had a lot of
22 swelling after the surgery, he -- he had swollen
23 enough to press his -- his viscera, colon right up
24 against the -- the fishing line-type suture and it
25 actually cut through the colon, and so later on he

1 had a -- a leak from the colon as a result of that.

2 Now, you know, what -- what I can see
3 not being there but as a surgeon is that
4 Dr. Randall was forced to -- to take care of -- of
5 a hernia in this man's abdominal wall, not with
6 mesh like we usually use because he had to take
7 that out because of necrotizing fasciitis, but
8 instead he was having to pull it together with
9 sutures, and likely there's going to be some
10 tension on it. The concern is that it's going to
11 start pulling apart. Over time that's the reason
12 we tend to use mesh to start with, but mesh was not
13 an option at this point.

14 And I imagine with -- with the
15 patient's postoperative swelling and so on that
16 it -- it pressed the colon against the suture
17 and -- and basically like a -- like a cheese cutter
18 or something cut into the colon and it started
19 leaking because of that.

20 I think this man, if I'm not mistaken,
21 was a homeless man, and I don't know if -- if that
22 has anything to do with his -- his tendency to
23 infection or -- or hygiene leading into the -- to
24 the operation and so on.

25 Later on in -- in its course the

1 patient thrombosed. The mesenteric vessel is part
2 of the small intestine. He had to be operated for
3 that. I can't tell from the record why that might
4 have happened in this particular situation, but it
5 was -- it was removed and a small bowel anastomosis
6 was done.

7 Q. A couple -- a month or more after the
8 initial surgeries he had heparin-induced
9 thrombocytopenia. They were clean -- cleaning him
10 out with heparin. Does that sound --

11 A. That -- that ER -- you are slurring my
12 memory on this -- on this number six of ten cases.
13 He did have heparin-induced thrombocytopenia, and I
14 think the -- the panel of physicians would know
15 that heparin-induced thrombocytopenia has a second
16 T with that, and that is heparin-induced
17 thrombocytopenia and thrombosis.

18 And, you know, certainly we -- many of
19 us -- most of us like to use heparin to try to
20 prevent a devastating complication of pulmonary
21 embolus or DVT, but unfortunately from time to time
22 our -- our efforts result in -- in untoward
23 consequences and -- and in this case the HIT was
24 the untoward consequence, and thrombosis in -- in
25 the small bowel vasculature occurred and -- and

1 resulted in a substantial problem, that is, small
2 bowel infarction requiring resection.

3 This man did ultimately wind up with a
4 small bowel fistula which, you know, this -- this
5 would be the kind of case where that might happen.
6 A -- a compromised patient requiring a small bowel
7 resection, that's -- that's high risk for -- for
8 any anastomosis.

9 Q. And the thrombose-induced cytopenia --
10 thrombose-induced HITT --

11 A. Yes.

12 Q. -- that is just something that for
13 whatever reason, his immune system or whatever,
14 changed him around from heparin working on your
15 clotting factors to doing the opposite and not
16 making him clot?

17 A. Right, there's an irony involved in
18 that in that heparin is an anticoagulant, but it
19 can in that situation become a procoagulant and --
20 and result in thrombosis and vessels that
21 ordinarily simply wouldn't thrombose, wouldn't
22 clot.

23 Q. And that's no one's fault that
24 occurred, is it?

25 A. I can't say that it is.

1 Q. Dr. Randall acted appropriately with
2 this difficult patient?

3 A. He did.

4 Q. And this is a -- this is a difficult
5 patient, especially, you know, being a -- he was a
6 homeless man in bad shape?

7 A. It's -- it's a difficult situation,
8 no -- no question.

9 Q. Okay. Now, C██████████ W██████████, that's
10 the man who came in with the appendicitis; is that
11 correct?

12 A. That is correct.

13 Q. And what appeared to be an
14 uncomplicated -- fairly uncomplicated appendectomy?
15 Was it uncomplicated or not?

16 A. Well, I -- I think it was described in
17 the operative note as being difficult --
18 technically difficult. He was a big man, not --
19 not huge, I think 220 pounds. Technic --
20 technically difficult, as I recall, from a long
21 appendix that extended down into the pelvis, and
22 those -- those can be difficult.

23 Q. All right. And then he had a
24 complication during surgery; is that correct?

25 A. I think not -- not during surgery. I

1 think he -- I think the -- the surgery was
2 technically difficult.

3 The patient on postoperative day two
4 was able to be up walking about and eating. But
5 late -- later on he started developing abdominal
6 pain again and developed an elevated white count.
7 A CT scan was done. I think it showed some
8 possible evidence of small bowel obstruction and --
9 and some fluid in the abdominal cavity, free fluid.
10 And this is a case where I think one of his
11 partners, Dr. Schroeder, if I'm saying it right --

12 Q. Yes, sir.

13 A. -- was -- I -- I don't know the exact
14 circumstances. Someone else would have to clarify
15 it. But I believe he was on call or maybe it was
16 the weekend or something, and he was covering for
17 this patient and -- and took this information
18 and -- and treated him with IV fluids and
19 antibiotics. I think the white count might have
20 been 9,000. A nasogastric tube was placed I -- I
21 imagine because of the -- the findings of bowel
22 obstruction or -- or findings on CT scan consistent
23 with bowel obstruction.

24 And I'm pretty sure this was going on
25 over a weekend. Then on a -- on a Tuesday night I

1 think the patient took a major turn for the worse
2 and a Dr. Revell was called. I'm -- I'm not sure
3 how it all transpired, but I believe Dr. Revell was
4 the first one made aware, then -- then maybe
5 Dr. Schroeder and -- and -- and eventually as the
6 patient was taking a turn for the worse they called
7 Dr. Randall who even though it was Tuesday my
8 understanding is that -- that Dr. Schroeder was
9 taking care of the patient on Monday because he had
10 I think readmitted him, if I'm not mistaken.

11 I think he had had readmitted the
12 patient, because he is one -- one that had gone
13 home presumably doing well enough after the
14 appendectomy and had came back. And so my
15 understanding is Dr. Schroeder was continuing the
16 care for him, but then Dr. Revell was on call on
17 Tuesday night when he took a turn for the worse.

18 But ultimately Dr. Revell being on call
19 at -- at what was the early morning hours, maybe
20 6:00 a.m., and he called Dr. Randall. Dr. Randall
21 explored him and found that the omentum was dead
22 which is an unusual thing, but, you know, for
23 whatever reason the -- the omentum had -- had
24 infarcted.

25 And my understanding also is that there

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1 was a leak at the appendiceal stump that had -- had
2 set up peritonitis that had been presumably the
3 cause of the free fluid in the abdominal cavity,
4 the cause of the -- the apparent bowel obstruction.
5 The obstruction may have been a true obstruction.
6 It may have been ileus. And I -- I would surmise
7 that the -- the affect of the peritonitis probably
8 led to the infarction of the omentum from a low
9 blood pressure.

10 Q. This is a patient you think probably
11 should have been taken back to surgery on Monday,
12 or do you have any opinion?

13 A. You know, it's -- in retrospect
14 certainly, yes. I mean, I think that would have
15 been -- would have been the best thing. And it
16 does look like there were indications in the chart
17 where I would say most surgeons would have -- would
18 have taken him back by Monday anyway.

19 Q. All right. And there are a number of
20 people caring for this particular patient, not just
21 surgeons; is that correct?

22 A. Yes, there were, and -- and a number of
23 surgeons too. I mean, it sounds like there were
24 three from the group that -- that were involved.
25 And, you know, unfortunately it's -- it's -- you

1 know, handoff situations can be dangerous.
2 situations, and not just handoff situations from
3 one surgeon to another on a weekend, but from one
4 hospital staff member to another like nursing or --
5 or with residents.

6 But this -- this is a situation where I
7 think there -- there sort of was a handoff and --
8 and it wasn't exactly a handoff. I guess the guy
9 came back in the hospital and Dr. Schroeder
10 admitted him and -- and was managing him.

11 But, again, I'm not claiming to know
12 the details of -- of the group dynamics and who was
13 in charge exactly on a Saturday night and Sunday
14 night and Monday and so on. I think others may
15 need to clarify that or -- but what I -- what I can
16 tell from the chart is Dr. Randall was -- was not
17 entering orders and progress notes on that patient
18 during that time.

19 Q. All right, sir. Now, the next patient
20 is a F█████ M█████, number eight.

21 A. Yes.

22 Q. And tell the panel about that patient
23 briefly.

24 A. F█████ M█████ my understanding, is a
25 65-year-old man with -- I -- I believe he was a

1 chronic nursing home patient. I'm not sure why --

2 Q. That's correct. He was in a --

3 A. I'm not sure -- I'm not sure I quite
4 have it clear in my mind why -- why he was at 65
5 having to be in a nursing home full time. But he
6 had a large -- large right inguinal hernia and --
7 and a history of a hernia repair on that side done
8 laparoscopically I believe by another group or a
9 surgeon in another group.

10 And Dr. Randall took this man to the
11 operating room for repair of this large symptomatic
12 hernia to -- to fix it, and it turned out that --
13 that this large hernia that I think was described
14 again as being the size of a large piece of fruit,
15 like a grapefruit or something like that, it turned
16 out that he had the bladder down in his scrotum or
17 down in the hernia sac.

18 Q. Is that unusual?

19 A. Very. Extremely unusual.

20 And I -- I don't know that I've seen a
21 substantial portion of the bladder in a hernia in
22 my career. I mean, if somebody asks me on -- on a
23 board examination what can get into a hernia, I'm
24 going to answer almost anything, but -- including
25 bladder, ovary, appendix, colon. It's all possible

1 if it's -- if it's in that part, but bladders don't
2 go into hernias very much. I -- I frankly have
3 never seen that.

4 But the operative findings suggest
5 that -- that the bulk of this man's bladder had
6 gone down into his hernia and that -- then the --
7 so it's a difficult situation being a -- a patient
8 that you know that has mesh inside from a previous
9 laparoscopic hernia repair that obviously has
10 failed because the man is presenting with a hernia
11 again. And the allegation is that in -- in the
12 course of performing the first surgery you
13 apparently created a bladder injury that was not
14 properly dealt with until the second operation.

15 You know, I can -- I can totally
16 understand how -- how a surgeon might not recognize
17 that this is bladder because bladder doesn't have
18 a -- have a real distinctive look to it compared to
19 other organs, and you don't expect to see a bladder
20 mostly outside the abdominal cavity or outside the
21 retroperitoneum but instead down in the hernia sac.

22 So what I -- what I think happened here
23 is that in the dissection the bladder was --- was
24 opened like a hernia sac might be opened, but it
25 turned out that there was urine inside of it and --

1 and it became apparent that, "Hey, this must be the
2 bladder."

3 And so, again, my understanding from
4 the record is that the bladder was then repaired
5 and the next thing a surgeon's going to do is try
6 to reduce the organ back through the hernia defect,
7 that is, to take the -- the bladder or in other
8 kind of hernias, if it's colon or small intestine,
9 you try to push it back through the hole and get it
10 back inside.

11 But that wasn't happening. It -- it
12 wasn't going back through the defect and so on.
13 And, again, my understanding from the record is
14 that he decided to not press on with -- with this,
15 realizing that something very odd was going on, and
16 I think he sought the -- the opinion and help of
17 a -- of a urologist. And a Dr. Livingston I think
18 was consulted and the two of them worked on it.

19 And what I can tell from -- from the
20 operative note was that there was a -- there was a
21 reason why the bladder would not reduce, and that
22 was -- that is, go back into the abdominal cavity,
23 and that was that when the first piece of mesh
24 was -- was placed laparoscopically, it was -- it
25 was placed over a portion of the bladder and in

1 such a way that the bladder was not really reduced
2 from the hernia and that the -- again, my
3 understanding is that the patient was saying that
4 his -- his belief was that -- that he had a --
5 after the laparoscopic repair, he couldn't tell
6 that it had been repaired.

7 There still was undue swelling down in
8 the groin, and his -- his feeling was that the
9 first operation hadn't really repaired the problem.
10 But then the reason becomes evident in the
11 operation that was done with the urologist, and
12 that is, that the mesh was covering at least a
13 portion of the bladder such that it was keeping it
14 from coming back in as opposed to really fixing the
15 hernia.

16 Q. The mesh was tacked onto the
17 bladder itself --

18 A. Yeah. So --

19 Q. -- or it was tacked onto something?

20 A. So apparently the -- the first surgeon
21 did not recognize that the bladder was -- was
22 sticking down in this man's hernia. Now, again,
23 I -- I can -- I can in part see where -- where he
24 failed to see that because bladders usually don't
25 go into hernias. That's a -- that's a very unusual

1 situation.

2 Q. The -- one of the allegations is that
3 Dr. Randall caused an injury to the bladder.
4 There's no injury to the bladder, is there?

5 A. Well, I mean, I guess you could say he
6 did create an injury to the bladder, but the
7 bladder is a -- is a forgiving organ, and, you
8 know, when you -- when things are all stuck to it
9 and so on, from time to time general surgeons will
10 get a hole in the bladder just like we'll get a
11 hole in the small intestine or colon, and
12 fortunately we're trained to fix those holes.

13 But this situation was a little
14 different in that I think Dr. Randall was expecting
15 to find the usual kind of things down in this
16 hernia, and that might be a peritoneal sac that --
17 that can become extremely thickened and -- and the
18 other thing is an ordinarily thick-walled bladder
19 can become not so thick walled when it's all
20 distended out.

21 So it's not hard for me to see how one
22 would think that, "Hey, I'm dealing with a hernia
23 sac." But he did recognize that when he got into
24 it, "This is bladder. It needs to be repaired. We
25 need to have a Foley catheter in place, and we need

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1 to get a urologist involved here."

2 So in my mind that's -- that's the
3 appropriate course.

4 Q. It's not like he cut the bladder and
5 didn't recognize that it was --

6 A. No, it's not like that and --

7 Q. It was repaired -- he realized it was a
8 bladder and sewed it up?

9 A. It's -- it's a very odd situation and a
10 very -- very odd presentation, and I think he
11 handled it appropriately.

12 Q. The patient apparently did well after
13 the second surgery?

14 A. That's my understanding.

15 Q. All right. Oh, there was another
16 criticism that a reviewer made, is that apparently
17 on the left side he had an inflamed scrotum with
18 some pus in it, and that was -- Dr. Randall I think
19 went ahead and drained that. There was a criticism
20 of doing that and not just waiting till they do all
21 the other surgeries. Anything to that at all?

22 A. I -- I -- I don't have any criticism of
23 that. I think that's a surgeon's judgment about --
24 about his comfort level with -- with the scrotum
25 and dealing with it, and most general surgeons do

1 operate sometimes on the scrotum for various
2 things. So I -- I don't find any criticisms of
3 that.

4 Q. It didn't cause any problems doing
5 that? It was something that had to be done
6 eventually, anyway?

7 A. Well, I mean, when there's pus, it's
8 nice to have it drained.

9 Q. Now, the last patient was J [REDACTED]
10 P [REDACTED].

11 A. No.

12 Q. Excuse me. J [REDACTED] R [REDACTED] I'm sorry.
13 I'm --

14 A. Have you done number nine in the
15 sequence?

16 Q. No, I haven't. I apologize.

17 A. That would be S [REDACTED] J [REDACTED]

18 Q. S [REDACTED] J [REDACTED]

19 A. Uh-huh.

20 Q. I apologize.

21 Well, tell the board about S [REDACTED]

22 J [REDACTED] There's a criticism of a -- what they call
23 sleeve gastrectomy on this patient.

24 A. Yeah. The -- the allegation is that
25 he -- the allegation is that Dr. Randall performed

1 a sleeve gastrectomy, a procedure rarely or never
2 employed for the indication of gastric bleeding.
3 And the first thing I saw was -- was the allegation
4 before I had a chance to read the chart. But many
5 of you know that the term sleeve gastrectomy
6 connotes a bariatric operation, and that's --
7 that's kind of what -- what the term came from is a
8 weight-loss operation.

9 And it's true that -- that I never have
10 heard of a sleeve gastrectomy before it became a
11 weight-loss operation. But I -- I don't think
12 that's really what happened here, and instead it
13 was a partial stomach resection trying to remove a
14 bleeding point.

15 And every other kind of gastrectomy
16 that you ever hear about involves one that --
17 that's going to require an anastomosis to
18 presumably the small intestine because there are
19 gastrectomies that are -- that are
20 hemigastrectomies where the antrum is taken out or
21 near total gastrectomies where almost all of it is
22 taken out. And then obviously something has to be
23 hooked up to it so the -- whatever food a person
24 eats can drain into the small intestine.

25 But any -- any surgeon knows that if

1 you have a bleeding point on the stomach wall or
2 even a tumor on the stomach wall that -- that you
3 can get out without disturbing the -- the flow
4 of -- of nutrients from -- from the esophagus, food
5 or stomach, right on down to the pylorus, that's
6 better. That is -- we often call that a wedge
7 resection on the stomach. And so that -- that's
8 what he was doing.

9 I -- at one point in his dictation he
10 does use the word sleeve gastrectomy, and I think
11 that may have been the -- the choice of terms that
12 resulted in some -- a reviewer picking on him about
13 that.

14 Q. Okay.

15 A. But in other parts he calls it a
16 segmental gastrectomy. But basically it's a
17 situation where portions of the stomach are taken
18 off of the greater curved side, the greater curve
19 of the stomach, and the lesser curve of the stomach
20 is left intact so that you may have a tubular
21 stomach.

22 But I don't know, you know, how in
23 detail you all have -- have reviewed all of these
24 cases. I know you don't have time to review the
25 details of ten cases, but just to summate what --

1 or -- or a summation of what occurred and my
2 understanding is that the man was having
3 gastrointestinal bleeding in -- in a serious way
4 from the stomach and that a gastroenterologist had
5 looked in there and had seen that there was a
6 bleeding ulcer on the stomach wall and that it
7 looked like it wasn't just an ulcer. It was likely
8 a tumor. Not a -- not a large tumor, but a tumor
9 that may have serious ramifications, possibly even
10 being malignant.

11 So the gastroenterologist tattooed
12 the -- the place on the stomach, something we often
13 ask them to do these days, which means he took some
14 India ink. He squirted it into the wall of the
15 stomach so that the operating surgeon could
16 recognize what part of the stomach had the problem.

17 And when Dr. Randall went in, he saw
18 the staining on the stomach and -- and chose to
19 segmentally resect that stained or tattooed part of
20 the stomach. So a portion of the -- of the
21 redundant stomach was taken out that way.

22 Unfortunately the -- when the specimen
23 was examined, the pathologist saw no tumor and saw
24 no ulcer there. Again, my understanding from the
25 record and from the operative note is that

1 Dr. Randall was -- was dissatisfied with that, as I
2 would have been, and removed more of the stomach
3 because the -- the India ink tattoo on the stomach
4 wasn't just in a small area like this. It had
5 spread out over a pretty broad area.

6 So rather than -- than leaving the
7 patient at risk of -- of further bleeding, he took
8 out more of the tattooed area, and at one point
9 he -- he logically opened the stomach, looked
10 inside and tried to identify I'm sure by
11 visualization and by palpation anything that
12 would -- that would represent an ulcer or a tumor
13 and couldn't -- couldn't feel or see anything like
14 that.

15 But ultimately he removed all of the
16 tattooed area which was a -- a good portion of the
17 greater curvature of the stomach. And that -- the
18 specimen sent to pathology never showed an ulcer
19 and never showed a -- a tumor.

20 Now, I -- I frankly don't recall
21 whether Dr. Randall was looking through the -- the
22 endoscope himself. I'm sure he can testify to
23 that, but a gastroenterologist was looking through
24 it and probably had pictures of it demonstrating
25 what appeared to be some sort of a tumor.

1 So the indications for the surgery
2 seemed to be secure. The approach does not seem to
3 be improper. Again, as a general rule if you can
4 leave the -- the lesser curve of the stomach intact
5 where the vagus nerves run, then you're better off.
6 You have a fairly normally functioning system. And
7 we know that that kind of an operation works
8 reasonably well for people because it's been done
9 thousands of times now in bariatric people leaving
10 sort of a relatively tubular stomach called a
11 sleeve gastrectomy based on the lesser curve.

12 Unfortunately this man did not empty
13 well. He -- fortunately it did stop the bleeding.
14 The man was not bleeding any more. As to -- as to
15 what the original cause of the bleeding, I -- I
16 think we can -- we can speculate about that. There
17 are -- are types of bleeders in the stomach,
18 something called a Dieulafoy lesion in the stomach
19 that's almost invisible except for the fact that it
20 squirts blood out when you put your endoscope in
21 there sometimes. They can be hard to find.
22 They're very hard for surgeons to find in the
23 operating room. They're very hard for pathologists
24 to find in the pathology lab.

25 It may have been something like that.

1 I can only speculate as to why it looked like a
2 tumor at the time and no tumor had shown up.

3 Anyway, the -- the man did not empty
4 well and, that is, he wasn't able to maintain
5 nourishment by -- by food going through that
6 tubular shaped stomach. And because of that, it --
7 I think it's appropriate that he ultimately had to
8 go back to the operating room for another
9 operation.

10 In that situation the lower part of the
11 stomach was taken out and a -- sort of a Billroth's
12 II reconstruction was done, something that all
13 surgeons are -- are trained on in their residency,
14 where -- where a small portion of the stomach
15 remains in the proximal aspect and a loop of small
16 intestine is brought up and hooked to it.

17 Q. And it looks like one of the things
18 that they're really critical about -- we had
19 different reviewers saying different things.
20 Apparently he had some kind of bleed or something
21 at the bedside and a little piece of needle broke
22 off in there --

23 A. Yeah.

24 Q. -- and Dr. Randall chose to leave it in
25 there.

1 A. Yeah. Well, yeah, I -- I -- I was
2 reading through that -- that chart, and I -- and I
3 saw that, and I thought, "Well, that's --" you
4 know, we -- all surgeons really hate that because
5 needles show up so great on x-rays. But a little
6 fragment of a -- of a sewing needle is -- is no
7 different in a human body than these little metal
8 clips we put in all the time to secure blood
9 vessels, hemoclips we call them, and they're often
10 quite a bit smaller. But it's -- you know,
11 plaintiff lawyers love those things, though,
12 because they -- they want to attribute all kinds of
13 ills to them, that is, to the fact that there's a
14 needle -- piece of metal in there.

15 Now, I honestly will tell you my -- my
16 position would be to, yes, look for it, but I'd
17 look for it for about ten minutes, and if I
18 couldn't find it, I wouldn't be subjecting the
19 patient to a prolonged exploration, and the only
20 reason I'd possibly be thinking about taking the
21 patient back to the operating room at a later time
22 to use fluoroscopy to find this, which would
23 probably be a three-hour operation and very
24 traumatic to the patient would be if somehow I
25 could demonstrate that this thing is actually

1 causing a symptom which is highly unlikely.

2 Q. And that's just a judgment call to
3 leave it alone?

4 A. That's a good judgment call in my
5 opinion.

6 Q. Now, the -- the last patient -- where
7 is the last patient -- is -- excuse me -- J████
8 R████. She's the patient who had a gangrenous
9 gallbladder and had a laparoscopic cholecystectomy.

10 A. That's right. I do have that one.

11 Let's see. J████ R████, 68 years old.
12 She had come into the emergency room with abdominal
13 pain. White count 22,000. Gallbladder ultrasound
14 showed some sludge. The next day she underwent a
15 laparoscopic cholecystectomy, was found to have
16 essentially a necrotic or dead gallbladder and some
17 sort of a necrotic mass within the gallbladder. I
18 think it was described as two and a half
19 centimeters.

20 From -- from my review of the record
21 I -- I can't tell exactly what that was, but maybe
22 because it was necrotic the pathologist couldn't
23 say what it was, but a necrotic mass within the
24 gallbladder. She had stones.

25 She was sick postoperatively from --

1 from having had a septic gallbladder. Again, the
2 white count was 22,000. I think she could be
3 qualified as being essentially septic in a way when
4 she went to PACU.

5 She had been a very difficult
6 intubation. She -- she had a tough postoperative
7 course, and I think she -- she extubated herself
8 accidentally. And one doctor -- I think maybe it
9 was the intensivist -- tried to reintubate her,
10 could not, managed to -- to use a mask and an Ambu
11 bag to ventilate her until an anesthesiologist
12 could get there. The anesthesia doctor was
13 successful. The -- the thought was in the record
14 that she aspirated at that time when she had
15 extubated herself and -- and during that period of
16 time possibly leading to some -- some pulmonary
17 problems.

18 But she -- she also after that
19 difficult cholecystectomy was having a gradual drop
20 in hemoglobin, and I think it was over a period of
21 around four days that -- that she would drop her
22 hemoglobin, be transfused, have it come back up
23 some or just respond partially, and then drop back
24 down. And in the end she got 11 units of blood
25 transfused over about four days.

1 The -- the rationale, as I understand
2 from -- from the chart, was that, "Yeah, it's bad
3 that she has bled, but it's going to be good if we
4 can avoid reoperating on her. She probably has
5 aspiration pneumonia, and it's looking like this
6 thing is going to stop," but in the end it didn't.

7 I would -- I would say very likely
8 that -- that if -- if one could know when the
9 bleeding first started that it was going to be 11
10 units transfused, that he might would have bitten
11 the bullet and gone ahead and reoperated, but, you
12 know, sometimes situations develop where it's a
13 gradual ooze and you -- you hate to be taking
14 somebody back to the operating room when -- when
15 the bleeding has just stopped, and it's because the
16 bleeding is complete and all you're doing is
17 cleaning out a hematoma at that point.

18 And it's -- sometimes that happens
19 with -- for surgeons. When we go in for bleeding,
20 we find blood, but we don't find a bleeder. And
21 that can be an abdominal surgery and other kinds of
22 surgery as well. But that's -- that's sort of
23 the -- the situation there.

24 Q. Okay. The -- the first reviewer who
25 didn't testify was critical about using a

1 laparoscope instead of doing this open. The man
2 that testified yesterday said he didn't -- he just
3 asserted his choice, basically that either way
4 would be fine.

5 A. Yeah. Well, I mean, it's a surgeon's
6 choice, and I -- I for one will -- will approach
7 gallbladders like this laparoscopically. And I --
8 I do recognize that there will be complications of
9 laparoscopic cholecystectomy, but I also recognize
10 that there are complications of open
11 cholecystectomy.

12 I'm old enough to remember when that
13 was the routine. And it's not like that's --
14 that's the absolute standby safe procedure. It's
15 a -- it's kind of a big deal when you're dealing
16 with somebody who has a necrotic gallbladder. And
17 I'm of a mind that if you can get it out
18 laparoscopically, do so.

19 Now, clearly at the conclusion of the
20 operation you have to have hemostasis. He did
21 document hemostasis in his operative note, that --
22 that bleeding was controlled. Now, hardly any
23 surgeon is -- is going to leave the operating room
24 when somebody is still bleeding without doing
25 something, that is, converting to open or packing

1 the patient or something like that.

2 So, you know, I have no reason to think
3 that the patient was bleeding as he left the
4 operating room. That would be inappropriate if
5 that was the case, but I have no reason to think
6 that was the case.

7 Q. And this patient -- you said you looked
8 at the lab values. They'd give her blood. Her
9 hemoglobin would go up and then it would go down.
10 You have a cat and mouse game with that.

11 A. It -- it is. And -- and, again, from
12 the benefit of retrospective vision, I think she
13 would have been better served by a reexploration at
14 some point in that four-day period, but I can -- I
15 can totally understand how one can be at a point
16 where there's been eight or ten units given, but
17 there's a reason to think at that point that --
18 that, "Gosh, she seems to have stopped and we might
19 can avoid reoperating here," because -- and it did.
20 It stopped at 11 units..

21 And, again, I'm not -- I'm not arguing
22 that that was the -- the greatest thing, but, you
23 know -- because I'm looking at it from a
24 retrospective view too.

25 Q. And the patient ended up doing fine?

1 A. That's my understanding.

2 MR. McKAY: Do you want to take a break
3 or keep going?

4 MR. COOKE: Ready for a break? Yeah.
5 How much more do you have on direct?

6 MR. McKAY: Oh, maybe 15 minutes or so.

7 MR. COOKE: Does anybody want to take a
8 break or do you want to wait until after this
9 witness is done?

10 MR. McKAY: It doesn't matter.

11 MR. COOKE: Why don't we take a
12 restroom break and then have you finish your
13 direct.

14 (A recess transpired.)

15 BY MS. HUTTO:

16 Q. And, Dr. Tribble, you say you've been
17 chief of staff -- how big of a hospital is Baptist?
18 400?

19 A. It -- it's about 400 patients -- 400
20 beds.

21 Q. Richland is six -- 600?

22 A. 500 or 600.

23 Q. You've been on peer review things many
24 times, I assume chaired and that type of thing?

25 A. From time to time.

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1 Q. Okay. All right, sir.

2 One of the witnesses yesterday was very
3 critical of Dr. Randall about using flawed judgment
4 in his decisions with patients, consistently
5 utilizing flawed judgment in either choice of
6 techniques or decisions involving patient care.

7 Did you see evidence of that in these
8 massive amount of records that you've seen?

9 A. I -- I don't.

10 Q. Okay. And is there -- I know general
11 surgery is a little bit different than some
12 professions. There's -- there are all kind of
13 different approaches that physicians have in
14 handling general surgery; is that correct? I mean,
15 there are different techniques, people are trained
16 differently, there are --

17 A. Right. There are -- are different --
18 differing ways to manage the same problem.

19 Q. And I'm sure that you and your nine
20 partners may disagree or may do things -- approach
21 the same problem in different ways, and that's
22 probably not uncommon, is it?

23 A. That's right.

24 Q. And also another allegation is that
25 there were significant technical failures of

1 Dr. Randall in performing these surgeries. Do you
2 see a pattern of significant technical failures
3 outside the standard of care that's frequent in
4 these ten patients?

5 A. You know, I -- I don't, but I -- it's
6 not like I'm in the operating room watching this
7 and -- and making judgments on -- on that part.

8 An example might be the -- the young
9 man whose appendiceal stump leaked. I mean, I
10 understand that a pursestring was used and a -- and
11 a so-called -- or a so-called Z stitch over it
12 which is a common way to -- to manage that. But
13 certainly having an appendiceal stump blow out or
14 leak is -- is something that happens from time to
15 time. It's not always clear why it does.

16 So the -- the complications that we've
17 talked about here are things that -- that do happen
18 in the course of a general surgery practice.

19 Q. Did you see any evidence -- there was
20 one thing that the expert yesterday Dr. Skudder
21 talked about. He talked about there was regular
22 evidence of -- the slightest probable cause by
23 improper or rough handling of a bowel and bowel
24 structures in devascular -- devascularization. Did
25 you see any evidence of that in the records?

1 A. I don't. And I would think if that's
2 going to be an allegation you ought to have
3 somebody that's been in the operating room to make
4 that observation, and there are opportunities for
5 that with -- with other surgeons scrubbing in on
6 cases. Surgical nurses can maybe testify to that
7 kind of thing. But other than that, I don't -- I
8 don't know how one can -- can make that allegation.

9 Q. Just speculation, that type of
10 allegation? You haven't seen it yourself; it's
11 just speculation?

12 A. Or -- or possibly seeing it on a video.
13 These days sometimes there's videos of operations,
14 and I'm -- I'm not aware of that being documented.

15 Q. And then there was a -- an allegation
16 that Dr. Randall didn't use good insight into the
17 reality and nature of the patients' problems. Do
18 you see any evidence of that, any significant
19 problems with it?

20 A. No, I can't come to that conclusion
21 from -- from looking at this. I think he made
22 appropriate decisions about -- about what
23 operations people needed. I mean, it's -- to me
24 it's not like the -- the diagnoses here are -- are
25 difficult. I mean, you have dead gallbladders.

1 You have appendicitis. You've got paraesophageal
2 hernia. These are definable diagnoses and the
3 operations were appropriate.

4 Q. And is it your opinion that Dr. Randall
5 generally complied with accepted standards of
6 surgical care in his care and treatment of these
7 ten patients?

8 A. The -- yes, except -- with the
9 exception of I think the group dynamics may have
10 been lacking in -- in one patient, number seven,
11 [REDACTED] W[REDACTED]. But, again, I'll have to have
12 others to testify about how that works within that
13 group and so on, but, you know, a lot of that -- or
14 most of that is having to do with his partners as I
15 can see it -- as I see it from the chart.

16 Q. Dr. Randall was notified and he took
17 the patient back to surgery promptly?

18 A. That's my understanding. I'd have
19 to -- he'll have to testify to how that worked and
20 so on, but I didn't see any evidence in the chart
21 that he was involved in the care of the patient
22 when -- when the -- when the patient had come back
23 with abdominal pain after an appendectomy..

24 Q. And surgeons -- you have to make
25 judgments and decisions at the time. You're not --

1 you as a surgeon would not be expected to be judged
2 in 20/20 hindsight, would you?

3 A. I would hope not.

4 You know, I did have a, you know,
5 criticism. I don't know if it's a minor criticism,
6 but I mentioned it earlier, and that was when the
7 tube feedings had gone into the patient, I would
8 have been inclined to operate sooner. But that
9 patient did recover from that. And we talked about
10 how tube feeding in the abdominal cavity is -- is
11 more of a chemical peritonitis like bile as opposed
12 to something that -- that rapidly spirals into
13 sepsis like -- like you see with a perforated
14 colon.

15 Q. And that's just -- again, that's a
16 judgment? You can't say it's malpractice, it's
17 just basically a judgment on what you would do?

18 A. Yeah, and I can't -- I can't really say
19 that it changed her course either.

20 Q. Okay.

21 A. I don't know that it did.

22 MR. MCKAY: Thank you. Answer any
23 questions that --

24 THE WITNESS: Thank you.

25 MR. COOKE: I'll give you the option if

1 you want to -- well, why don't you go ahead -- why
2 don't you go ahead and do -- do the cross and
3 we'll -- since we just had a break recently --
4 unless -- unless you need a break for that.

5 MS. KREBS: I'm fine.

6 MR. COOKE: Sometimes people like to
7 have a break before they do cross-exam.

8 EXAMINATION

9 BY MS. KREBS:

10 Q. Hi, Dr. Tribble. My name is Julia
11 Krebs and this is Cynthia Hutto, and we've been
12 asked to present the case on behalf of the Medical
13 Executive Committee here.

14 You said that you have reviewed
15 materials for this case. What -- what exactly did
16 you review?

17 A. I have not as many records as I see
18 sitting over there, but I -- I've got records that
19 include discharge summaries, operative notes, some
20 progress notes. So it's -- it's a partial record,
21 and I don't -- I don't have the -- all the vital
22 signs and that sort of thing.

23 Q. So -- so you didn't -- you didn't get a
24 CD of the record -- of the records for these 11 --
25 or ten patients?

DEPOSITION TRANSCRIPT EXCERPTS

DR. ROBERT BAKER

State of South Carolina	)	
	)	
County of York	)	
Robert Randall, M.D.,	)	2012-CP-46-167
	)	
Plaintiff,	)	
	)	
vs.	)	Deposition
	)	
Amisub of South	)	of
Carolina, Inc. d/b/a/	)	
Piedmont Medical Center,	)	Robert Wayne Baker,
Nathaniel Edwards, M.D.,	)	MD
and Richard Patterson,	)	
M.D.,	)	
	)	
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

Robert Wayne Baker, MD

1 Q Okay. And Dr. Randall, according to these notes,
2 stated that under the proposal, "not do cases," he
3 can't continue his practice. Did -- do you recall
4 him making that statement?

5 A I remember a statement along that line. Yes, sir.

6 Q Okay. And then under the notes here, it says,
7 "Questions: none." Is that consistent with your
8 recollection of what happened?

9 A I -- like I said, I don't remember. I don't know
10 if that applies to questions about the specific
11 cases or -- or what. I don't recall if any
12 questions were asked.

13 Q Okay. And then if you look at the second page of
14 this document, it says under the handwritten notes,
15 something "informal group review," and then it
16 says, "If adverse action receive," and then it
17 says, "Notice to MD; period of time to appeal" --

18 A Where are you?

19 Q -- or -- I'm right here.

20 A Okay.

21 Q And it says, "Period of time to appeal or" --
22 something "ACE; thirty days, reasonable time;
23 counsel present." Did you understand that under
24 the recommendation that Dr. Randall would have had
25 an opportunity to appeal the decision, have counsel

Robert Wayne Baker, MD

1 participate, and have a full hearing?

2 A That's my understanding.

3 Q Okay. Where people could ask questions or --

4 A Right.

5 Q Okay. And where Dr. Randall would be afforded the
6 opportunity to ask questions of -- of external
7 reviewers? Is --

8 A Correct.

9 Q And -- and present experts on his behalf; is that
10 correct?

11 A Yes, sir.

12 Q Okay. And was that your understanding of the --
13 that the -- that that was the action that was going
14 to be taken by the --

15 A That's where --

16 Q -- MEC?

17 A -- we were at this point. Yes, sir.

18 Q Okay. And then -- then we'll --

19 MR. GRIFFIN: (To the court reporter)

20 Whatever the next exhibit number is.

21 THE COURT REPORTER: Seven.

22 Plaintiff's Exhibit Number 7, Medical
23 Executive Committee agenda.

24 Q Dr. Baker, I'll show you Exhibit 7, which are
25 minutes of the MEC meeting of October 10, 2010.

Robert Wayne Baker, MD

1 letter.

2 A Yes, sir.

3 Q Okay. When were you made aware of the summary
4 suspension of Dr. Randall?

5 A I can't recall if -- if we had a called meeting or
6 if it was at the November meeting. I'm sure I
7 heard of it informally before then.

8 Q Okay. Well, and I guess you're working in the
9 operating room --

10 A Yeah. That's --

11 Q -- every day? Sure.

12 The -- were you surprised that Dr. Edwards had
13 summarily suspended Dr. Randall?

14 A I mean, it wasn't what I anticipated was going to
15 occur, if that's what you're asking. No, sir.

16 Q Okay.

17 A Not by -- by our previous meetings.

18 Q Sure. Did you ever have a conversation with Dr.
19 Edwards on --

20 A Not that I recall, no, sir.

21 Q -- about that?

22 Were you -- there was a -- the -- the third
23 case, I believe, that Dr. Edwards refers to in his
24 October 15th letter is a case involving a patient
25 who required 11 units of blood --

1 that unless he actually believed that.

2 Q Okay. Well, and two days -- or a few days before,
3 the MEC voted that patients -- I mean, was danger
4 of patients considered in the MEC decision to allow
5 Dr. Randall to have his appellate review rights?

6 A Yes.

7 Q Okay.

8 A Because as -- as I recall, the -- the -- the
9 suspension was discussed at that point as well, as
10 we -- as we talked about already --

11 Q Right.

12 A -- and we elected to go through the normal process.

13 Q Right.

14 A But there were concerns expressed.

15 Plaintiff's Exhibit Number 10,

16 Handwritten notes, dated 10/25/10.

17 Q Right. The -- the next exhibit --

18 THE COURT REPORTER: Ten.

19 Q -- ten, again, are Ms. West's notes of this
20 meeting. And when -- this is the October 25th,
21 2010 meeting where it says, "Call to order 5:45
22 p.m. Address summary 10/15/10 Restriction of
23 privileges." And -- and then, at the top of the
24 page, it lists the attendees. And --

25 A Yes, sir.

DEPOSITION TRANSCRIPT EXCERPTS

DR. NATHANIEL EDWARDS

State of South Carolina	)	
	)	
County of York	)	
	)	
Robert Randall, M.D.,	)	2012-CP-46-167
	)	
Plaintiff,	)	
	)	
vs.	)	Deposition
	)	
Amisub of South	)	of
Carolina, Inc., d/b/a/	)	
Piedmont Medical Center,	)	Nathaniel Edwards,
Nathaniel Edwards, M.D.,	)	M.D.
and Richard Patterson,	)	
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

Nathaniel Edwards, M.D.

1 document. I'll represent to you, it was produced
2 by Piedmont in this lawsuit as portions of their
3 bylaws. It's by no means all of the bylaws and --
4 and I have -- and what I have produced is Section
5 6: Duties of Officers, and Subparagraph A: Chief
6 of Staff. And -- and -- and the -- the duties as
7 set forth in the -- in the bylaws say as, "Chief of
8 staff" -- and, I guess, just for the record, in
9 2010, you held this position as chief of staff?

10 A That's correct.

11 Q In -- in 20 -- 2009, you were the vice chief of
12 staff?

13 A That's correct.

14 Q And who was the chief of staff in 2009?

15 A I believe it was Sushil Singhi, S-i-n-g-h-i. But I
16 could be wrong.

17 Q Okay. And -- and in -- then 2010, would Dr. Singhi
18 be considered the immediate past chief?

19 A Yes.

20 Q Okay. And there's a secretary-treasurer; were you
21 secretary-treasurer in 2008?

22 A 2008, yes.

23 Q And is that how it works? Once you -- once you get
24 in the rotation, you -- unless you do something
25 really bad, you just progress up to the chief of

Nathaniel Edwards, M.D.

1 Dianna (as spoken) West.

2 Q Okay. So --

3 A I think.

4 Q So it's your understanding that -- that, when
5 you're chief of staff, you -- you have under this -
6 - under the bylaws, you know, the ability to assign
7 yourself to different committees?

8 A No. You know, it's -- it's -- later on, I think it
9 says you work -- I think, it -- in the bylaws, it
10 states that the chief of staff will serve as
11 chairman of peer reviews. And I think that's in --
12 that's in the bylaws and not up to the discretion
13 of the chief.

14 Q Okay. And that -- and that -- that does lead to my
15 line of questioning. What -- what other committees
16 did you serve on when you were the chief of staff
17 in 2010?

18 A The only other on that I can recall is the ad hoc
19 review committee that we created later in this
20 process.

21 Q And the ad hoc review committee consisted of
22 members of the medical executive committee, the
23 peer review committee, and the credentials
24 committee?

25 A Yes, sir.

Nathaniel Edwards, M.D.

1 Q Okay. And -- and -- and I think some of the
2 standing members of those committees, perhaps,
3 recused themselves from consideration?

4 A Correct.

5 Q Okay. In Number 6, it says, "Appoint committee
6 members to all standing, special, and
7 multidisciplinary medical staff committees." Would
8 -- would that -- Number 6 that I just read, would
9 that include the -- the ad hoc committee that --
10 that you just referenced?

11 A Yes. As a standing special, yes.

12 Q Okay. And so did you appoint the members of the ad
13 hoc committee that was convened in the -- well,
14 late summer, early fall of 2010, to consider --

15 A Well, we had the --

16 Q -- Dr. Randall's situation?

17 A We had a general discussion in the medical
18 executive committee meeting and came up with that
19 idea, but I don't remember specifically -- I don't
20 know that I wrote any formal document, appointing
21 members.

22 Q Okay. Did you appoint the members that -- that
23 served on the hearing committee that entertained
24 Dr. Randall's appeal that was ultimately held in
25 February 2011?

Nathanial Edwards, M.D.

1 A Yes. I did.

2 Q Okay. And how did you go about making that
3 selection? What --

4 A So we --

5 Q -- what was your criteria?

6 A Well, I looked at people who had not had prior
7 knowledge of the proceedings, which eliminated a
8 lot of physicians, physicians who were well
9 respected, ethical, and had good judgment. And had
10 some knowledge of surgery. We didn't have a
11 general surgeon on the committee, as you know,
12 because all the general surgeons on staff were
13 either direct competitors, which is not allowed in
14 the bylaws, or partners -- current or former
15 partners of Dr. Randall.

16 Q Okay. Did -- did you -- I mean, you came up with a
17 slate of -- of names; did -- did you run that slate
18 of names by --

19 A I discussed it --

20 Q -- any committee?

21 A -- with Richard Patterson. But did not -- I don't
22 recall if we discussed it, and we discussed the
23 general composition of the committee in the medical
24 -- medical executive committee. The specific
25 people, I don't remember --

1 Q Okay.

2 A -- discussing in the medical executive committee.

3 Q And -- and you mentioned Dr. Patterson; did you
4 discuss the slate with Dr. Patterson?

5 A Yes.

6 Q Okay. Before becoming chief, what -- in 2009, did
7 you serve on any -- did you -- well, let me ask --

8 A Yes.

9 Q Did you serve on the peer review committee in 2009?

10 A No.

11 Q Did you serve on the credentials committee in 2009?

12 A No.

13 Q Did you serve on the medical executive committee in
14 2009?

15 A Yes.

16 Q Did you serve on the medical executive committee in
17 2008?

18 A Yes.

19 Q Okay. Did you serve on the credentials committee
20 in 2008?

21 A No.

22 Q Did you serve on the peer review committee in 2008?

23 A No.

24 Q Had -- had -- before 20 -- 2009, had you served on
25 the peer review committee?

1 A Never. That was my first time, 2010.

2 Q 2010 was your first time?

3 What other committees -- of -- of the three
4 that -- that I'm talking about: credentials, peer
5 review, and -- and medical executive committee.
6 Well, which before 20 -- I guess, 2009, what --
7 what -- I'm getting lost here. But 2009, you had --
8 -- you were medical exec; is that correct?

9 A Eight. And '9 and '10, med exec.

10 Q Okay. Before 2008, were you on any of those three
11 committees?

12 A Not that I recall.

13 Q Okay. And how -- in 2008, you were -- were you
14 elected secretary-treasurer?

15 A Yes.

16 Q And how was that election -- or who was --

17 A That was held -- held at one of those meetings of
18 the general medical staff that we were discussing
19 earlier.

20 Q Okay. And did -- as -- and is that -- is a vote
21 taken of all members --

22 A -- present.

23 Q -- of the active medical staff?

24 A Yes.

25 Q Okay.

Nathaniel Edwards, M.D.

1 practitioner's privileges in any way, isn't --
2 isn't there a requirement that a letter be sent to
3 -- to the CEO of the hospital and that -- that be
4 formally put in writing to the medical executive
5 committee?

6 MR. DAYHUFF: Object to the form of the
7 question.

8 Q Or --

9 MR. DAYHUFF: (To the deponent) You can
10 answer.

11 Q -- do you know if that's --

12 A I don't -- I don't really -- I -- I'm not -- it's
13 been a while since I've studied the bylaws and this
14 has all happened, so I'm not totally -- I don't
15 know.

16 Q Okay. Let me see. Okay. The -- going back on
17 Exhibit Number 5 -- and if you'll look at the
18 second page of this exhibit, under "Conclusions and
19 Recommendations" again, and that is the second
20 column to the -- to the right.

21 A Uh-huh.

22 Q Under Item Number 4, it says, "CMO will determine
23 whether an external physician in this specialty
24 could be added to the 9/27/2010 meeting." Let me
25 ask you first, Who is the -- who was the CMO in --

1 A Richard Patterson.

2 Q Okay. And when it says with -- "A physician in
3 this specialty," what specialty's being referred
4 to?

5 A I think it's referring to general surgery.

6 Q Okay. And did that indicate that the -- that no
7 one on the ad hoc committee was a specialist in the
8 field of general surgery?

9 A Yeah. On the ad hoc committee, there were
10 surgeons, but they were subspecialists -- OB/GYN,
11 but no general surgeon.

12 Q And do you know whether or not -- well, do you know
13 what the result of the CMO's efforts were, whether
14 -- that he was --

15 A There was no general surgeon added.

16 Q Okay. I understand that. Do you know why there
17 was no general surgeon added?

18 A No.

19 Q Do you have any -- do you recall having any further
20 communications with the CMO about the ability to
21 obtain a external physician to come in?

22 A Not really.

23 Q Okay.

24 A Unh-unh.

25 Q And -- and in -- and under

Nathaniel Edwards, M.D.

1 A -- was a lot --

2 Q -- honest.

3 A -- of them. Yeah. It was a lot of them.

4 Q Okay.

5 A It wasn't one. It wasn't one physician driving.
6 It was definitely a -- it just felt like a lot of
7 people in the room.

8 Q Okay. All right.

9 MR. GRIFFIN: Now Exhibit 10.

10 Plaintiff's Exhibit Number 10, Letter to
11 Charles F. Miller from Nathaniel Edwards,
12 MD, 10/12/10.

13 Q Now, is this a -- Exhibit 10 is another document.
14 Has Number 612. Okay. It's dated October 12th,
15 2010, and it's an -- a -- a letter that you sent to
16 Mr. Miller, as referenced by the first paragraph,
17 that it was the action of the medical executive
18 committee notifying Mr. Miller of that action?

19 A Yes, sir.

20 Q Okay. Okay. And the -- and the last sentence
21 says, "This recommendation will not be forwarded to
22 the Board of Governors until Dr. Randall has
23 exhausted his rights under the bylaws."

24 Did -- was this letter also prepared by Dr.
25 Patterson?

Nathaniel Edwards, M.D.

1 A Yes.

2 Q Okay. And did you have an understanding of what --
3 what the significance is of -- under the bylaws of
4 forwarding the letter to -- the recommendation to
5 the Board of Governors?

6 A At this time, I don't recall.

7 Q Okay.

8 A I might have then.

9 MR. GRIFFIN: And then Exhibit 11.

10 Plaintiff's Exhibit Number 11, Letter to
11 Robert D. Randall, Jr., MD, from
12 Nathaniel Edwards, MD, dated 10/15/10.

13 Q Now, Exhibit 11 is a two-page document dated
14 October 15th, 2010. And it -- it's 588 and 589,
15 document numbers.

16 And let me ask you: Is that your signature on
17 the second page?

18 A Yes, sir.

19 Q And what is this letter?

20 A Okay. This is a letter to Dr. Randall from me, and
21 I -- I -- just having it right in front of me, I'll
22 have to --

23 Q Yeah.

24 A -- like --

25 Q Take --

Nathaniel Edwards, M.D.

1 A -- before --

2 Q -- your time.

3 A -- read it --

4 Q Please take --

5 A -- a little bit.

6 Q Please take your time.

7 A So this looks like the letter sent to him informing
8 him of his summary restriction of privileges.

9 Q Okay. And who made the decision to summarily
10 suspend Dr. Randall's privileges?

11 A I did.

12 Q And did you do that in your capacity as chief of
13 staff?

14 A Yes.

15 Q And you had that authority under the bylaws; is
16 that correct?

17 A Yes, sir. And I felt that I had it -- I felt
18 comfortable in sending this letter because there
19 was such a strong feeling among -- among the
20 medical executive committee member meetings and the
21 previously referenced meeting.

22 Q Okay. What transpired from October 12th, 2010,
23 when you wrote a letter to Mr. Miller, which is
24 Exhibit 10, saying that the recommendation that --
25 will not be forwarded to the Board of Governors

Nathaniel Edwards, M.D.

1 until Dr. Randall has had -- has exhausted his
2 rights under the bylaws, until October 15th and
3 Exhibit 11 when you, in your capacity as chief of
4 staff, summarily suspended him?

5 A There was a complaint by, as I recall, a family
6 member of J[REDACTED] R[REDACTED] about a large bleed after
7 abdominal surgery, who was a patient of Dr.
8 Randall's.

9 Q Okay. Where did you learn of that complaint?

10 A Dr. -- I'm pretty sure, Dr. Patterson told me of
11 that complaint.

12 Q And when did he tell you of that complaint?

13 A I don't recall.

14 Q Did he tell you of the complaint on the 15th, or
15 did you know prior to the 15th?

16 A I don't know.

17 Q Did you know of the case of Ms. R[REDACTED] on -- on
18 October the 12th, when you wrote a letter to Mr.
19 Miller?

20 A No.

21 Q Did you know --

22 A I don't --

23 Q -- of the --

24 A -- think so.

25 Q -- case on October the 10th, at the time of the MEC

1 meeting?

2 A No.

3 Q Okay. So you believe you had learned of that case
4 sometime after October the 12th --

5 A Based on these letters, yeah.

6 Q -- but before October 15th?

7 A Yes.

8 Q And what did Mr. -- Dr. Patterson tell you about
9 Ms. [REDACTED]'s case?

10 A That she had had abdominal surgery and -- again, my
11 recollection's fuzzy, but she had had, I think,
12 cholecystitis, had had surgery by Dr. Randall, and
13 then had bled for several days after, getting
14 transfused and having an 11-unit bleed.
15 Ultimately, she was discharged from the hospital
16 and went to rehab.

17 Q Did -- were you provided any medical records of Ms.
18 [REDACTED] to review?

19 A I don't recall, but I think there was a paper
20 record, and we also have electronic record in the
21 computer. But I don't, honestly, recall.

22 Q Do you recall whether you looked at the records?

23 A I don't honestly recall, to be honest.

24 Q Do you know whether Dr. Patterson had looked at the
25 records?

Nathaniel Edwards, M.D.

1 A I feel confident he did, but I can't tell you.

2 Q Did he give you any recommendation as what you
3 should do in response to this additional --

4 A Yeah.

5 Q -- complaint?

6 A He was concerned that this was another case that
7 should prompt summary restriction of privileges.

8 Q Okay. And was -- was he advocating summary
9 restriction of privileges?

10 A I don't know that he was advocating it, but he
11 certainly brought it to my attention, saying --
12 based on the discussions in the prior MEC, you
13 know, that there was a strong feeling about summary
14 restriction. Yeah. "This -- the -- and here's
15 another case that came in."

16 Throughout the process, as we were looking at
17 those original seven or eight cases, you know,
18 additional cases were coming in. And that, I
19 think, made the MEC more concerned about ongoing
20 potential harm to patients. And then, here was
21 another case, you know, coming in. And so we felt
22 -- I felt, at that point, there was certainly was
23 imminent danger to patients and that something
24 needed to be done.

25 Q And when you felt that imminent -- that there was a

Nathanlel Edwards, M.D.

1 risk of imminent -- imminent danger to patients and
2 something needed to be done --

3 A Yeah.

4 Q -- you -- it sounds like you were aware --

5 A Summary.

6 Q -- that -- that she had -- that Ms. R[REDACTED] had
7 been discharged?

8 A Yes.

9 Q Into some rehab?

10 A Yes.

11 Q That you did -- and that that had -- and so were
12 you aware that the surgery was in July of 2010?

13 A Yes. Yes.

14 Q Okay. So you knew it was months --

15 A Yeah. It was just a compilation that -- cases kept
16 coming in throughout the process, and people kept
17 being harmed and -- and -- yeah. That was why the

18 --

19 Q But did you --

20 A -- summary suspension was put in place.

21 Q Did -- did -- did you make the assessment that --
22 that Dr. Randall had harmed Ms. R[REDACTED], based on
23 his treatment of her --

24 A Yes.

25 Q -- in July 2010?

Nathaniel Edwards, M.D.

1 A Yep.

2 Q And -- and what did you base that determination on?

3 A I -- I -- I don't -- I don't recall, at this point.

4 I think it was review of records in the case with

5 Dr. Patterson.

6 Q Okay. Did -- did you speak to the intensivist who
7 was working with Ms. R [REDACTED] and Dr. Randall as
8 they were treating her, as to whether she should go
9 back to surgery or not?

10 A No. That was prior to my knowledge of the case.

11 You mean during her treatment?

12 Q No. I'm -- I'm -- what -- what I'm asking is --

13 A Later, did I interview? No.

14 Q Before you suspended Dr. Randall's privileges, did
15 you --

16 A Yes.

17 Q -- do any further investigation, like talk to the
18 intensivist, who was working with this patient, to
19 ask his or her assessment of Dr. Randall's care?

20 A No, sir.

21 Q Okay. You took it upon yourself, as a
22 cardiologist, to express your judgment as -- that
23 he -- that he harmed Ms. R [REDACTED] by his conduct.

24 Is that what you did?

25 A Yes.

Nathaniel Edwards, M.D.

1 Q And did -- did Dr. Patterson express his opinion as
2 to whether Dr. Randall's conduct was below the
3 standard of care, with regard --

4 A I --

5 Q -- to --

6 A I --

7 Q -- this patient?

8 A -- think so, by my recollection.

9 Q Okay. And -- and who wrote the letter, Exhibit
10 Number 11 --

11 A Hold on.

12 Q -- which is the October 15th --

13 A Essentially, Dr. Patterson. I looked over it and
14 made minor changes to -- I don't remember exact
15 letters, but I made minor changes to some letters.
16 But he did the bulk of the work --

17 Q Okay.

18 A -- on all the correspondence.

19 Q Okay. Let me ask you, after issuing the summary
20 suspension of Dr. Randall, did -- did you take any
21 effort to further investigate the -- Ms. R[REDACTED]'s
22 case?

23 A Oh, the case was sent off to the external peer
24 review. I'm -- I'm sure it came through the peer
25 review committee, through the normal process --

Nathanlel Edwards, M.D.

1 Q Right.

2 A -- and I was the chairman of that, at that point.

3 Q Right. But -- okay. I'll get back to that. The

4 --

5 MR. GRIFFIN: Exhibit 12, please.

6 Plaintiff's Exhibit Number 12, "Peer

7 Reviewer Final Report."

8 Q And take your time to take a look at this.

9 A Okay.

10 Q You did mention the case was sent off to external

11 review, and Exhibit 12 is a "AMR Peer Reviewer

12 Final -- Final Report, Reference Patient Name:

13 J██████████R██████████." It says, "Date completed:

14 11/4/2010." It's a two-page document, Numbers

15 1121, 1122.

16 A Okay.

17 Q Now, the -- it says, "Date completed: 11/4/2010."

18 And I -- if -- if that is the case, obviously you

19 didn't have this external review available to you

20 when you made the decision to suspend Dr. Randall?

21 A That's --

22 Q Is that correct?

23 A -- correct, yeah.

24 Q And -- but it was sent out to a -- a -- it says,

25 "Reviewer specialty: Surgery general -- general;

Nathaniel Edwards, M.D.

1 Surgery vascular; Surgery transplant; Surgery
2 critical care." So --

3 A Uh-huh.

4 Q -- it was sent to someone in Dr. Randall's
5 specialty; is that correct?

6 A It looks like it. General surgery is listed.

7 Q Yep. And this specialist whose -- apparently does
8 this for this company, Advanced Medical Reviews,
9 says, "It's difficult to know if Dr. Randall has a
10 quality issue for a reckless pursuit of a
11 laparoscopic approach, for he and his patient may
12 not be as fortunate next time, or if he should be
13 praised as a very skillful laparoscopic surgeon."

14 It -- it -- it says, "Again, watching an 11-
15 unit bleed, knowing that this patient had a
16 gangrenous gallbladder with high risk of infectious
17 intra-abdominal complication appears very cavalier,
18 while intervening may have prevented some of the
19 patient's ICU morbidity. Again, if this patient
20 continues to do well, it's just simply hard to
21 argue with success. This case needs to be included
22 with other cases to assess if there's an overall
23 lack of good surgical reasoning, judgment, and/or
24 skills."

25 Did I read that correctly?

Nathaniel Edwards, M.D.

1 A Yes, sir.

2 Q Were you -- and now, I think we've established, you
3 were aware that -- that -- that -- that the patient
4 was discharged to --

5 A Yes.

6 Q Okay. And that you were aware that -- were you
7 aware that the 11-unit bleed took over four days?
8 It wasn't --

9 A Over several days, yes.

10 Q Okay. And the options of someone who's slow
11 bleeding like that, he's either taken back into
12 surgery and explore them or -- or watch --

13 A Or --

14 Q -- them and see if they get better; is that right?

15 A Yes, sir.

16 Q Again, it's easy in retrospect to -- to say, "Wow.
17 That -- they didn't stop till after 11 units." But
18 you don't know, on the front end, that it's going
19 to take 11 units before they stop, do you?

20 A That's correct.

21 Q Okay. And, at the -- above the paragraph, under
22 "Peer Reviewer Final Report," it says, "Again, if
23 this patient, post-discharge, continues to do well,
24 then Dr. Randall did stare -- spare this patient a
25 second operation."

Nathaniel Edwards, M.D.

1 Wasn't -- wasn't Dr. Randall being criticized
2 in the -- on most of these cases for taking
3 patients back to surgery too quickly?

4 A I don't think it was taking it -- no. There was a
5 -- there was a concern about what -- appropriately
6 taking patients back.

7 One patient, that I recall, had developing
8 sepsis, post-operatively, and wasn't taken back.
9 There was that review of a unplanned return to OR
10 cases, and the -- and the -- and he had a high rate
11 of unplanned return to OR compared to the other
12 general surgeons at Piedmont Medical Center.

13 But the criticism wasn't that patients were
14 going back too much, it was that the original --
15 that there was problem with pre-operative
16 assessment, potentially; intra-operative
17 management; technique of handling bowel and
18 dissecting around the liver and gallbladder; and
19 then post-operative management, which included, not
20 really going back too early, but, at least in the
21 one that I can remember, going back too late.

22 Q Okay.

23 A Yeah.

24 Q And in -- in this description, it says, "From the
25 description of this patient's operative note, dated

1 7/20/10, this patient and Dr. Randall are very
2 fortunate -- fortunate that there was not a major
3 bowel injury and/or Dr. Randall is a very skillful
4 and experienced laparoscopic surgeon."

5 So here, there was no bowel injury; is that
6 correct?

7 A That -- that -- that -- that's what it appears to
8 say.

9 Q Okay. And, again, you didn't have the benefit of
10 this when you decided to summarily suspend Dr.
11 Randall; is that --

12 A That's correct.

13 Q In your letter of suspension to Dr. Randall, which
14 is Exhibit 11, says, "You have . . ."

15 Do you have that in front of you?

16 A Yes, sir.

17 Q It says, "As Chief of Staff at Piedmont Medical
18 Center, having -- having taken into account the
19 case materials previously presented to you and, in
20 addition, three more recent cases and an analysis
21 of your unplanned returns to the operating room
22 compared to the records of your peers, I have
23 determined that summary suspension of your
24 privilege is warranted to ensure there will be no
25 immediate -- imminent danger to person -- persons

Nathaniel Edwards, M.D.

1 for whom you might provide services under those
2 privileges."

3 A Summary of restriction, that's correct.

4 Q So you don't -- is -- were you basing your decision
5 solely upon Ms. R[REDACTED]'s case, or was it a --

6 A That was one more piece of -- one more piece of
7 data, but, as I said in that meeting, previously,
8 there had been a strong discussion about summary
9 restriction in the October 10th, or so, meeting.
10 So it -- it was based on the -- everything. All of
11 the -- all of the data reviewed, as listed in the
12 letter here.

13 Q Now, you say a "strong discussion," but you --
14 unable to tell us who was voicing a -- an opinion
15 that Dr. Randall should be suspended at that
16 meeting?

17 A I mean, I could guess, but I might be wrong.

18 Q Okay.

19 A I didn't hear much discussion about not summarily
20 restricting in the meeting. It -- the -- the
21 majority of the comments were in favor, but . . .

22 Q Okay. The -- I'll show you this one.

23 MR. GRIFFIN: Exhibit 13.

24 Plaintiff's Exhibit Number 13, Letter to
25 Dr. Nathaniel Edwards from Robert D.

1 Randall, Jr., MD, dated 10/18/10.

2 Q Exhibit 13 is a Document Number 618. It's a letter
3 from Dr. Randall to you as chief of staff, dated
4 October 18th, 2010, in -- in which he's requesting
5 a review of his summary restrictions; is that
6 correct?

7 A Yes, sir.

8 Q Okay. Now, here he says, "In addition, your letter
9 states that there were three additional cases, and
10 I have no knowledge of these cases, nor have I
11 received any information about either of these
12 cases or the outside reviewer's findings." Is that
13 consistent with your understanding of what notice
14 Dr. Randall had been given, as of October 18th --

15 A As best --

16 Q -- 2010?

17 A -- as I can recall, at this point.

18 Q Okay. You think it would've been a fair to give
19 Dr. Randall notice of these cases that were under
20 consideration that led to his summary suspension,
21 before action was taken, to hear his side of the
22 story?

23 A Well, I think that the -- the concern of the MEC,
24 and my concern, was that his restriction should go
25 into effect immediately to prevent patient harm,

Nathaniel Edwards, M.D.

1 and that there would be a review process in place
2 for him to hear about the additional cases.

3 Q But -- now, you -- you -- you -- you --

4 A I may be wrong. I -- I may --

5 Q I -- I --

6 A -- have misspoke.

7 Q -- understand. I know, but, just so we're -- you
8 had the ability, as chief of staff, to, you know,
9 lock him out or not lock him out.

10 A You mean -- and in terms of --

11 Q In the -- in the -- in the operating room.

12 A -- the -- a summary restriction of privileges, is
13 what you're --

14 Q Yeah.

15 A -- referring when you say "lock him out"?

16 Q That's what I mean.

17 A Yeah.

18 Q Now, you could -- you --

19 A Yes.

20 Q -- could lock -- lock him out of the operating room
21 or not?

22 A Yes.

23 Q And you exercised that authority to lock him out on
24 -- on the -- when -- within the scope of the
25 revocation that we've seen in the letter; is that

1 right?

2 A Yes. That's correct.

3 Q Before you made that decision, did you ever think
4 about picking up the call -- phone and calling Dr.
5 Randall, and say, "Bob, come over here. You know,
6 I -- I have to make a hard decision, but tell me
7 about these cases. Why we're wrong"?

8 A No. I honestly did not.

9 Q And why not?

10 A I -- I can't tell you. I guess there was such a
11 strong feeling prior to that, that -- I -- I can't
12 -- I don't know.

13 Q Okay. Do you know whether Dr. Randall was in the
14 hospital on October 15th, 2010?

15 A I don't.

16 Q So -- but you made no effort to try to locate him?

17 A No, sir.

18 Q Is that correct?

19 A That's correct.

20 Q Did you even give thought to trying to get in touch
21 with him?

22 A Not that I recall.

23 Plaintiff's Exhibit Number 14, Medical
24 Executive Committee agenda; Peer Review
25 Committee agenda.

Nathaniel Edwards, M.D.

1 A Yeah.

2 Q Did --

3 A Yeah.

4 Q Does your -- does your wife currently, or did she
5 previously, practice medicine with a Dr. M[REDACTED]?

6 A No.

7 Q Okay. Was -- do you -- do you know a Dr. M[REDACTED]?

8 A Yes.

9 Q Okay. Do you recall there being a point in time
10 Dr. M[REDACTED]'s, at the time, 12-year-old daughter was
11 admitted to the hospital for appendicitis?

12 A Yes.

13 Q And was your wife following the care of Dr.
14 M[REDACTED]'s daughter?

15 A Yes.

16 Q And did your -- do you recall your wife complaining
17 about Dr. Randall's care and treatment of Dr.
18 M[REDACTED]'s daughter?

19 A Yes.

20 Q Okay. And what was the nature of her complaint?

21 A So she was staying -- the -- the -- Dr. M[REDACTED] was
22 on call -- so he's a obstetrician, and the wife had
23 small children. So my wife offered to stay with
24 the girl, [REDACTED], when the mom couldn't be there.

25 And, while she was there, she was concerned

1 that [REDACTED] didn't get better after an
2 appendectomy, and she was having persistent
3 problems with, I think, nausea, vomiting, probably
4 abdominal pain -- I'm not sure, fever. And she
5 felt like that things were not being addressed like
6 they should be.

7 Ultimately, [REDACTED] had a CT scan that showed
8 a abscess in her abdomen, and that was drained and
9 she did fine --

10 Q Okay.

11 A -- and went home.

12 Q All right. Did -- did your -- you recall that your
13 wife contacted some surgeon in -- in Charlotte
14 about the case?

15 A Yes.

16 Q And asked him to intervene?

17 A I don't -- I don't recall. I remember she talked
18 to a pediatric surgeon in Charlotte about the
19 surgery and should -- and what should be done. I
20 don't -- I don't recall details, but I know she
21 talked to a pediatric surgeon in Charlotte.

22 Q Okay. Is -- is your wife on -- in 2010, did she
23 have privileges here at Piedmont?

24 A Yes. I think so.

25 Q Okay. And -- and -- and did she express to you her

Nathaniel Edwards, M.D.

1 opinion of Dr. Randall's competency?

2 A She wasn't happy with the care that [REDACTED] was
3 receiving from Dr. Randall.

4 Q Okay.

5 MR. GRIFFIN: That's all the questions I've
6 got.

7 EXAMINATION

8 BY MR. DAYHUFF:

9 Q Doctor, I've got a few questions for you. Let's --
10 let's start with [REDACTED] and -- and your wife.

11 And do you recall when Dr. M[REDACTED]'s daughter
12 was receiving the care that Mr. Griffin was just
13 discussing with you?

14 A Honestly, I don't. I know it must've been over
15 eight years ago, at least. Or, at least, over six
16 years ago.

17 Q All right. Six to eight years ago?

18 A Yeah.

19 Q All right.

20 A That's a guess.

21 Q Did the care that Dr. Randall provided to [REDACTED]
22 and/or communications that your wife had with Dr.
23 Randall about that care have any effect upon the
24 decisions you ultimately made in the peer review
25 action?

DEPOSITION TRANSCRIPT EXCERPTS

JULIUS "JAY" MCKAY, ESQUIRE

Julius W. "Jay" McKay, II, Esq.

State of South Carolina)

County of York)

Robert Randall, M.D.,)

Plaintiff,)

vs.)

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

Defendants.)

2012-CP-46-167

Deposition

of

Julius W. "Jay"
McKay, II, Esq.

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

1 here to take your deposition in connection with
2 that lawsuit.

3 I want to ask you, just for the record,
4 background information. Are you an -- are you an
5 attorney?

6 A I'm an attorney licensed in South Carolina.

7 Q How long have you been a lawyer?

8 A Since 1977.

9 Q And what's the nature of your practice?

10 A My practice -- I do a lot of health care law. I do
11 some corporate litigation, complex litigation. But
12 primarily health care law, medical malpractice, and
13 other areas of health care law. But that's --
14 that's been the bulk of -- but I have a firm that
15 people do different things. --

16 Q Sure.

17 A -- and I've certainly done a lot of different
18 things during my tenure as an attorney.

19 Q And at some point in time, did you have an
20 opportunity to represent Dr. Randall in connection
21 with a -- I guess, a -- an action brought by the
22 medical executive committee to revoke his
23 privileges there at Piedmont Medical Center?

24 A Yes. I did.

25 Q And -- and do you recall what your first

Julius W. "Jay" McKay, II, Esq.

1 involvement was in this matter?

2 A I was representing Dr. Randall in a lawsuit that
3 was against the hospital and an ER doc, so we
4 talked from time to time about that. And then, at
5 some point, he mentioned having some issues with
6 the hospital, and I didn't think much about it.

7 But -- and then he contacted me later, and I'm
8 assuming it was in October -- I believe that's when
9 his suspension came up -- that he had received a
10 hand-delivered letter -- I believe it was hand-
11 delivered from the hospital summarily suspending
12 his abdominal surgical privileges.

13 Q Right.

14 A And so I got as much information as I could from
15 him and headed to Rock Hill, and we met. And I'm
16 not sure . . .

17 Q And was it October 2010?

18 A Yes. It was in October 2010, and I think his
19 privileges were suspended, I believe, October 15th,
20 but I could be wrong about that. I think it was a
21 Friday.

22 Q And -- and do you recall on or about October 25th,
23 some 10 days after, that there was a -- a -- I
24 guess, a -- a meeting convened by members of the
25 medical executive committee to consider that

1 summary suspension?

2 A Yes.

3 Q And did -- did you appear at that meeting --

4 A I --

5 Q -- on behalf of Dr. Randall?

6 A I went up there with Dr. Randall. I want to say
7 that the meeting maybe was a six at night. And I
8 -- I did go to a -- with him, yes.

9 Q Were -- were you allowed to participate in any form
10 or fashion in that --

11 A No.

12 Q -- meeting?

13 A I -- Dr. -- I was there. I went in the room. I
14 set my computer up and some notes, and then Dr.
15 Patterson -- and there was some people in there,
16 and I may have known -- I know a lot of physicians.
17 I may have known one or two of them in there. But
18 then Dr. Patterson approached me and told me that I
19 had to leave, that it's -- you know, that Dr.
20 Randall would not be allowed to have his attorney
21 there, so . . .

22 Q Were you surprised to learn that information?

23 A I was. I was very surprised, because my role,
24 basically, is I wanted Dr. Randall to be able to
25 effectively communicate to these people. Doctors

Julius W. "Jny" McKay, II, Esq.

1 can be somewhat dry in their presentations, and I
2 wanted to make sure that he was able to convey his
3 message about these various patients. But I was
4 surprised, but I was asked -- I was asked to leave
5 -- or told that I could not be there -- so I didn't
6 want security come -- to come get me, so I left.

7 Q Okay. Had -- had you ever previously appeared on
8 behalf of a medical physician in connection with a
9 -- a -- a proposed action to be taken against their
10 privileges in this type of context?

11 A I'm just not sure. I have dealt with privilege
12 violations before, and I'm thinking the -- usually,
13 they're more informal than this. And I know that I
14 have represented a hospital board member before in
15 a privilege revocation action, but I'm not sure
16 I've ever handled one like this, all the way from
17 start to finish.

18 Q Now -- now, you mentioned your -- your -- at the
19 time, you were also representing Dr. Randall in
20 connection with a -- I guess, a medical negligence
21 lawsuit brought against him and the hospital?

22 A That's correct.

23 Q And was that pending in Rock Hill?

24 A It was pending -- yes. It was pending in Rock
25 Hill. It was -- it was against the -- I guess,

1 Q -- summary suspension?

2 Now, did you understand that, after the -- the
3 meeting or -- that you attempted to attend, that
4 the -- at that meeting, I think the records reflect
5 it was October 25th, 2010 -- that the medical
6 executive committee voted to uphold the summary
7 suspension?

8 A That's my understanding of it.

9 Q Okay. And then, from that point forward, were you
10 involved in appellate -- internal appellate review
11 of -- of that decision?

12 A I was. I approached the hospital's attorneys at
13 some point, basically, offering Dr. Randall would
14 resign his privileges if you would reinstate -- if
15 you would reinstate his privileges and take him out
16 of the data bank -- well, let me back up. I'm
17 sorry.

18 There's a period of time from a summary
19 suspension that it's not in the National
20 Practitioners' Data Bank, and I can't remember if
21 it's 30 or 45 days. I think it's 30, but I could
22 be wrong about that. During that period of time, I
23 made some requests of the hospital that the summary
24 suspension be lifted and Dr. Randall would resign
25 his privileges because I understood that he had

Julius W. "Jay" McKay, II, Esq.

1 assume it -- I'm not sure how the makeup was of it,
2 but I know that I had some issues with the makeup
3 of the -- of the --

4 Q And I want to --

5 A -- committee.

6 Q -- get to that in a minute, but were there -- under
7 the bylaws, did Dr. Randall have a -- a right to
8 have a hearing within a certain period of time?

9 A He did.

10 Q And do you recall what that period was?

11 A It's in the bylaws, and it's a short period of
12 time. And I think the hearing was, ultimately,
13 after that period of time.

14 Q Okay. When --

15 A Because the short period of time would be important
16 to him because he's basically -- has an office and
17 a staff, expenses of -- and he's dead in the water,
18 as far as being a general surgeon, if he can't --

19 Q Okay.

20 A -- operate. So we wanted to get this hearing
21 sooner rather than later, so . . .

22 Q And -- and the longer it took, the more, I guess,
23 financial harm it was doing to Dr. Randall?

24 A I think -- yes.

25 Q Okay. Now, this says, "On December 28th, Dr. Gary

Julius W. "Jay" McKay, II, Esq.

1 Barone," B-a-r-o-n-e, "the expert witness expected
2 to testify on behalf of MEC at the hearing,
3 notified MEC representatives that he had
4 encountered a scheduling problem because coverage
5 was unavailable for him in Little Rock where he
6 works." Then it goes on to say, "Dr. Barone's
7 testimony is a critical part of the evidence the
8 MEC will present in that" -- and so they have
9 requested a -- a postponement because of the
10 scheduling conflict of -- of this expert witness.
11 Is that what you were led to believe?

12 A That's correct.

13 Q Now, did Dr. Gary Barone ever appear and testify at
14 this hearing?

15 A No. He didn't. And I'd prepared to cross-examine
16 Dr. Barone, and I -- you know, all I found out is
17 that he was not going to come, period. And I don't
18 -- I don't know the reason. And I took -- you
19 know, I made assumptions about the reason is that
20 he was not as critical of the care, but, you know,
21 I don't know that because he never testified. I'd
22 looked him up. He looked like he had good
23 credentials, but he didn't come.

24 Q Now, were -- now, were you informed or led to
25 believe that -- that Dr. Barone was the external

Julius W. "Jay" McKay, II, Esq.

1 request for continuance?

2 A I did.

3 Q Okay.

4 A I said, you know, we had moved a lot of stuff
5 around. This was a very difficult task. We were
6 ready to go. We had our experts lined up, our
7 witnesses lined up. And I thought, Well, if their
8 expert has backed out, then it shows that this is
9 really just a travesty they're doing against him.
10 And I thought we could, you know, get it thrown
11 out, but I -- we were denied that.

12 Q Right. If -- if the case is called to trial and
13 one side doesn't have an expert witness, what's --
14 and an expert witness is required to prove their
15 case, in -- in your line of work, what's -- what's
16 the general --

17 A Well, if --

18 Q -- result?

19 A -- the -- if the jury's been sworn in, then you're
20 sunk.

21 Q Right.

22 A You lose.

23 Q And so here you had -- you had a hearing date, and,
24 as I understand it, the hospital, through the
25 medical executive committee, had identified their

1 recollection, I think.

2 Q And is that a -- a for-profit entity?

3 A Yeah. I think it's traded on the New York Stock
4 Exchange.

5 Q Okay. Now, this second paragraph speaks to a --
6 "Your client's request" -- talking to you --
7 "request for a general surgeon to serve on the
8 hearing committee. It is our understanding that a
9 general surgeon from the hospital's medical staff
10 is not available to serve as a member of the
11 hearing committee, and the hospital declines to
12 appoint a general surgeon who is not a member of
13 the hospital's medical staff." Let me -- let me
14 ask you, did --

15 A Okay.

16 Q -- did you make that request that --

17 A I did.

18 Q -- a general surgeon --

19 And what was the purpose of the request?

20 A Well, this suspension dealt with a surgery of the
21 abdomen, and Dr. Randall believed it was very
22 important to his case that someone be on that panel
23 who had knowledge of abdominal surgery and all of
24 the dangers and problems associated with abdominal
25 surgery. And so that's why we made that request.

Julius W. "Jay" McKay, II, Esq.

1 Q Now, you spent the course of your career -- I guess
2 more than thirty years practicing law, and -- and
3 -- and a lot of that has been in the medical
4 negligent/malpractice arena; is that correct?

5 A That's correct.

6 Q And, over the years, have you found it to be
7 important in evaluating a situation to have an
8 expert witness who's -- who has expertise in the
9 same field of medicine that's at issue of whatever
10 is being litigated, discussed, or reviewed?

11 A I did.

12 Q Okay. And -- and is -- is this what Dr. Randall
13 was requesting?

14 A Yes.

15 Q And was that a legitimate request?

16 A I believe it was. I mean, there was a wide variety
17 of people on this panel, but no -- no one who did
18 anything within the abdomen -- invasive procedures,
19 where you've got to open the abdomen up.

20 I seem to have some recollection of possibly a
21 gynecologist being -- would have some knowledge of
22 going into the abdomen, but some -- I believe that
23 they -- they were not on the ultimate panel that
24 heard the case. And I can't remember who that was,
25 and I don't know the reasons why, but I seem to

1 recall that there may have been a gynecologist that
2 we thought might be on the panel that -- but --
3 which would've been at least someone who had some
4 knowledge about --

5 Q Sure.

6 A -- problems in operating in the abdomen.

7 Q Do -- do you -- do you recall there being a -- a
8 discussion that -- that there were no general
9 surgeons on the medical staff who were not in
10 either a -- in competition with Dr. Randall or had
11 some financial relationship with him to -- to
12 serve?

13 A I know it was -- I remember the -- the -- I
14 remember a discussion about the financial -- not
15 the financial -- being in competition with him. I
16 don't -- I just don't recall, one way or the other,
17 whether there was a -- a discussion about
18 financial, but Dr. Randall was willing to waive
19 that because he wanted a general surgeon, even if
20 -- even somebody who didn't like him. He wanted
21 that on that committee.

22 Q Sure.

23 A You know, just to -- to offer their insights.

24 Q Now, Mr. McKay, if -- if they're -- if the hospital
25 has a rule that -- that a person who cannot sit and

Julius W. "Jay" McKay, II, Esq.

1 review a -- the case of someone on medical staff
2 who is in competition or has a financial interest
3 with that person, can you think of any situation
4 where -- where someone of the same specialty as the
5 person who the case was being reviewed would be
6 qualified?

7 A No. Not if that's their --

8 Q Right.

9 A -- their rule.

10 Q Yeah. If that's their rule, then -- then it's --
11 sets it up where there -- does it set it up where
12 -- that there's -- that -- that would not -- you
13 would not be able to have a -- someone review your
14 case who has expertise in the same field as you?

15 A That's correct.

16 Q Okay. And -- and you mentioned that Dr. Randall's
17 willing to waive whatever conflict issues there
18 were?

19 A Yes.

20 Q Okay. And was the hospital willing to waive any
21 conflict issues?

22 A They were not.

23 Q Okay. And then, as of January 19th, 2011, were you
24 -- had you been informed of any person who has the
25 same specialty as Dr. Randall who was even going to

1 order, would be "Based on all the findings and
2 conclusions, the hearing committee recommends that
3 the medical executive committee recommendation for
4 revocation and summary suspension of clinical
5 privileges to perform abdominal surgery" -- BFL; is
6 -- is that correct?

7 A That's correct.

8 Q And was that the ultimate result of the -- the
9 hearing committee?

10 A Yes. It was.

11 Q Okay. And -- and the -- the recommendation that --
12 that you proposed, would be to vacate the decision
13 on -- of the summary suspension?

14 A Basically, yes. I mean, I'd have to go back and
15 look at it, but . . .

16 Q Well, if you look at Page 31 of -- of your
17 document --

18 A Yeah. That -- that -- it -- that his abdominal
19 surgery privileges be reinstated and that the
20 National Practitioners' Data Bank be notified of
21 the reinstatement.

22 Q Now, Mr. McKay, and I'm asking your -- your,
23 frankly, professional opinion, did Dr. Randall get
24 a fair hearing from the medical executive committee
25 upon review of his summary suspensions and then

Julius W. "Jay" McKay, II, Esq.

1 through the hearing panel as a result of the
2 composition of the panel and the late naming of
3 experts?

4 MR. DAYHUFF: Object to the form of question.

5 A Well, they listed it as evidence, but I -- I
6 believe that they -- they summarily dismissed any
7 legitimate objections that we had. And I think we
8 had some very legitimate objections regarding the
9 timing of the hearing, the name -- the naming of a
10 new expert after the 90-day time frame -- set up in
11 the hospital's bylaws -- had expired, which was
12 greatly prejudicial to him, not placing a general
13 surgeon who'd have particular knowledge of the
14 complications that can arise with abdominal
15 surgery, and then for whatever reason the
16 gynecologist, who would have knowledge about
17 getting into problem with the bowel or other
18 adjacent organs to what they work on, which would
19 be the reproductive organs, was not on the panel.
20 So I think that deprived him of a fair hearing --

21 Q Okay.

22 A -- that's my opinion.

23 MR. GRIFFIN: That's all the questions I have.

24 MR. DAYHUFF: Good. You guys want to take a
25 couple of minutes?

DEPOSITION TRANSCRIPT EXCERPTS

DR. CHARLES MILLER

STATE OF SOUTH CAROLINA
COUNTY OF YORK
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.)

IN THE COURT OF COMMON
PLEAS FOR THE
THIRTEENTH JUDICIAL
CIRCUIT

Case No.: 2012-CP-46-167

Deposition of:

CHARLES F. MILLER

Taken on behalf of the Plaintiff

August 15, 2013

ALPHA REPORTING CORPORATION
APRIL C. HOWARD
236 Adams Avenue
Memphis, Tennessee 38103
(901) 523-8975

Alpha Reporting Corporation

1 in Dallas?

2 A. That's correct.

3 Q. Where in Dallas? My wife is from Dallas.
4 I am just curious?

5 A. On Ross Road. It's a building attach to
6 the Fairmont.

7 Q. Okay. Did -- when you were -- when you
8 were CEO of Piedmont, did there come a time when
9 Piedmont hired hospital employee surgeons?

10 A. Yes.

11 Q. And do you recall when the -- the -- this
12 hiring took place?

13 A. The first was a cardiovascular surgeon
14 that we hired in 1996, '97 which actually predated
15 me. And then we hired some general surgeons, and
16 in 2011 -- early '12, late '11 -- I don't remember
17 the exact date.

18 Q. Okay. And the surgeons that you hired,
19 were there more than one?

20 A. There were four.

21 Q. Four surgeons?

22 A. Correct.

23 Q. And before hiring the -- well, let ask you
24 first, did you have to recruit these surgeons from

1 out of state?

2 A. There were two recruited and two obtained
3 from an existing in-market practice.

4 Q. Okay. And prior to hiring the surgeon
5 in-house, did Piedmont or any Tenet affiliated
6 company, conduct a, I guess, survey or study as to
7 whether there was a need for additional general
8 surgeons in the marketplace?

9 A. There was no formal study conducted, no.

10 Q. Okay. Are you familiar with Dr. Randall?

11 A. I am.

12 Q. Were you aware that at some point in time
13 he -- his practice -- surgical practice at the
14 time -- I think it was called Rock Hill Surgical
15 Associates was acquired by Novant?

16 A. I am.

17 Q. At the time the Rock Hill Surgical
18 practice was acquired by Novant was Tenet
19 attempting to obtain a certificate of need for a new
20 hospital in York County?

21 A. Well, we began the process of obtaining a
22 certificate of need for the new hospital in 2005. I
23 don't recall when their practice was acquired.

24 Q. Okay. And was Tenet, for lack of a better

1 out of state?

2 A. There were two recruited and two obtained
3 from an existing in-market practice.

4 Q. Okay. And prior to hiring the surgeon
5 in-house, did Piedmont or any Tenet affiliated
6 company, conduct a, I guess, survey or study as to
7 whether there was a need for additional general
8 surgeons in the marketplace?

9 A. There was no formal study conducted, no.

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11 A. I am.

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13 he -- his practice -- surgical practice at the
14 time -- I think it was called Rock Hill Surgical
15 Associates was acquired by Novant?

16 A. I am.

17 Q. At the time the Rock Hill Surgical
18 practice was acquired by Novant was Tenet
19 attempting to obtain a certificate of need for a new
20 hospital in York County?

21 A. Well, we began the process of obtaining a
22 certificate of need for the new hospital in 2005. I
23 don't recall when their practice was acquired.

24 Q. Okay. And was Tenet, for lack of a better

1 term, competing with other entities in an effort to
2 obtain the certificate of need?

3 A. The other entities were competing with us.
4 Yes. There were competing applications by Carolina
5 Health System and Novant Presbyterian.

6 Q. When you left in March of 2012 -- I think
7 it was March 2012, did -- what was the status of the
8 CON?

9 A. The CON was under appeal. It had gone
10 through a number of generations. It was originally
11 D. Hix's decision to award it to Piedmont. That was
12 appealed. It was returned to the department.

13 The second review awarded it to Carolina
14 Health System. That was -- that is currently under
15 appeal, and the administrative law judge has held
16 the trial hearing whatever you call it, but yet has
17 not rendered any decision in that case.

18 Q. Okay. Before Novant purchased the
19 surgical practice -- Rock Hill Surgical Associates,
20 do you know whether or not they had a footprint in
21 York County?

22 A. Novant initial footprint was with an OB
23 group that I think was acquired about the same time
24 they filed their competing application. They

1 subsequently acquired some family practice sites in
2 York county, and then I believe the surgical group
3 was the last acquisition or the most recent
4 acquisition in their footprint there.

5 Q. Did you become aware that at some point in
6 time, Novant and Dr. Randall terminated their
7 business, slash, employment relationship with each
8 other?

9 A. Yes.

10 Q. And how did you learn of that?

11 A. Dr. Randall informed me.

12 Q. And do you recall that Dr. Randall for a
13 period of time had to withdraw his surgical
14 privileges at Piedmont because he did not have
15 malpractice insurance?

16 A. That's correct.

17 Q. And during the time period when
18 Dr. Randall -- well, let scratch that. When
19 Dr. Randall withdrew his privileges at Piedmont
20 because he did not have malpractice insurance, did
21 you or Piedmont or Tenet affiliated group do any
22 market study to determine whether there was a need
23 or need assessment for another surgeon since
24 Dr. Randall, at the time, had left the market?

DEPOSITION TRANSCRIPT EXCERPTS

DR. CHARLES PATTERSON

1 State of South Carolina)
2 County of York)
3) C/A no. 2012-CP-46-167
4 Robert Randall, M.D.,)
5 Plaintiff,)
6 vs.)
7 Amisub of South Carolina,) Deposition of
8 Inc. d/b/a Piedmont Medical) Charles Richard
9 Center, Nathaniel Edwards,) Patterson, M.D.
10 M.D., and Richard)
11 Patterson, M.D.,)
12 Defendants.)
13)
14)
15)
16)
17)
18)
19)
20)
21)
22)
23)
24)
25)

CONFIDENTIAL

14 Deposition of Charles Richard Patterson, M.D.,
15 taken before Carolyn M. Beam, a notary public in and
16 for the State of South Carolina, commencing at the
17 hour of 1:15 p.m., Wednesday, July 24, 2013, at, 1742
18 Cavendale Drive, Rock Hill, South Carolina.

20 Reported by
21 Carolyn M. Beam

1 Q The -- do -- do you recall why the peer review
2 committee -- well, let me -- do you recall why
3 Dr. Edwards, in his capacity as chief of staff
4 and chairman of the peer review committee,
5 brought the results of the peer review
6 committee review to the credentials committee?

7 A In the -- as a matter of course, the peer
8 review results would go to credentials
9 committee for their consideration at the time
10 of reapplication or if the peer review
11 committee felt that some special interim
12 consideration should be made from the peer
13 review committee. Because the credentials
14 committee's comprised of former chiefs of
15 staff who have had considerable experience.
16 And the peer review committee is comprised
17 principally of physicians who have not held
18 that sort of leadership position, with
19 exception of the chair.

20 They wanted to put the matter in the --
21 before the credentials committee for their
22 consideration as well, and for recommendation,
23 one way or another, or not, to the MEC.

24 Q Does the credentials committee have, I guess,
25 authority to recommend suspension, revocation?

1 the two new cases that would be considered by
2 the MEC, as well as the result of an analysis
3 of return to the OR within 30 days of the
4 first operation, for the period 2008 and
5 January through July 2009.

6 And then the next one says:
7 Dr. Randall met with the MEC on October 25 to
8 contest the summary suspension. The -- and it
9 says he addressed the case involving the
10 11-unit bleed that had led to the summary
11 suspension, as well as the two newer cases
12 that had been sent for external review. He
13 also discussed the cases that led to the
14 recommendation for revocation. Now, what I
15 want to ask you, this timeline, from the
16 moment that Dr. Edwards initiated this summary
17 suspension, until the hearing or the
18 opportunity that Dr. Randall met with MEC on
19 October 25th --

20 A Uh-huh.

21 Q -- did -- did Dr. Edwards appoint or did any
22 committee get created to investigate the
23 grounds for the summary suspension?

24 A No, sir. That -- the bylaws stipulate that
25 that's the function of the MEC, not of any

Charles Richard Patterson, M.D.

1 other committee or body.

2 Q Okay. And -- and did the MEC do anything
3 about -- take any action, as a result of
4 Dr. Edwards' summary suspension, until the
5 meeting -- other than give Dr. Randall notice
6 and provide him documents, did they do
7 anything prior to the meeting on October 25th?

8 A Not -- not that I recall or would expect.

9 Q So what was the -- I guess what was the
10 urgency of -- of the summary suspension that
11 -- that Dr. Edwards had to act on his own,
12 without taking it to the committee?

13 A Well, that's as the bylaws stipulate. Only
14 the chief of staff -- maybe the chair of the
15 board and perhaps the CEO can summarily
16 suspend a member, if the chief of staff is not
17 available. But only the chief of staff can do
18 that. And that action then has to be reviewed
19 within some time limit by the MEC. And
20 either, as I said, upheld, amended or
21 overturned.

22 Q Did you attend the October 25th meeting?

23 A I think I did. Here's a two-page document.
24 There was some meeting at which I and any
25 other non-credentialed member of the medical

1 that Dr. Randall brought an attorney to this?

2 A Was this the meeting? Then I was there.

3 Q Okay.

4 A Yes. Yes, I was there.

5 Q Okay.

6 A I don't know why I'm not listed.

7 Q Okay. And the -- and what do you recall about
8 -- about Mr. Randall -- Dr. Randall bringing
9 an attorney?

10 A Well, Dr. Randall, excuse me, appeared with
11 someone who appeared to be an attorney.

12 Q Right.

13 A He was well-dressed and had a briefcase and he
14 wasn't one of our doctors.

15 Q Did he represent himself to be an attorney?

16 A Well, I -- I said, could we step into the
17 hall? And so the three of us stepped into the
18 hall, and he introduced himself as
19 Dr. Randall's attorney. And I explained that,
20 under our bylaws, this was still an informal
21 process, a collegial process, and that there
22 was to be no outside representation for either
23 medical staff, hospital or the physician at
24 that meeting. And he said, fine, give me a
25 call. And he left.

Charles Richard Patterson, M.D.

1 Q And -- and you believe that it was part of the
2 -- that a doctor could be suspended, summarily
3 suspended, have certain -- certain privileges
4 revoked and that still be an informal process?

5 A Well, maybe I used the term informal
6 inappropriately. All I'm saying is that the
7 bylaws stipulated that, at this sort of
8 meeting, at this point in the process, there
9 was to be no external counsel present for any
10 -- for representing anyone. Just --

11 Q Either the committee or --

12 A Either the committee or the member.

13 Q And do you recall, at this meeting, whether --
14 whether Dr. Randall -- whether anyone
15 questioned Dr. Randall about cases that he
16 discussed?

17 A I do not recall. I don't really recall this
18 discussion.

19 Q Okay. Do you recall what the -- do you recall
20 whether there was a vote taken?

21 A I'm sure -- well, as I recall, there was a
22 vote and that it was unanimous.

23 Q Okay. And this says motion was made and
24 seconded and then it says motion passed
25 unanimously.

DEPOSITION TRANSCRIPT EXCERPTS

DR. ROBERT RANDALL

1 STATE OF SOUTH CAROLINA

COURT OF COMMON PLEAS

2 COUNTY OF YORK

3

4 ROBERT RANDALL, M.D.,

5 Plaintiff(s),

6 vs.

Case No.: 2012-CP-46-167

7 AMISUB OF SOUTH CAROLINA, INC.

D/B/A PIEDMONT MEDICAL CENTER,

8 NATHANIEL EDWARDS, M.D., AND

RICHARD PATTERSON, M.D.,

9

Defendant(s).

10

11 C O N F I D E N T I A L

12 D E P O S I T I O N

13 WITNESS: ROBERT RANDALL, M.D.

14 DATE: Friday, July 19, 2013

15 TIME: 10:04 a.m.

16 LOCATION: Lewis, Babcock & Griffin, LLP
1513 Hampton Street
17 Columbia, South Carolina

18 TAKEN BY: Attorneys for the Defendants
19

20 REPORTED BY: SHERI L. BYERS
Registered Professional Reporter

21 - - - - -

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24 803-988-0086
1-888-988-0086
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1 about it."

2 So I went and talked to one surgeon and one
3 psychiatrist or internist. That addiction stuff, they
4 wanted to know if there's any ongoing medical problem
5 with drugs or alcohol. Which there was not. And after
6 that, they terminated my malpractice.

7 Q. After they collected all the data they wanted
8 to collect on the matter?

9 A. Yes.

10 Q. They terminated your malpractice? I guess
11 terminated your employment agreement?

12 A. Correct. They carried the malpractice.

13 Q. I got you. I guess we should go back.

14 When you became part of Novant in 2008, what
15 month was that?

16 A. I don't remember exact month. I think it was
17 September.

18 Q. That's fine. I'm sure there's documents that
19 reflect that.

20 Fall of 2008, they came to you and the
21 structure of their relationship with you was you were
22 going to be employed by them?

23 A. Correct. Correct.

24 Q. All right. And they offered employment to
25 you. And did they offer employment to the other

1 recommendation?

2 A. Correct.

3 Q. All right. And that recommendation is one
4 for revocation of abdominal surgery including
5 herniorrhaphy, which is hard for me to say. And then
6 they provide a more detailed description of that below,
7 right?

8 A. Correct.

9 Q. And then they tell you that you can meet with
10 the ad hoc group.

11 A. Uh-huh.

12 Q. So my guess is that you had -- maybe you
13 didn't meet with them on September 27?

14 A. No, I met with them on September 27.

15 Q. Okay.

16 A. When I went into that meeting, I was prepared
17 to discuss the cases outlined in the letter.
18 Dr. Edwards brought forth three other cases, totally
19 out of the blue, and questioned me on them without my
20 even knowing they were going to be discussed.

21 Q. Okay. All right. You think that was on the
22 27th?

23 A. Well, I assume from the date that it supposed
24 to meet. I don't remember the exact date of that
25 meeting, but I do recall the meeting.

1 Q. Well, tell me what -- other than him bringing
2 up three new cases, do you remember the names for me to
3 better identify them? I guess they were more recent
4 cases that had occurred?

5 A. Yeah. If I can tell you, I'll tell you. It
6 was a patient S.J., which is MR 135540.

7 Q. That was one of the new ones?

8 A. Correct.

9 Q. Okay.

10 A. J.R., I don't have the number on her.

11 Q. You say J.R.? I'm sorry.

12 A. Yes. And let's see. Patient F.M., which is
13 MR 17929.

14 Q. Okay. So in addition to the cases that you
15 had written about, you had three other cases that they
16 were asking you about?

17 A. Correct.

18 Q. All right.

19 A. Which I was not given advance notice or
20 anything about.

21 Q. Okay. So I imagine you weren't able to
22 address those that night?

23 A. I addressed them to the best of my knowledge,
24 and I thought adequately.

25 Q. Okay. What kind of concerns did the ad hoc

1 the issues because of their lack of specialty in your
2 area.

3 A. Correct.

4 Q. But their motivations were pure.

5 A. Yes. I have no problem with the motivations
6 for their action.

7 Q. Fair enough. Now, Dr. Edwards, you want to
8 carve him out of that?

9 A. Yeah. Dr. Edwards has a long, long going
10 animosity towards me going back many years.

11 Q. Okay. Well, let me ask you I guess more
12 pointedly. Do you believe that he was motivated by
13 something other than concern for patients and quality
14 of care?

15 A. Yes.

16 Q. All right. And explain to me what he was
17 motivated by.

18 A. Well, as I said, he's got a personal
19 animosity towards me going back many, many years. And
20 I think that played a factor in this.

21 Q. Okay. And what was the -- do you know the
22 origin of the personal animosity?

23 A. Yes. I don't remember the year, but well
24 before this. His wife is a pediatrician who's -- well,
25 she doesn't practice at all now, but at that time was

1 in part-time practice. And a friend of theirs -- well,
2 one of the OB/GYNs in town's daughter became sick with
3 abdominal pain, so they sent her to see Steve Thies at
4 that time, who was one of my partners. And Steve saw
5 her and thought everything was fine and sent her home.

6 Well, the next day she's still having pain.
7 They call Thies about it, but he was on the way to the
8 airport or going somewhere. So called me and said,
9 "Would you look at her?"

10 I looked at her and it was real apparent that
11 she had appendicitis and it had ruptured at that point.
12 I took her to the operating room, and she was ruptured.
13 And at that point his wife hovered over her care, ..
14 became involved in her care, was convinced I was not
15 caring for this child properly because she was just not
16 up and around and going home. But she had a ruptured
17 appendix. She was not like a typical appendix.

18 She started calling Jim Attorri, who is a
19 pediatric surgeon in Charlotte, just angry and saying
20 that I was improperly caring for this child.

21 Attorri knew Rick Gettys, who was one of my
22 partners, because Rick had a daughter who had multiple
23 problems and was operated on by Attorri. So they had a
24 personal relationship. So Attorri called Rick and
25 said, "I don't know what's going on. This woman's

1 crazy. What's she calling me about?"

2 So Rick goes and looks at her and says,
3 "Well, everything's fine." I said, "Look, I'm just
4 going to get out of this. You take over the care of
5 the child." Which he did, and she recovered.

6 I mean, then after that there was two
7 instances where Edwards came into the service lounge
8 just berating me because I parked too close to his car.
9 I parked within the lines, but he had trouble getting
10 out of his car. It was just things like that.

11 Q. Sure. Let me make sure I understand the
12 first incident. Dr. Edwards' wife is a pediatrician?

13 A. Correct. Martha is her name.

14 Q. Martha?

15 A. Martha Edwards.

16 Q. Martha Edwards.

17 A. Yes.

18 Q. Is she on staff at Piedmont?

19 A. I don't think so now. I don't think she
20 practices anymore. She was only part-time at that
21 time. I don't know whether she is or is not or her
22 status.

23 Q. What's the approximate date of this care of
24 this child?

25 A. I would say maybe 2007, '8. I don't

1 remember. Somewhere in there.

2 Q. Do you recall the name of the patient?

3 A. You would ask me that. I'm blanking on his
4 name. It's one of the OB/GYNs. I can give it to you.
5 It's [REDACTED] -- it's Rock Hill OB/GYN. And I'm blanking
6 on his last name.

7 Q. Rock Hill OB/GYN. [REDACTED] is his first name?

8 A. Correct. One of his daughters.

9 Q. Daughter.

10 A. I don't remember her name.

11 Q. She had an appendicitis, seen by your
12 partner?

13 A. Steve Thies.

14 Q. He didn't perceive of the appendix problem?

15 A. Correct.

16 Q. You do. You get her in, and you remove the
17 ruptured appendix?

18 A. Correct.

19 Q. Okay. And the doctor she called in
20 Charlotte, I didn't get his name.

21 A. Attorri. It's A-t-t-o-r-i (sic), I think.
22 it's James, Jim.

23 Q. What kind of doctor is he?

24 A. Pediatric surgeon.

25 Q. I see. And the call went from him to Gettys?

1 A. Rick Gettys.

2 Q. Who is a --

3 A. Well, he was one of our partners at the time.

4 Q. Okay. He's a surgeon.

5 A. He's general surgeon. I say he had a
6 daughter, who is now expired, but had multiple problems
7 and was undergoing a lot of surgeries that Attorri had
8 done. So they had a personal relationship. So he
9 called Rick about that.

10 Q. I see. And you turned over care to Gettys?

11 A. Correct.

12 Q. What was the remainder of her course?

13 A. She recovered. She did fine. She recovered
14 and did fine.

15 Q. You think that's in 2007 sometime?

16 A. I think. I don't remember. It would be
17 around that period of time. I can't state exactly.

18 Q. Sure. Sure. That sounds like a lot of
19 interaction between Dr. Edwards' wife and you. Any
20 interaction between Dr. Edwards and you over that
21 patient?

22 A. Not over that patient, no. Subsequent to
23 that is when he would do stuff like, "You're parked too
24 close to me."

25 It's just not a friendly environment between

1 the two of us.

2 Q. I see. And what was the -- was that just one
3 incident, the parking incident?

4 A. Two.

5 Q. Two. Same issue?

6 A. Uh-huh.

7 Q. Both in the doctor's lounge?

8 A. Yeah, I think they were both.

9 Q. Okay.

10 A. I know one was elevated in the dressing -- in
11 that area, right.

12 Q. Just you and he?

13 A. Yes.

14 Q. Anyone else witnessing, is the other follow
15 up.

16 A. Not to my recollection, no.

17 Q. And as best as you can recall, what was the
18 date of that? Was that before or after this 2007?

19 A. That would have been -- they go on like 2009,
20 2010. I don't remember exactly. It was well after
21 that period of time.

22 Q. How long has he been on staff, Dr. Edwards?
23 A long time?

24 A. No.

25 Q. He's a younger guy, isn't he?

UNPUBLISHED OPINIONS

Unpublished Disposition
215 F.3d 1324

NOTICE: THIS IS AN UNPUBLISHED OPINION.
(The Court's decision is referenced in a "Table of
Decisions Without Reported Opinions" appearing in
the Federal Reporter. See CTA4 Rule 32.1.
United States Court of Appeals, Fourth Circuit.

John D. WUCHENICH, M.D., Plaintiff-Appellant,
v.
SHENANDOAH MEMORIAL HOSPITAL; Robert
Karny, M.D.; David Ciochetti, M.D.; George
Phillips, M.D., Defendants-Appellees.

No. 99-1273. | Argued Jan. 28, 2000. | Decided May
22, 2000.

Appeal from the United States District Court for the
Western District of Virginia, at Harrisonburg. James H.
Michael, Jr., Senior District Judge. (CA-98-41-5).

Attorneys and Law Firms

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ON BRIEF: Robert A. Kantas, Michie, Hamlett, Lowry,
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appellee Phillips.

Before NIEMEYER, Circuit Judge, HAMILTON, Senior
Circuit Judge, and SMALKIN, United States District
Judge for the District of Maryland, sitting by designation.

Opinion

OPINION

PER CURIAM.

*1 Pursuant to Federal Rule of Civil Procedure 12(b)(6)

(Rule 12(b)(6)), the district court dismissed the complaint
of Dr. John Wuchenich, M.D. (Dr. Wuchenich), a
professionally licensed anesthesiologist, alleging
numerous causes of action under Virginia law, premised
upon diversity jurisdiction, against Shenandoah Memorial
Hospital (SMH) and/or three fellow physicians in
connection with the lack of patient volume in his
anesthesiology practice and SMH's revocation of his
medical staff privileges. Dr. Wuchenich appeals the
district court's dismissal of his complaint. For the reasons
that follow, we affirm in part, vacate in part, and remand
for further proceedings.

I

Because this case is before us on appeal from a Rule
12(b)(6) dismissal, we must accept all of the factual
allegations contained in Dr. Wuchenich's complaint as
true and draw all reasonable factual inferences therefrom
in his favor. *See Edwards v. City of Goldsboro*, 178 F.3d
231, 244 (4th Cir.1999). In light of this mandate, the facts
for purposes of this appeal are as follows.

In April 1995, SMH, located in Woodstock, Virginia,
recruited Dr. Wuchenich as an anesthesiologist to provide
services to its patients. At that time, Dr. Wuchenich was
practicing anesthesiology in his well-established private
medical practice in California. In August 1995, Dr.
Wuchenich and SMH entered into a written twelve-month
agreement (the Physician Guarantee Agreement or the
Agreement), which guaranteed Dr. Wuchenich an income
of \$15,000 per month for the first four months after he
obtained medical staff privileges at SMH. The Physician
Guarantee Agreement also called for Dr. Wuchenich to
repay any monies received from the income guarantee
over the ensuing eight-month period to the extent he
earned an income over \$15,000 a month. Dr. Wuchenich
alleges that SMH induced him to sign the Physician
Guarantee Agreement by orally assuring him that it would
be hiring more surgeons, updating its equipment, and
making other changes that would ensure his success in
establishing an anesthesiology practice at SMH.

Of relevance to the issues on appeal, Article I of the
Physician Guarantee Agreement provided as follows:

[Dr. Wuchenich], in consideration
of the covenants and agreements
made by [SMH] contained herein,
covenants and agrees to practice
medicine in the specialty of
Anesthesia at [SMH] and upon the
effective date hereof to

immediately apply, become upon commencement of this medical practice at [SMH] and remain continuously during the term of this Agreement, a member of [SMH's] Active Medical Staff as defined in its Medical Staff Bylaws subject, however, to said Bylaws.

(J.A. 34-35). Also of relevance to the issues on appeal, Article XVII of the Physician Guarantee Agreement contained the following merger clause:

This writing constitutes the entire agreement between [Dr. Wuchenich] and [SMH]. No oral or written prior or contemporaneous agreements shall have any force or effect, nor shall any subsequent agreements have any force or affect [sic], unless signed and embodied in writing.

*2 (J.A. 41).

By its terms, the Physician Guarantee Agreement was not terminable at will. Specifically, Article IV provided for an effective duration of twelve months from the date Dr. Wuchenich began practice in Woodstock, Virginia, unless earlier terminated as provided in the Agreement. For example, Article VIII provided that the Agreement would terminate if Dr. Wuchenich became mentally ill in the opinion of a panel of three independent health practitioners so that he became unable to carry on the practice of anesthesiology for a period of three months.

In accord with the terms of the Physician Guarantee Agreement, upon the effective date of that Agreement, Dr. Wuchenich immediately applied for medical staff privileges at SMH. SMH in turn granted him medical staff privileges.

After setting up his practice in Woodstock, Dr. Wuchenich did not receive a warm reception from several of the physicians who practiced at SMH. For example, Dr. George Phillips (Dr. Phillips), the only other physician practicing anesthesiology at SMH prior to Dr. David Ciochetty (Dr. Ciochetty) arriving to fill the position of Chief of Anesthesiology in the early spring of 1996, engaged in several actions in an effort to quell competition from Dr. Wuchenich. First, although Dr. Wuchenich postponed two surgeries for medical reasons on patients of Dr. Baumunk, an orthopedic surgeon, Dr. Phillips falsely told Dr. Baumunk that the postponements

were unnecessary, and that Dr. Wuchenich "was not a very good anesthesiologist." (J.A. 13). Thereafter, Dr. Baumunk refused to use Dr. Wuchenich's services for a period of three months. Second, in his capacity as senior anesthesiologist at SMH, Dr. Phillips instigated the implementation of a new policy causing all operating room cases to be assigned to anesthesiologists according to surgeon request. He then asked all surgeons to request him for their anesthesia needs, indicating to them that Dr. Wuchenich was less than competent. Third, prior to the time the surgeon request policy was in place, Dr. Phillips, in his capacity as senior anesthesiologist assigned the vast majority of cases to himself and to Certified Registered Nurse Anesthetists (CRNA) performing services under his supervision, for which he was compensated.

Another example of hostility encountered by Dr. Wuchenich at SMH related to SMH's appointment of a Chief of Anesthesiology. Prior to Dr. Ciochetty's appointment to the position of Chief of Anesthesiology, CRNA Clark held the position. After CRNA Clark resigned, Dr. Wuchenich inquired regarding the availability of the position of Chief of Anesthesiology at SMH and requested a job description. SMH refused to provide him with a job description and shortly thereafter told him in a letter dated January 17, 1996, that it intended to continue to fill the position with a CRNA. SMH then approved a thirty-day appointment of CRNA Hubbard pending completion of her application. CRNA Hubbard is the wife of Dr. C. Hubbard, an orthopedic surgeon who practiced at SMH. By hiring CRNA Hubbard in this fashion, SMH facilitated and participated in a plan to allow Dr. Phillips to maintain control of two operating rooms thereby ensuring that Dr. Wuchenich would not succeed financially.

*3 Approximately six weeks later, in March 1996, without consulting Dr. Wuchenich or Dr. Phillips, SMH circulated a memorandum announcing that it had contracted with Dr. Ciochetty to become Chief of Anesthesiology. SMH did not ask for Dr. Wuchenich's opinion regarding what effect the hiring of a third anesthesiologist would have on his ability to earn a living, nor did SMH pay any attention to the fact that there was an insufficient number of anesthesiology patients to support the practices of two or more anesthesiologists and several CRNAs.

Upon his appointment as Chief of Anesthesiology, Dr. Ciochetty stated that he would be assigning all anesthesia cases. Concerned about the effect a third anesthesiologist would have on his practice, Dr. Wuchenich asked Dr. Ciochetty how he planned to deal with the apparent lack of work to support three anesthesiologists and expressed

his concern that there was insufficient work for two anesthesiologists. Dr. Ciochetty responded that Dr. Wuchenich would not need to work full time and that whatever SMH had promised him was "old news" because he (Dr. Ciochetty) was in charge, and SMH had hired him to do things his way. (J.A. 15). In his capacity as Chief of Anesthesiology, acting for his own independent benefit and acting in conspiracy with SMH, Dr. Ciochetty picked up where Dr. Phillips left off, assigning the vast majority of cases to himself and the CRNAs whom he was paid to supervise.

On or about March 20, 1996, Dr. Phillips and Linda Aleska, the Co-Chief Operating Officer of SMH, had a conversation during which Linda Aleska stated that "they would have to get rid of Dr. Wuchenich because he won't work with us." (J.A. 15) (internal quotation marks omitted). On or about April 15, 1996, SMH unexpectedly forced Dr. Phillips to resign his medical staff privileges at SMH.

After Dr. Phillips resigned, SMH, in consultation with Dr. Ciochetty, once again began recruiting another anesthesiologist, despite the fact that Dr. Wuchenich had voiced his concerns over the lack of sufficient cases for two, let alone three, anesthesiologists. As part of SMH's recruiting efforts, in May 1996, Dr. Ciochetty sent a note to Jim Greer stating that he (Dr. Ciochetty) would need a partner for his pain clinic, even though Dr. Ciochetty had not discussed personnel needs with Dr. Wuchenich.¹ In sending this letter, Dr. Ciochetty acted in his capacity as Chief of Anesthesiology, for his own economic benefit, as well as in conspiracy with SMH to injure Dr. Wuchenich.

In addition to Dr. Phillips and Dr. Ciochetty's hostile actions towards Dr. Wuchenich, Dr. Wuchenich was subjected to hostile conduct by Dr. Robert Karmy (Dr. Karmy). At the same time SMH engaged in efforts to recruit Dr. Wuchenich, and after Dr. Wuchenich accepted SMH's offer, SMH engaged in efforts to recruit Dr. Wuchenich's sister, Dr. Nanette Wuchenich. Dr. Nanette Wuchenich maintained a successful medical practice in obstetrics and gynecology (OB/GYN) in California. As an experienced, practicing OB/GYN physician, Dr. Nanette Wuchenich posed a financial threat to Dr. Karmy, who at the time was the only OB/GYN physician on staff at SMH, and in the City of Woodstock. As a result of this financial threat, Dr. Karmy had an openly hostile attitude toward Dr. Wuchenich in hopes of scaring off Dr. Wuchenich's sister from accepting medical staff privileges at SMH. Out of the dozens of cases performed by Dr. Karmy during Dr. Wuchenich's time at SMH, Dr. Wuchenich was only assigned four of them and none at the request of Dr. Karmy. Dr. Karmy falsely reported to

Dr. Ciochetty, the Chief of Anesthesiology at SMH, that Dr. Wuchenich possibly committed malpractice with respect to two cases. These two cases ultimately came before the Peer Review Committee for evaluation of Dr. Wuchenich's professional performance.

*4 On or about May 28, 1996, at a regularly scheduled Peer Review Committee meeting, four cases in which Dr. Wuchenich was involved, including the two instigated by Dr. Karmy, were reviewed. None of the patients involved in the four cases suffered any adverse consequences as a result of the care provided by Dr. Wuchenich. Nor did the Peer Review Committee obtain an opinion from an anesthesiologist with respect to the actions of Dr. Wuchenich in the four cases. Furthermore, the Peer Review Committee did not give Dr. Wuchenich an opportunity to respond to any allegations made against him. In spite of these facts and the fact that the actions of Dr. Wuchenich were within the relevant standard of care for anesthesiologists in each of the four cases, the Peer Review Committee recommended to the Executive Committee of SMH that Dr. Wuchenich's privileges to practice at SMH be revoked.

Dr. Wuchenich then received a letter dated May 31, 1996 (the Suspension Letter), which stated, *inter alia*:

Based upon the results of the Peer Review, the Executive Committee of the General Medical Staff has recommended that your privileges be suspended at Shenandoah Memorial Hospital. Based upon this recommendation and the fact that the allegations pertain to matters that could endanger the safety and well-being of patients, the acting Chief Executive Officers have directed that you be removed from On Call status until further notice. This action is deemed necessary based upon the results of the Peer Review and the facts surrounding the cases that were submitted for review.

(J.A. 49). SMH then promptly reported Dr. Wuchenich's suspension to the State Board of Medical Examiners. SMH knew the State Board of Medical Examiners would in turn report the suspension to the National Practitioner's Data Bank, which would operate as a bar to Dr. Wuchenich obtaining medical staff privileges at any other hospital in the United States.

On September 12, 1996, SMH held a hearing to review Dr. Wuchenich's suspension. SMH appointed attorney Paul Neal as the hearing officer. Paul Neal also serves as legal counsel to SMH. Paul Neal along with six members of SMH's medical staff not previously mentioned constituted the hearing committee (the Hearing Committee). The Hearing Committee heard opinions from anesthesiologists relating to Dr. Wuchenich's four cases. None stated they believed suspension of Dr. Wuchenich's medical staff privileges was appropriate. Indeed, the only two outside expert anesthesiologists to testify were brought by Dr. Wuchenich. These two experts testified without contradiction that Dr. Wuchenich did not depart from the appropriate standard of care for anesthesiologists with respect to the four cases at issue.

On September 24, 1996, the Hearing Committee issued its report. In its report, the Hearing Committee recommended that Dr. Wuchenich's medical staff privileges be reinstated, but that he undergo proctoring, education, and training as follows: (1) "Observation by Staff Anesthesiologist of not less than five inductions including at least two obstetric inductions"; (2) "In service training in the troubleshooting and repair of the specific pieces of anesthesia equipment in use at SMH"; and (3) "In service training as to the location of anesthesia related equipment and resuscitation equipment in the Operating Room at SMH." (J.A. 20). The Hearing Committee forwarded its report to SMH's Medical Staff Executive Committee, which in turn recommended to the Board of Directors of SMH that: (1) Dr. Wuchenich's medical staff privileges be reinstated; (2) prior to engaging in further work at SMH, Dr. Wuchenich should be observed by a Director of Anesthesiology at a health care facility on not less than twenty-five inductions, including at least five obstetric inductions; (3) prior to engaging in further work at SMH, Dr. Wuchenich should participate in an in service training program on the trouble shooting and repair of four particular pieces of anesthesia equipment; and (4) prior to performing further independent work at SMH, Dr. Wuchenich should undergo in service training with regard to the specific location of anesthesia-related equipment and resuscitation equipment in the operating room at SMH. Subsequently, on December 6, 1996, the Executive Committee offered to lift the suspension of Dr. Wuchenich's medical staff privileges if Dr. Wuchenich would submit his immediate resignation from the SMH Associate General Medical Staff.

*5 On December 12, 1996, Dr. Wuchenich met with the Board of Appeals Committee who inquired regarding the circumstances of the cases in question. Then on January 28, 1997, SMH offered to reinstate Dr. Wuchenich's medical staff privileges without conditions in exchange

for Dr. Wuchenich agreeing in writing to waive any claims against SMH, its employees, directors, or agents. Dr. Wuchenich refused; yet, on April 16, 1997, nearly one year after SMH suspended Dr. Wuchenich's medical staff privileges, SMH's Board of Director's passed a resolution voiding the suspension of Dr. Wuchenich.

On or about May 2, 1997, SMH purported to send information regarding the voided suspension to the National Practitioner's Data Bank but failed to properly address the envelope causing it to be returned and causing further delays in clearing Dr. Wuchenich's name. Subsequently, SMH sent the information to the correct address, but sent an improperly completed form. Therefore, the National Practitioner's Data Bank returned the form to SMH for proper completion. Finally, on or about June 10, 1997, the National Practitioner's Data Bank removed all mention of Dr. Wuchenich's suspension from its records, approximately one year after SMH suspended his medical staff privileges.

On May 21, 1998, following a detailed investigation, a hearing was conducted by the Informal Conference Committee of the Commonwealth of Virginia Board of Medicine to determine if the allegations against Dr. Wuchenich with respect to the four cases at issue were supported by evidence. After thoroughly reviewing the record, which included the transcript of the hearing before the Hearing Committee, the Informal Conference Committee voted to dismiss all charges against Dr. Wuchenich and instructed its staff to note on the notice of action that Dr. Wuchenich was completely exonerated of all wrongdoing.

The following sections of SMH's bylaws setting forth the procedures SMH should follow when considering the suspension of a physician's medical staff privileges are at issue in this case: SMH Bylaws §§ 6.1(a), (c)-(e) and 6.2(a). SMH Bylaws § 6.1(a) states that once a case alleging professional misconduct has been reviewed by the Peer Review Committee, the Peer Review Committee should refer it to the Informal Review Committee in accordance with SMH Bylaws § 6.1(c). SMH Bylaws § 6.1(c) provides that "before curtailment or suspension of clinical privileges is implemented, the Executive Committee shall immediately appoint an ad hoc committee for a preliminary review of the matter (the Informal Review Committee)." (J.A. 17) (internal quotation marks omitted). SMH Bylaws § 6.1(d) provides, *inter alia*, that prior to the Informal Review Committee making its report and recommendations for corrective action to the Executive Committee, "the practitioner against whom corrective action has been requested shall have an opportunity for an interview with the [Informal]

Review 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." (J.A. 17) (internal quotation marks omitted). SMH Bylaws § 6.1(e) provides that upon receipt of a report and recommendation of the Informal Review Committee requesting reduction or suspension of clinical privileges, SMH's "President/CEO shall notify the affected practitioner that he/she shall be permitted to make an appearance before the Executive Committee prior to its taking action on such request." (J.A. 17-18) (internal quotation marks omitted). SMH Bylaws § 6.2(a) provides that a "Summary Suspension," *i.e.*, suspension of medical staff privileges without following the procedures required in SMH Bylaws § 6.1, "may only be imposed whenever action must be taken immediately, to protect the life of any patient or to reduce the substantial likelihood of immediate injury or damage to the health of[r] safety of any patient, employee, or other person present in SMH." (J.A. 18-19) (internal quotation marks omitted).

*6 According to Dr. Wuchenich's complaint, SMH did not suspend Dr. Wuchenich's medical staff privileges pursuant to SMH Bylaws § 6.2(a). Therefore, under SMH's Bylaws, SMH was required to comply with the procedures set forth in SMH Bylaws § 6.1 in suspending Dr. Wuchenich's medical staff privileges.⁶ SMH failed to comply with several of the procedures. First, SMH failed to appoint an Informal Review Committee prior to suspending Dr. Wuchenich's medical staff privileges as required by SMH Bylaws § 6.1(c). Second, SMH failed to allow Dr. Wuchenich the opportunity for an interview with the Informal Review Committee prior to suspending his medical staff privileges as required by SMH Bylaws § 6.1(d). Third, neither of SMH's Co-Chief Executive Officers notified Dr. Wuchenich that he was permitted to make an appearance before the Executive Committee prior to the Executive Committee suspending his medical staff privileges as required by SMH Bylaws § 6.1(e).

On June 1, 1998, Dr. Wuchenich filed a six-count complaint in the United States District Court for the Western District of Virginia based upon diversity jurisdiction. *See* 28 U.S.C. § 1332. The complaint asserts claims alleging breach of contract by SMH; negligent breach of contract by SMH; statutory conspiracy to injure a person in his reputation, business or profession against SMH, Dr. Karmy, Dr. Ciochetty, and Dr. Phillips (collectively the Defendants); common law conspiracy to breach a contract against the Defendants; defamation against SMH, Dr. Karmy, and Dr. Phillips; and tortious interference with an existing contract and business expectancies against the Defendants. The complaint alleged that as a result of the actions complained about,

Dr. Wuchenich suffered \$1,121,000 in economic damages and \$500,000 in damages for emotional distress and loss of reputation. His complaint also sought punitive damages.

The Defendants timely filed Rule 12(b)(6) motions to dismiss. A magistrate judge considered the motions and reported and recommended dismissal of the claims alleging breach of contract, negligent breach of contract, and common law conspiracy to breach a contract. However, the magistrate judge recommended refusing dismissal with respect to the claims alleging statutory conspiracy to injure a person in his reputation, business, trade or profession and tortious interference with an existing contract and business expectancies. With respect to the claim alleging defamation, the magistrate judge granted Dr. Wuchenich ten days to supplement and amend his complaint to state the precise words of the alleged defamation, but Dr. Wuchenich elected not to do so.

On January 29, 1999, in a memorandum opinion, the district court adopted the magistrate judge's report and recommendations with respect to the claims alleging breach of contract, negligent breach of contract, and common law conspiracy to breach a contract. The district court, however, declined to adopt the magistrate judge's recommendations with respect to the claims alleging statutory conspiracy to injure a person in his reputation, business, trade or profession and tortious interference with an existing contract and business expectancies. Thus, the district court dismissed those claims as well. The district court also dismissed the claim alleging defamation. Thus, the district court dismissed all counts of Dr. Wuchenich's complaint pursuant to Rule 12(b)(6).

*7 On February 12, 1999, Dr. Wuchenich made a motion for reconsideration, which the district court denied on March 24, 1999. This timely appeal followed. On appeal, Dr. Wuchenich challenges the district court's dismissal of all of his claims.

II

Dr. Wuchenich first contends the district court erred in granting the Defendants' Rule 12(b)(6) motion with respect to his breach of contract claim. In that claim, Dr. Wuchenich alleges, *inter alia*: (1) SMH violated SMH Bylaws § 6.1(c) by failing to appoint an Informal Review Committee prior to suspending his medical staff privileges; (2) SMH violated SMH Bylaws § 6.1(d) by failing to allow him the opportunity for an interview with the Informal Review Committee to discuss, explain or refute the allegations against him prior to suspending his

medical staff privileges; and (3) SMH violated SMH Bylaws § 6.1(e) when neither of SMH's Co-Chief Executive Officers notified Dr. Wuchenich that he was permitted to make an appearance before the Executive Committee prior to the Executive Committee suspending his medical staff privileges. In a somewhat different vein, Dr. Wuchenich alleges that SMH breached its oral assurances made *before and after* the execution of the Physician Guarantee Agreement that it would assign him an adequate number of patients to assure his ability to establish his practice within the Woodstock, Virginia area.

We agree with Dr. Wuchenich that he has stated a breach of contract claim against SMH with respect to SMH's Bylaws. However, we disagree with Dr. Wuchenich that he has stated a claim for breach of SMH's alleged oral assurances.

Rule 12(b)(6) provides for dismissal of a complaint for "failure to state a claim upon which relief can be granted." Fed.R.Civ.P. 12(b)(6). The purpose of a Rule 12(b)(6) motion is to test the sufficiency of a complaint; "importantly, [a Rule 12(b)(6) motion] does not resolve contests surrounding the facts, the merits of a claim, or the applicability of defenses." *Republican Party v. Martin*, 980 F.2d 943, 952 (4th Cir.1992). Rather, a Rule 12(b)(6) motion should only be granted if, after accepting all well-pleaded allegations in the plaintiff's complaint as true and drawing all reasonable factual inferences from those facts in the plaintiff's favor, it appears certain that the plaintiff cannot prove any set of facts in support of his claim entitling him to relief. *See id.* For purposes of a Rule 12(b)(6) motion, we are not required to accept as true the legal conclusions set forth in a plaintiff's complaint. *See District 28, United Mine Workers of Am., Inc. v. Wellmore Coal Corp.*, 609 F.2d 1083, 1085 (4th Cir.1979).

A. SMH's Alleged Breach of Its Bylaws.

The parties agree that the law of Virginia controls all substantive legal issues in this case. Under Virginia law, "[t]he essential elements of a cause of action for breach of contract are: (1) a legal obligation of a defendant to the plaintiff, (2) a violation or breach of that right or duty, and (3) a consequential injury or damage to the plaintiff." *Westminster Investing Corp. v. Lamps Unlimited, Inc.*, 379 S.E.2d 316, 317 (Va.1989) (internal quotation marks and footnote omitted).

*8 Dr. Wuchenich first argues that the following language constituting Article I in the Physician Guarantee Agreement expressly incorporated SMH's Bylaws as

binding obligations on both himself and SMH:

[Dr. Wuchenich], in consideration of the covenants and agreements made by [SMH] contained herein, covenants and agrees to practice medicine in the specialty of *Anesthesia* at [SMH] and upon the effective date hereof to immediately apply, become upon commencement of this medical practice at [SMH] and remain continuously during the term of this Agreement, a member of [SMH's] Active Medical Staff as defined in its Medical Staff Bylaws subject, however, to said Bylaws.

(J.A. 34-35) (emphasis added). Alternatively, Dr. Wuchenich argues that because SMH made his medical staff privileges subject to and governed by its bylaws, SMH had a corresponding obligation implied by law to abide by its bylaws in any attempt to suspend or revoke his medical staff privileges. The merger clause in the Physician Guarantee Agreement, Dr. Wuchenich contends, does not preclude him from alleging the existence of such an implied legal obligation because an exception to the parol evidence rule known as the collateral contract doctrine applies.

SMH vigorously denies that by agreeing to the terms of Article I of the Physician Guarantee Agreement it intended to be legally obligated to Dr. Wuchenich to follow its bylaws in suspending his medical staff privileges. Furthermore, SMH argues that the merger clause in the Physician Guarantee Agreement precludes Dr. Wuchenich from relying upon parol evidence to establish such an obligation. Finally, SMH argues that even if we determine that it had an obligation (under the Physician Guarantee Agreement or implied by law) to follow its bylaws in suspending Dr. Wuchenich's medical staff privileges, the facts as alleged in the complaint establish that it fully complied with its bylaws in suspending Dr. Wuchenich's medical staff privileges.

In our review of the district court's decision to dismiss Dr. Wuchenich's breach of contract claim alleging SMH breached its bylaws in suspending Dr. Wuchenich's medical staff privileges, we are guided by the following principles:

If the terms of the parties' agreement are contained in a clear explicit writing, that writing is the sole memorial of the contract and the sole evidence of the agreement.

In that event, ... parol evidence ... could not be used to explain the written contractual terms.

Conversely, the rule excluding parol evidence has no application where the writing on its face is ambiguous, vague, or indefinite. In such a case, the proper construction of the contract is an issue for the trier of fact, and the court should receive extrinsic evidence to ascertain the intention of the parties and to establish the real contract between them.

Cascades N. Venture v. PRC, Inc., 457 S.E.2d 370, 373 (Va.1995) (internal citations omitted). The language of a written contract is ambiguous if it is reasonably susceptible to more than one interpretation or makes reference to two or more things at the same time. See *Tuomala v. Regent Univ.*, 477 S.E.2d 501, 505 (Va.1996). "The question of whether a writing is ambiguous is one of law, not of fact." *Id.* at 505.

*9 Below, the district court concluded that the language contained in Article I "cannot be construed under a fair reading as giving rise to an incorporation by reference of the provision of the Bylaws as provisions of the contract binding on SMH as well as plaintiff." (J.A. 158). We disagree with this conclusion. In our view, the language contained in Article I referring to SMH's Bylaws (*i.e.*, "subject ... to said Bylaws," (J.A. 35)), is reasonably susceptible to two interpretations, and is, therefore, ambiguous. One reasonable interpretation is that only Dr. Wuchenich was obligated to abide by SMH's Bylaws. The other is that both Dr. Wuchenich and SMH had a legal obligation in favor of each other to abide by SMH's Bylaws. In this regard, the trier of fact could reasonably construe the language "subject ... to said Bylaws," *id.*, as implying that SMH intended to follow its bylaws with respect to its conduct toward Dr. Wuchenich.

Given our conclusion that the terms of the Physician Guarantee Agreement are ambiguous regarding whether SMH had a legal obligation to abide by its bylaws with respect to its conduct toward Dr. Wuchenich, the merger clause does not bar Dr. Wuchenich from offering parol evidence to establish that he and SMH intended such an obligation to exist on the part of SMH at the time they executed the Physician Guarantee Agreement. In light of this conclusion, we need not and do not address Dr. Wuchenich's alternative argument that SMH has an obligation implied by law to abide by its bylaws with respect to Dr. Wuchenich.

We next address SMH's argument that in any event, it fully complied with its bylaws in suspending Dr. Wuchenich's medical staff privileges. Specifically, SMH asserts the facts as alleged in the complaint and contained in Exhibit H to the complaint establish that it gave Dr.

Wuchenich sufficient notice to appear before the Peer Review Committee at its regularly scheduled meeting on May 28, 1996. In this regard, SMH is referring to Dr. Wuchenich's allegation in the complaint that a regularly scheduled Peer Review Committee meeting was held on or about May 28, 1996, and to the following statements in Exhibit H to the complaint: (1) "Cases 2 and 4 were placed in Dr. Wuchenich's mailbox for review on May 22, 1996," (J.A. 57); and (2) "Case 3 was placed in Dr. Wuchenich's mailbox for review on May 22, 1996," (J.A. 58).⁹ SMH argues that, collectively, the allegation about the meeting on May 28, 1996, and these statements contained in Exhibit H conclusively establish that Dr. Wuchenich received sufficient notice to appear in his defense before the Peer Review Committee on May 28, 1996.

We disagree. First, the complaint in no way incorporates by reference, as factual allegations of the complaint, the statements in Exhibit H relied upon by SMH. Indeed, as is clear from simply reading the complaint, the complaint only includes Exhibit H as an attachment for the limited purpose of providing direct support for the allegation that "on December 6, 1996, the [Executive Committee] offered to lift the Summary Suspension of Dr. Wuchenich's privileges if Dr. Wuchenich would 'submit his immediate resignation from the Shenandoah Memorial Hospital Associate General Medical Staff.'" (J.A. 21) (quoting Ex. H at p. 6). Alternatively, even considering, for purposes of argument, that the statements in Exhibit H at issue are factual allegations of the complaint, they do not allege sufficient notice to Dr. Wuchenich to appear before the Peer Review Committee on May 28, 1996, even when coupled with the allegation that "[o]n or about May 28, 1996, at a regularly scheduled Peer Review Committee meeting four cases in which Dr. Wuchenich was involved were reviewed," (J.A. 16). Critically, nothing in this combination of allegations suggests that SMH alerted Dr. Wuchenich that it would be reviewing his four cases at the regularly scheduled Peer Review Committee meeting on May 28, 1996.⁴

*10 In sum, we hold the complaint sufficiently alleges that SMH owed Dr. Wuchenich the legal obligation to follow its bylaws, SMH breached that obligation, and Dr. Wuchenich suffered damages as a result. Thus, the district court erred by dismissing Dr. Wuchenich's breach of contract claim alleging breach of SMH's Bylaws. We, therefore, vacate the district court's dismissal of this portion of Dr. Wuchenich's breach of contract claim and remand for further proceedings.

B. Oral Assurances Regarding Assigning Patients.

We next consider Dr. Wuchenich's challenge to the district court's dismissal of the portion of his breach of contract claim attempting to enforce oral assurances on the part of SMH made prior and subsequent to execution of the Physician Guarantee Agreement to the effect that it would assign him a sufficient volume of patients to establish a full-time practice in the Woodstock, Virginia area. Applying Virginia substantive law, we uphold the district court's dismissal as it relates to these alleged oral assurances.

The parol evidence rule is a basic principle of contract law providing that parol evidence is not admissible if offered to vary or contradict the terms of a complete and unambiguous written instrument. *See Amos v. Coffey*, 320 S.E.2d 335, 337 (Va.1984). Under Virginia law, the parol evidence rule is not applicable if either the partial integration doctrine or the collateral contract doctrine is applicable. *See Jim Carpenter Co. v. Potts*, 495 S.E.2d 828, 833 (Va.1998). Under the partial integration doctrine "[w]here the entire agreement has not been reduced to writing, parol evidence is admissible, not to contradict or vary its terms but to show additional independent facts contemporaneously agreed upon, in order to establish the entire contract between the parties." *Remmer Plumbing, Heating & Air Conditioning, Inc. v. Remmer*, 303 S.E.2d 894, 898 (Va.1983) (internal quotation marks omitted). Under the collateral contract doctrine, parol evidence is admissible to establish a "prior or contemporaneous oral agreement that is independent of, collateral to and not inconsistent with the written contract, and which would not ordinarily be expected to be embodied in the writing." *Jim Carpenter Co.*, 495 S.E.2d at 833 (internal quotation marks omitted).

The language of the Physician Guarantee Agreement makes clear that its purpose was to assist Dr. Wuchenich in establishing an anesthesiology practice in the Woodstock, Virginia area. The merger clause states that the Physician Guarantee Agreement is the entire agreement between the parties. Thus, to the extent the Physician Guarantee Agreement addresses efforts on the part of SMH to assist Dr. Wuchenich in establishing an anesthesiology practice in the Woodstock, Virginia area, it represents the entire agreement between the parties.

Under the parol evidence rule, Dr. Wuchenich cannot introduce evidence that prior to execution of the Physician Guarantee Agreement, SMH assured him of a sufficient patient volume to establish an anesthesiology practice in the Woodstock, Virginia area, because to do so would clearly contradict the unambiguous language of the Physician Guarantee Agreement limiting SMH's obligation to assist Dr. Wuchenich in establishing his

anesthesiology practice to providing him a salary guarantee under the terms specified. *See Amos*, 320 S.E.2d at 337. Hand in glove with this conclusion is the conclusion that the partial integration doctrine is not applicable here given the fact that the Physician Guarantee Agreement is a complete integration of the parties' agreement with respect to SMH's obligations to assist Dr. Wuchenich in establishing his anesthesiology practice. *See Remmer Plumbing*, 303 S.E.2d at 898. Furthermore, because assurances by a hospital to assign a new physician a sufficient number of patients to establish a practice in the area in which the hospital is located would ordinarily be expected to be included in an agreement between the physician and the hospital whereby the hospital guarantees the physician a salary for a specified period of time, the collateral contract doctrine is also inapplicable. *See Jim Carpenter Co.*, 495 S.E.2d at 833.

*11 Finally, to the extent Dr. Wuchenich alleges an oral modification of the Physician Guarantee Agreement with respect to SMH's oral assurances of patient volume allegedly made subsequent to execution of the Physician Guarantee Agreement, his argument is foreclosed by Virginia case law requiring a mutual intention to modify the existing contract. *See Cardinal Dev. v. Stanley Const. Co.*, 497 S.E.2d 847, 850-51 (Va.1998). Even viewing the allegations in the complaint in the light most favorable to Dr. Wuchenich, one cannot reasonably conclude that SMH intended to modify any terms of the Physician Guarantee Agreement.

For these reasons, we affirm the district court's dismissal of the portion of Dr. Wuchenich's breach of contract claim seeking to enforce oral assurances allegedly made by SMH to assign him a sufficient volume of patients to establish an anesthesiology practice in the Woodstock, Virginia area.³

III

Dr. Wuchenich next challenges the district court's dismissal of his claim alleging the Defendants committed civil conspiracy in violation of Virginia Code § 18.2-499 to 500 by conspiring to injure him in his reputation, business, trade and profession. Before addressing the merits of Dr. Wuchenich's challenge, it is necessary to set forth the terms of Virginia's civil conspiracy statute and the relevant case law.

Virginia's civil conspiracy statute states, in pertinent part, that "[a]ny two or more persons who combine, associate, agree, mutually undertake or concert together for the purpose of ... willfully and maliciously injuring another in

his reputation, trade, business or profession by any means whatever" shall be liable civilly for treble damages. Va.Code Ann. § 18.2-499 to 500 (Michie 1996). The Virginia Supreme Court has made clear that this statute does not require proof that a conspirator's primary and overriding purpose is to injure another in his reputation, business, trade or profession. *See Commercial Bus. Sys., Inc. v. BellSouth Servs. Inc.*, 453 S.E.2d 261, 267 (Va.1995). Instead, only legal malice is required, i.e., proof that the defendant acted intentionally, purposely, and without lawful justification. *See id.*

Furthermore, the "two or more persons" requirement is not satisfied by proof that a principal conspired with one of its agents acting within the scope of his agency. *See Charles E. Brauer Co. v. Nationsbank*, 466 S.E.2d 382, 386-87 (Va.1996); *Fox v. Deese*, 362 S.E.2d 699, 708 (Va.1987). Under such a circumstance, a conspiracy is a legal impossibility because a principal and an agent are not separate persons for purposes of the conspiracy statute. *See id.*

Virginia has thus far not recognized an exception to the general rule that a principal cannot conspire with one of its agents to form a conspiracy, a rule sometimes referred to as the intracorporate immunity rule. However, in *Greenville Publ'g Co. v. Daily Reflector, Inc.*, 496 F.2d 391 (4th Cir.1974), we observed that an exception to the general rule "may be justified when the officer has an independent personal stake in achieving the corporation's illegal objective." *Id.* at 399. In that case, we held that the president of the defendant company could conspire with it for purposes of an antitrust claim under the Sherman Act, *see* 15 U.S.C. § 1, where he had a financial interest in another company that competed with the plaintiff company and he would directly benefit if the plaintiff company was eliminated as a competitor. *See id.* at 400.

*12 In an *en banc* case seventeen years later, we revisited the personal stake exception in a case somewhat similar to the facts in the case before us. *See Oksanen v. Page Mem'l Hosp.*, 945 F.2d 696 (4th Cir.1991) (*en banc*). In *Oksanen*, a physician brought an antitrust claim under the Sherman Act against a hospital and several other physicians who were members of its medical staff as a result of his medical staff privileges being revoked. *See id.* at 702. The plaintiff physician alleged that the hospital and the other physicians violated the Sherman Act by conspiring to revoke his medical staff privileges. *See id.* The hospital and the other physicians argued that they were legally incapable of conspiring. *See id.* The plaintiff physician argued in response that the personal stake exception applied. *See id.* at 702-03.

We held that under the circumstances of that case, the exception did not apply. First, we recognized that only one of the individual defendants stood to directly gain from the revocation of the plaintiff physician's medical staff privileges. *See id.* at 705. That physician was the only defendant physician who could be said to have been in competition with the plaintiff physician. *See id.* We explained that in any event, the

more important aspect of *Greenville* for the purposes of peer review is the degree of control the officer or agent with the independent interest exercised over the defendant firm's decision making process. *If the officer cannot cause a restraint to be imposed and his firm would have taken the action anyway, then any independent interest is largely irrelevant to the antitrust analysis.*

Id. (emphasis added). In *Oksanen*, the hospital board retained authority in the end over staff privilege decisions. *See id.* at 705-06. Because revocation of the plaintiff physician's medical staff privileges was subject to review by the hospital, and because decision making authority in the plaintiff physician's case was dispersed among a number of individuals, we held the personal stake exception did not apply. *See id.* at 706.

Liberalized construed, Dr. Wuchenich's complaint alleges that Drs. Phillips, Ciochetty, and Karmy, on the one hand and SMH on the other hand conspired to injure Dr. Wuchenich in his reputation, business, trade, and profession by: (1) Dr. Phillips and Dr. Ciochetty failing to assign Dr. Wuchenich a fair share of the patient load; (2) Dr. Karmy instigating peer review of two of Dr. Wuchenich's cases without just cause; and (3) SMH suspending Dr. Wuchenich's medical staff privileges without just cause. Initially, the rule that a principal cannot conspire with one of its agents appears to resolve this claim in favor of the Defendants. Clearly, the actions of the individual physicians of which Dr. Wuchenich complains fell within the scope of their agency authority from SMH. Thus, the question arises as to whether the personal stake exception applies.⁶

*13 Our careful review of the allegations in the complaint reveals that the exception applies in part. The personal stake exception does not apply to the extent Dr. Wuchenich alleges a conspiracy to suspend his medical staff privileges, including Dr. Karmy's action in recommending that two of Dr. Wuchenich's cases be

subject to peer review. This is because the facts alleged in Dr. Wuchenich's complaint parallel the facts of *Oksanen*: SMH's Board of Directors, its governing body, retained decision making authority over decisions involving medical staff privileges and review was disbursed among various committees that did not include the defendant physicians. See *id.* at 705-06. The personal stake exception does apply, however, to the allegation that SMH conspired with Dr. Phillips and Dr. Ciochetty to injure Dr. Wuchenich in his reputation, business, trade and profession by failing to assign Dr. Wuchenich a fair number of patients. Dr. Wuchenich's complaint plainly alleges that in so doing these physicians were acting for their own independent financial benefit by reducing direct competition. Therefore, we affirm the district court's dismissal of Dr. Wuchenich's claim alleging civil statutory conspiracy against the Defendants except to the extent it alleges a conspiracy by SMH, Dr. Phillips, and Dr. Ciochetty to injure Dr. Wuchenich in his reputation and to injure his ability to engage in his business, trade, and profession by failing to assign him a fair number of patients. On that point, we vacate the district court's dismissal and remand for further proceedings.

IV

Next, Dr. Wuchenich contends the district court erred in dismissing his claim against the Defendants alleging common law conspiracy to breach contractual obligations.

Applying Virginia substantive law, we hold the district court acted properly in dismissing Dr. Wuchenich's claim alleging common law conspiracy to breach contractual obligations. Virginia "common law recognizes a cause of action against those who conspire to induce the breach of a contract, even when one of the alleged conspirators is a party to the contract." *Catercorp, Inc. v. Catering Concepts, Inc.*, 431 S.E.2d 277, 281 (Va.1993). The "foundation" of an action alleging common law conspiracy "is the damage caused by the acts committed in furtherance of the conspiracy." *Commercial Bus. Sys., Inc.*, 453 S.E.2d at 267.

Here, the only contractual obligation that Dr. Wuchenich sufficiently alleges SMH breached is the obligation to abide by its bylaws in suspending his medical staff privileges. Thus, we must consider whether the allegations in the complaint sufficiently allege a cause of action with respect to each defendant for common law conspiracy to cause SMH to breach its bylaws with respect to suspending Dr. Wuchenich's medical staff privileges.

Ciochetty had any hand in any of the proceedings leading to the suspension of Dr. Wuchenich's medical staff privileges; indeed, the allegations in the complaint suggest no involvement. With respect to Dr. Phillips, the complaint alleges that he was "[u]nexpectedly ... forced to resign his medical staff privileges at SMH on or about April 15, 1996," (J.A. 15), which is a month and a half before the first meeting in the review process took place on May 28, 1996. With respect to Dr. Ciochetty, the complaint alleges that even though Dr. Ciochetty was Chief of Anesthesiology, he was not interviewed by the Peer Review Committee or asked to give an opinion before the Peer Review Committee regarding Dr. Wuchenich's cases. In sum, the complaint fails to allege sufficient facts, viewed in the light most favorable to Dr. Wuchenich, from which a reasonable jury could find that Dr. Phillips or Dr. Ciochetty conspired with any other defendant to cause SMH to breach its contractual obligation to Dr. Wuchenich to abide by its bylaws.

*14 The only allegation pertaining to Dr. Karmy and the proceedings leading to Dr. Wuchenich's suspension is that Dr. Karmy instigated, without just cause, two of the four cases reviewed by the Peer Review Committee. We are at a loss to see how this allegation supports a claim for conspiracy to cause SMH to breach its obligation to Dr. Wuchenich to abide by the procedural protections in its bylaws in suspending Dr. Wuchenich's medical staff privileges. Finally, without a party with whom to conspire, Dr. Wuchenich's claim alleging common law conspiracy against SMH necessarily fails. In sum, we affirm the district court's dismissal of Dr. Wuchenich's claim alleging common law conspiracy to breach contractual obligations.⁷

V

Dr. Wuchenich next challenges the district court's dismissal of his claim against SMH, Dr. Karmy, and Dr. Phillips alleging common law defamation.

The district court dismissed Dr. Wuchenich's defamation claim because, according to the district court, Dr. Wuchenich failed to plead the "exact words allegedly defaming plaintiff, or the precise occasions on which those statements were made, or to whom they were made." (J.A. 166). In so doing, the district court relied upon *Federal Land Bank v. Birchfield*, 3 S.E.2d 405 (Va.1939), which requires a plaintiff asserting a defamation claim in Virginia state court to plead the exact words that the plaintiff alleges are defamatory in order to survive a motion to dismiss. See *id.* at 410.

The complaint does not allege that Dr. Phillips or Dr.

The district court's analysis is erroneous because the

sufficiency of Dr. Wuchenich's complaint to properly state a claim for relief should be tested under Federal Rule of Civil Procedure 8 (Rule 8), which specifies the general rules of pleading in federal court. See *Hanna v. Plumer*, 380 U.S. 460, 465 (1965) (holding that federal courts sitting in diversity must apply state substantive law and federal procedural law). Rule 8 does not contain a special pleading requirement for defamation. Thus, according to Rule 8(a), we should test the sufficiency of Dr. Wuchenich's claim alleging defamation to determine whether it meets Rule 8(a)'s liberal pleading requirement of a short and plain statement showing that he is entitled to relief. See 5 Charles Alan Wright & Arthur R. Miller, *Federal Practice & Procedure: Civil 2d* § 1245 (1990).

In general, defamation consists of the publication of an injurious falsehood. See *Gazette, Inc. v. Harris*, 325 S.E.2d 713, 724-25 (Va.1985). Unlike other jurisdictions, Virginia makes no distinction between slander (spoken words) and libel (written words) in actions for common law defamation. See *Fleming v. Moore*, 275 S.E.2d 632, 635 (Va.1981). Virginia recognizes two general varieties of defamation: (1) words that are defamatory *per se*; and (2) all other defamatory words which, though not in themselves actionable, occasion a person special damage. See *Wells v. Liddy*, 186 F.3d 505, 522 (4th Cir.1999), cert. denied, 120 S.Ct. 939 (2000). Words that are defamatory *per se* are words that: (1) impute the commission of a criminal offense involving moral turpitude; (2) impute infection of a contagious disease, where if true, would exclude the plaintiff from society; (3) impute unfitness to perform the offices or duties of employment, or lack of integrity in the discharge of those duties; or, (4) prejudice a person in his or her profession or trade. See *id.* Furthermore, "the author or originator of a defamation is liable for a republication or repetition thereof by third persons, provided it is the natural and probable consequence of his act, or he has presumptively or actually authorized or directed its republication." *Weaver v. Beneficial Fin. Co.*, 98 S.E.2d 687, 690 (Va.1957); see also *Blue Ridge Bank v. Veribanc, Inc.*, 866 F.2d 681, 689 (4th Cir.1989).

*15 Effective July 1, 1995, a cause of action for defamation under Virginia law has been governed by a one-year statute of limitation prescribed by Virginia Code § 8.01-247.1. See Va.Code Ann. § 8.01-247.1 (Michie 1999 Supp.). A cause of action for defamation accrues for statute of limitation purposes on the date the defamatory acts allegedly occurred. See *Jordan v. Shands*, 500 S.E.2d 215, 218 (Va.1998).

Construing the allegations in the complaint in the light most favorable to Dr. Wuchenich, and drawing all

reasonable inferences in his favor, Dr. Wuchenich's defamation claim seeks redress for the following alleged conduct: (1) Dr. Phillips falsely stating to Dr. Baumunk and all surgeons practicing at SMH, at some point in time prior to April 6, 1996, that Dr. Wuchenich "was not a very good anesthesiologist," (J.A. 13), and that he was less than competent; (2) Dr. Karmy instigating two peer review cases of Dr. Wuchenich by falsely reporting, at some point in time prior to May 28, 1996, that Dr. Wuchenich did not meet the standard of care with respect to two patients; (3) SMH falsely reporting on May 31, 1996, to various persons, including staff members and administrators of SMH, that Dr. Wuchenich is not competent to practice anesthesiology; (4) SMH reporting shortly after May 31, 1996, to the State Board of Medicine, which in turn reported to the National Practitioner Data Bank, that it (SMH) suspended Dr. Wuchenich's medical staff privileges for lack of professional competence; (5) SMH continuing to publish the false statement that Dr. Wuchenich is professionally incompetent in hearings held by SMH after SMH suspended Dr. Wuchenich's medical staff privileges, the last of which occurred on December 12, 1996; (6) SMH publishing the false statement that Dr. Wuchenich is professionally incompetent through conversations within SMH and the community at large and through written correspondence with its staff and administrators until SMH reinstated his medical staff privileges on April 16, 1997; (7) SMH knowingly allowing the National Practitioner Data Bank to continue to report until June 10, 1997 that SMH had suspended Dr. Wuchenich for professional incompetence; and (8) SMH publishing the false statement that Dr. Wuchenich is professionally incompetent during the post June 1, 1997 portion of the State Board of Medicine's investigation of the allegations that lead to the suspension of Dr. Wuchenich's medical staff privileges at SMH. We conclude that all of the alleged conduct just listed constitutes defamation *per se*, because each statement, whether oral or written, falsely imputed unfitness on the part of Dr. Wuchenich to perform his duties as an anesthesiologist and prejudiced him in his profession. See *Wells*, 186 F.3d at 522. Furthermore, each statement was either published originally by the specified defendant or was republished by a third party as the natural and probable consequence of the specified defendant's original publication. See *Weaver*, 98 S.E.2d at 690.

*16 We now consider whether each of these instances of defamatory conduct is actionable under Virginia's one-year statute of limitation for defamation claims.¹ Our review of each of these instances of defamatory conduct leads us to conclude that only two are alleged to have occurred within one year of the filing of Dr. Wuchenich's

complaint on June 1, 1998:(1) the ongoing publication (knowingly allowed and expected by SMH) in the National Practitioner's Data Bank that SMH had suspended Dr. Wuchenich's medical staff privileges for professional incompetency; and (2) SMH publishing the false statement that Dr. Wuchenich is professionally incompetent during the post June 1, 1997 portion of the Board of Medicine's investigation of the allegations that lead to the suspension of Dr. Wuchenich's medical staff privileges at SMH. According to SMH, Virginia Code § 54.1-2906(C) provides it with immunity from suit with respect to both of these instances of alleged defamatory conduct. Virginia Code § 54.1-2906(C) provides any person immunity from civil liability for making a report to the State Board of Medicine regarding disciplinary action resulting from professional incompetence or testifying in a judicial or administrative proceeding as a result of such a report *unless such person acted in bad faith or with malicious intent*. See Va.Code Ann. § 54.1-2906(C) (Michie 1998). Assuming *arguendo* that § 54.1-2906(C) would otherwise provide SMH with immunity from suit with respect to the two instances of defamatory conduct on its part not barred by the statute of limitations, we conclude it does not provide SMH with immunity at the early dismissal stage of litigation because the complaint clearly alleges that SMH engaged in the defamatory conduct in bad faith and with malicious intent.

In sum, we hold the district court properly dismissed all portions of Dr. Wuchenich's claim alleging defamation except for the portion seeking redress against SMH for the ongoing publication (knowingly allowed and expected by SMH) in the National Practitioner's Data Bank that SMH had suspended Dr. Wuchenich's medical staff privileges for professional incompetency, and for SMH's publication of the false statement that Dr. Wuchenich is professionally incompetent during the post June 1, 1997 portion of the Board of Medicine's investigation of the allegations that lead to the suspension of Dr. Wuchenich's medical staff privileges at SMH. We, accordingly, vacate the district court's dismissal of these specified allegations, remand them for further proceedings, and affirm the district court's dismissal of the balance.

VI

Dr. Wuchenich lastly challenges the district court's dismissal of his claims alleging tortious interference with an existing contract and tortious interference with his business expectancies. Liberally construed, the complaint alleges that the actions and statements of the Defendants tortiously interfered with SMH's Bylaws as contractual provisions of the Physicians Guarantee Agreement and as

an implied contract between Dr. Wuchenich and SMH. Furthermore, the complaint alleges that the Defendants tortiously interfered with Dr. Wuchenich's business expectancy of continued referrals of patients for his care and treatment from SMH and the physicians who had medical staff privileges at SMH.

*17 Under Virginia law, a cause of action for tortious interference by a third party with a contract that is not terminable at will, such as the Physician Guarantee Agreement, is comprised of the following elements: "(1) the existence of a valid contractual relationship or business expectancy; (2) knowledge of the relationship or expectancy on the part of the interferor; (3) intentional interference inducing or causing a breach or termination of the relationship or expectancy; and (4) resultant damage to the party whose relationship or expectancy has been disrupted." *Duggin v. Adams*, 360 S.E.2d 832, 835 (Va.1987) (internal quotation marks omitted). If the contract at issue is terminable at will, the plaintiff must also allege and prove that the defendant interfered with the contract by employing improper methods. See *id.* at 836.

Under Virginia law, a cause of action for tortious interference with a contractual or business expectancy is comprised of the following elements: (1) the existence of a contractual or business expectancy, (2) knowledge on the part of the third-party of the expectancy; (3) intentional interference with the expectancy; (4) the third-party's use of improper methods to interfere with the expectancy; and (5) damage to the party making the claim proximately resulting from the third-party's conduct. See *Maximus, Inc. v. Lockheed Info. Management Sys. Co.*, 493 S.E.2d 375, 378 (Va.1997). Independently tortious conduct (*i.e.*, conduct that in and of itself would be an actionable tort) is recognized under Virginia law as an improper method. See *Duggin*, 360 S.E.2d at 836. But, independently tortious conduct is but one species of improper methods. As the Virginia Supreme Court in *Maximus* explained, actions may also be improper which are neither independently tortious nor illegal, for example, unfair competition and unethical conduct. See *Maximus*, 493 S.E.2d at 379. Finally, we note that while a person cannot intentionally interfere with his own contract, if it can be shown that an agent of a party to the contract was acting outside the scope of his employment in tortiously interfering with such contract, then the aggrieved party may be entitled to recover in the event the agent is unable to establish an affirmative defense of justification or privilege. See *Fox*, 362 S.E.2d at 708.

The district court properly dismissed the causes of action against SMH for tortious interference with the Physician

Guarantee Agreement and any implied agreement between SMH and Dr. Wuchenich to abide by SMH's Bylaws, because SMH, as a party to both the Physician Guarantee Agreement and any such implied contract, cannot intentionally interfere with its own contract. *See Fox*, 362 S.E.2d at 708. The district court also properly dismissed these same causes of action against Dr. Karmy, Dr. Ciochetty, and Dr. Phillips, because none of their conduct (failing to assign Dr. Wuchenich patients and referring two cases of Dr. Wuchenich for peer review without just cause) could be reasonably considered as having interfered with the procedural protections of SMH's Bylaws.

*18 We do, however, conclude that Dr. Wuchenich has sufficiently stated a cause of action at this early pleading stage against the Defendants for tortious interference with his expectancy of entering into contractual relationships with some patients at SMH. In this regard, Dr. Wuchenich has alleged the existence of the contractual expectancy, knowledge on the part of each defendant of the expectancy, and intentional interference with the expectancy by unfair competition (*i.e.*, Dr. Phillips and Dr. Ciochetty failing to assign Dr. Wuchenich a fair share of anesthesiology patients) and unethical conduct (*i.e.*, SMH suspending Dr. Wuchenich's medical staff privileges without just cause and Dr. Karmy reporting two cases of Dr. Wuchenich to peer review without just cause) proximately resulting in damage to Dr. Wuchenich. *See Maximus*, 493 S.E.2d at 378.

In sum, we affirm the district court's dismissal of Dr. Wuchenich's tortious interference claims pertaining to SMH's Bylaws. However, we vacate the district court's dismissal of his contractual expectancy claim against the Defendants and remand that claim for further proceedings.

VII

In conclusion, we: (1) vacate the district court's dismissal of Dr. Wuchenich's claim alleging breach of SMH's Bylaws; (2) affirm the district court's dismissal of the portion of Dr. Wuchenich's breach of contract claim seeking to enforce oral assurances allegedly made by SMH to assign him a sufficient number of patients to establish an anesthesiology practice in the Woodstock, Virginia area; (3) affirm the district court's dismissal of Dr. Wuchenich's claim alleging negligent breach of contract; (4) affirm the district court's dismissal of Dr. Wuchenich's claim alleging civil conspiracy except to the extent it alleges a conspiracy among SMH, Dr. Phillips,

and Dr. Ciochetty to injure Dr. Wuchenich's ability to engage in the practice of his profession by failing to assign him a fair number of patients; (5) vacate the district court's dismissal of Dr. Wuchenich's claim alleging civil conspiracy to the extent it alleges a conspiracy among SMH, Dr. Phillips, and Dr. Ciochetty to injure Dr. Wuchenich's ability to engage in the practice of his profession by failing to assign him a fair number of patients; (6) affirm the district court's dismissal of Dr. Wuchenich's claim alleging common law conspiracy to breach contractual obligations; (7) affirm the district court's dismissal of Dr. Wuchenich's claim alleging defamation except for the portion seeking redress against SMH for the ongoing publication (knowingly allowed and expected by SMH) in the National Practitioner's Data Bank that SMH had suspended Dr. Wuchenich's medical staff privileges for professional incompetency, and for SMH's publishing the false statement that Dr. Wuchenich is professionally incompetent during the post June 1, 1997 portion of the Board of Medicine's investigation of the allegations that lead to the suspension of Dr. Wuchenich's medical staff privileges at SMH; (8) vacate the portion of the district court's dismissal of Dr. Wuchenich's defamation claim seeking redress against SMH for the ongoing publication (knowingly allowed and expected by SMH) in the National Practitioner's Data Bank that SMH had suspended Dr. Wuchenich's medical staff privileges for professional incompetency, and for SMH's publishing the false statement that Dr. Wuchenich is professionally incompetent during the post June 1, 1997 portion of the Board of Medicine's investigation of the allegations leading to Dr. Wuchenich's suspension; (9) affirm the district court's dismissal of Dr. Wuchenich's claims alleging tortious interference with the Physician Guarantee Agreement and any implied agreement between SMH and Dr. Wuchenich to abide by SMH's Bylaws; (10) vacate the district court's dismissal of Dr. Wuchenich's claim alleging the Defendants tortiously interfered with his contractual expectancy of entering into contractual relationships with some patients at SMH; and (11) remand all vacated claims for further proceedings.

*19 *AFFIRMED IN PART, VACATED IN PART, AND REMANDED.*

Parallel Citations

2000 WL 665633 (C.A.4 (Va.)), 2000-1 Trade Cases P 72,913

Footnotes

- 1 The complaint does not allege any facts describing the identity of Jim Greer.
- 2 We note that SMH argues in its brief and asserted at oral argument that liberally construing the factual allegations of Dr. Wuchenich's complaint reveals that it suspended Dr. Wuchenich's medical staff privileges pursuant to SMH Bylaws § 6.2(a). SMH Bylaws § 6.2(a) allows for the summary suspension of a physician's medical staff privileges (*i.e.*, suspension without prior notice to the physician or an opportunity to be heard) "whenever action must be taken immediately, to protect the life of any patient or to reduce the substantial likelihood of immediate injury or damage to health of safety of any patient." (J.A. 19). In support of its assertion, SMH relies upon the following language found in its May 31, 1996 letter to Dr. Wuchenich, which is attached as Exhibit G to the complaint: "Based upon the results of the Peer Review, the Executive Committee of the General Medical Staff has recommended that your privileges be suspended at Shenandoah Memorial Hospital. Based upon this recommendation and the fact that the allegations pertain to matters *that could endanger the safety and well-being of patients*, the acting Chief Executive Officers have directed that you be removed from On Call status until further notice." (J.A. 49) (*emphasis added*). Liberally viewing this language in the light most favorable to Dr. Wuchenich reveals that SMH did not necessarily suspend Dr. Wuchenich's medical staff privileges pursuant to SMH Bylaws § 6.2(a). The language in SMH's letter is simply not as definitive as that required by SMH Bylaws § 6.2(a).
- 3 Exhibit H is the Written Statement of the Executive Committee, issued on December 6, 1996, regarding the professional misconduct charges against Dr. Wuchenich. The Written Statement of the Executive Committee contains a sequence of events that the Executive Committee opines demonstrate that SMH took the charges against Dr. Wuchenich very seriously and adhered to its bylaws throughout the review process.
- 4 SMH also argues that the following statement in Exhibit H shows that it gave Dr. Wuchenich sufficient notice under its bylaws to appear before the Executive Committee: "Attempts to reach Dr. Wuchenich on Thursday, May 30, 1996 to inform him of the pending [Executive Committee meeting] at which time Dr. Wuchenich would have been invited to attend were further explained. All attempts were unsuccessful and messages left had no response." (J.A. 59). SMH's argument is without merit, because, as we have already explained, these statements are not incorporated as allegations in the complaint. Furthermore, assuming *arguendo* they are, viewing them in the light most favorable to Dr. Wuchenich, they do not establish that SMH gave Dr. Wuchenich sufficient notice under its bylaws to appear before the Executive Committee to defend himself.
- 5 Dr. Wuchenich also contends the district court erred in dismissing his claim alleging negligent breach of contract, which claim he admits in his Reply Brief is identical in substance to his claim alleging breach of contract. Because Dr. Wuchenich's claim alleging negligent breach of contract is duplicative of his claim alleging breach of contract, and because Virginia substantive law does not recognize a tort cause of action based solely on the negligent breach of a contractual duty with no corresponding common law duty, we hold the district court properly dismissed Dr. Wuchenich's claim alleging negligent breach of contract. *See Foreign Mission Bd. v. Wade*, 409 S.E.2d 144, 148 (Va.1991) (rejecting plaintiff's attempt to establish a tort action based solely on the negligent breach of a contractual duty with no corresponding common law duty).
- 6 The Defendants do not dispute that under the appropriate set of facts, Virginia law would recognize the applicability of the personal stake exception to the intracorporate immunity rule as developed by our court with respect to the Sherman Act.
- 7 Given our reasons for affirming the district court's dismissal of this claim, we need not address the Defendants' alternative argument that the claim fails under the general rule that a principal cannot legally conspire with its agents.
- 8 SMH, Dr. Karny, and Dr. Phillips raised the statute of limitations defense below in support of their Rule 12(b)(6) motions.

336 Fed.Appx. 311

This case was not selected for
publication in the Federal Reporter.
Not for Publication in West's Federal Reporter.

See Fed. Rule of Appellate Procedure 32.1
generally governing citation of judicial decisions
issued on or after Jan. 1, 2007. See also Fourth
Circuit Rule 32.1 (Find CTA 4 Rule 32.1)

United States Court of Appeals,
Fourth Circuit.

Calvin ANTHONY, Plaintiff-Appellee,
v.

Robert WARD; Charles Sheppard, in their
individual capacities, Defendants-Appellants,
and

South Carolina Department
of Corrections, Defendant.

No. 07-1932. | Argued: May
12, 2009. | Decided: July 7, 2009.

Synopsis

Background: Former correctional facility warden brought
action against state Department of Corrections officials,
alleging civil conspiracy under South Carolina law. The
United States District Court for the District of South Carolina,
Margaret B. Seymour, J., entered judgment on a jury award
of \$510,000, and officials appealed.

[Holding:] The Court of Appeals held that district court did
not abuse its discretion in refusing to charge jury on scope of
employment immunity for state employees.

Affirmed.

West Headnotes (3)

[1] Federal Courts

⇒ Failure or refusal to instruct; modification
of request

District court's error in failing to give jury
instruction concerning scope of employment

in former correctional facility warden's civil
conspiracy action against state Department
of Corrections officials under South Carolina
law was not prejudicial, since there was
ample evidence that officials' actions against
warden, including their conduct in seeking his
termination after hostage situation at facility,
were personally, rather than professionally,
motivated.

1 Cases that cite this headnote

[2] Conspiracy

⇒ Conspiracy to injure in person or reputation

District court did not abuse its discretion in
refusing to charge jury on scope of employment
immunity for state employees under South
Carolina Tort Claims Act (SCTCA) in former
correctional facility warden's civil conspiracy
action against state Department of Corrections
officials under South Carolina law; Act was not
intended to protect state employees from liability
for their intentional torts, and jury was required
to find that officials intentionally injured warden
in order to impose liability for civil conspiracy.
S.C. Code 1976, § 15-78-70.

1 Cases that cite this headnote

[3] Conspiracy

⇒ Evidence

Evidence was sufficient to support jury
finding that state Department of Corrections
officials acted with common design to force
former correctional facility warden's involuntary
retirement, as required to establish civil
conspiracy under South Carolina law; evidence
indicated that officials met together to discuss
warden on numerous occasions, sought his
termination following hostage situation at
facility and acted contrary to Department policy
and procedure in forcing warden's demotion.

*312 Appeal from the United States District Court for
the District of South Carolina, at Columbia. Margaret B.
Seymour, District Judge. (3:05-cv-01636-MBS).

Attorneys and Law Firms

ARGUED: William L. Howard, Sr., Young, Clement & Rivers, LLP, Charleston, South Carolina, for Appellants. J. Lewis Mann Cromer, Cromer & Mabry, Columbia, South Carolina, for Appellee. **ON BRIEF:** Stephen L. Brown, Young, Clement & Rivers, LLP, Charleston, South Carolina, for Appellants.

Before NIEMEYER and MICHAEL, Circuit Judges, and FREDERICK P. STAMP, JR., Senior United States District Judge for the Northern District of West Virginia, sitting by designation.

Opinion

Affirmed by unpublished PER CURIAM opinion.

Unpublished opinions are not binding precedent in this circuit.

PER CURIAM:

Defendants Robert Ward and Charles Sheppard, officials in the South Carolina Department of Corrections (SCDC or the Department), appeal a judgment based on a jury award of \$510,000 to plaintiff Calvin Anthony, the former warden of Lee Correctional Institution, for civil conspiracy under South Carolina law. According to Anthony, Ward and Sheppard conspired for personal and malicious reasons to force his termination from the Department. On appeal Ward and Sheppard raise numerous challenges to trial and post-trial proceedings. Because we conclude that there is no reversible error, we affirm the judgment.

I.

We recite the facts in the light most favorable to Anthony, the prevailing party. *See Lack v. Wal-Mart Stores, Inc.*, 240 F.3d 255, 258 (4th Cir.2001). From 1999 until his involuntary retirement from the Department in 2004, Anthony was the warden at Lee Correctional Institution, a maximum security prison in South Carolina. Anthony, who is African-American, began working for the Central Correctional Institution at SCDC in 1978. He was promoted through the ranks and attained his wardenship at Lee in 1999. Anthony received excellent reviews as a warden from 1999 until 2002 and was named Warden of the Year in 2002. In 2002 defendant Ward, the Director of Operations for SCDC,

became Anthony's supervisor and thereafter Anthony did not receive evaluations.

Anthony initially drew Ward's ire following a hostage situation that occurred at Lee in late October 2003, during Anthony's tenure at that institution. At the time of the hostage incident, Laurie Bessinger was the Director of Security and Training at SCDC. Bessinger had been a candidate for Ward's job as Director of Operations. After Bessinger was passed over for the Operations Director position, he was placed under the supervision of defendant Charles Sheppard, the Inspector General for SCDC, with whom Bessinger had an acrimonious relationship. Even before the hostage situation Sheppard sought to undermine and discredit Bessinger, soliciting information from Bessinger's subordinates to accomplish that goal.

Both Ward and Sheppard voiced strong disapproval of Bessinger's handling of the *313 hostage situation at Lee, and Ward went so far as to ask Jon Ozmint, the Director of SCDC, to "relieve" Bessinger the night of the incident. J.A. 1067. Anthony, as the warden of Lee, was responsible for compiling an After Action Report about what had occurred that night. After Anthony gave Ward a draft of the report, Ward asked Anthony to "put some negative things in" the report about Bessinger, J.A. 155, including things that were untrue. Anthony refused and thereafter Ward's attitude toward him changed.

Sheppard's dislike for Anthony stemmed from Anthony's role in the grievance process of Rickie Harrison, an African-American warden at Kershaw Correctional Institution who was demoted by Ward in 2002. The events leading to Harrison's demotion began with a surprise "shakedown" (or inspection) of Kershaw. In Harrison's eighteen years of experience as a warden, this was the only shakedown that had occurred without the warden receiving prior notification. Sheppard was Harrison's interviewer during the investigation following the shakedown and ultimately recommended Harrison's demotion. After Harrison's demotion, Sheppard handled both the investigation of Harrison's grievance and acted as the lawyer for the SCDC at the grievance hearing, which was an unprecedented action for the Inspector General. Sheppard initially subpoenaed Anthony to testify at the grievance hearing, but after Anthony made pre-hearing statements to Sheppard and others in the Department that he believed Harrison was the victim of racial discrimination, Sheppard declined to call Anthony as a witness.

Like Harrison's demotion, Anthony's termination from SCDC resulted from an unannounced shakedown of his institution. In the spring of 2003 Sheppard placed an investigator, Karen Hair, at Lee. Hair reported directly to Sheppard, and Anthony had no knowledge of the nature of Hair's investigative activities prior to the shakedown. At 6 a.m. on January 29, 2004, Anthony received a call from Ward informing him that a shakedown of Lee was about to commence. As with the shakedown at Kershaw, but unlike any other shakedown Anthony (or Bessinger) could remember, Anthony was given no advance warning of the event. Ward participated directly in the shakedown.

The shakedown targeted the boiler room at Lee. The inspection revealed a significant number of items in the boiler room that were classified by Ward and Sheppard as contraband, including unaccounted for computer parts, televisions, cameras, a scanner and various bulk food items. The inspection also revealed a number of other irregularities in the boiler room, including inmates working without supervision, possible access to outside phone lines and the Internet, and video surveillance cameras being used to monitor entry and exit from the room.

There were four levels of oversight of the boiler room below Anthony on the prison's organizational chart, and Anthony himself was never linked to any of the problems that occurred in the boiler room. Anthony inspected the boiler room regularly, including within the month prior to the shakedown, but had not observed anything out of the ordinary. During his inspections he checked mainly for cleanliness and sanitation, and not to see whether there were unauthorized computers in the room.

Regarding unsupervised inmates, there were identical memoranda dating from 1996 and 2000 and posted on the walls in the boiler room that authorized inmates to work in the room with minimal supervision from the courtyard officer in the event that the officer with direct supervision over the boiler room needed to attend to *314 business outside the room. The former memorandum predated Anthony's wardenship, but the latter was signed by Anthony and the four other employees with direct supervisory responsibility over the boiler room.

In April 2004, slightly over two months after the shakedown, Anthony made a decision to pursue the Teacher and Employee Retention Initiative (TERI)—a program through which qualified employees are permitted to retire early, begin

receiving their retirement, and at the same time return to work for a substantial fraction of their original pay. Anthony informed Ward about his decision to "accept the retirement opportunity," and Ward told him that he was "approved and to plan to return." J.A. 201-02. Ward also informed Anthony at that time that the investigation was over: "don't worry about it, go back to your institution and run your institution, because that's over with." J.A. 202.

On June 16, 2004, Anthony's immediate supervisor, Carl Fredericks, handed Anthony a corrective action charging him with gross negligence (for permitting inmates to work unsupervised in the boiler room) and falsification of documents (specifically, documents signed by Anthony in which he stated that he had inspected the maintenance area of Lee, in which the boiler room was located, and failed to detect any of the irregularities discovered during the shakedown). Anthony maintained that he never falsified any documents. He talked with Sheppard after receiving the corrective action, and Sheppard told him to "think about retiring." J.A. 253. On June 22, 2004, Anthony met with Ward and was informed that if he had not already put in his retirement papers, he would have been terminated. He was permitted to retire in lieu of termination.

Anthony then filed this action in federal district court for the District of South Carolina. He sued Ward and Sheppard in their individual capacities alleging that they conspired to force him out of his job at Lee. His complaint also included a claim against the Department itself alleging that he was discriminated against on the basis of his race in violation of Title VII of the 1991 Civil Rights Act. The case went to trial and the jury returned a verdict in SCDC's favor on the Title VII discrimination claim and in Anthony's favor on the civil conspiracy claim. The jury awarded Anthony \$510,000 in damages against Ward and Sheppard in their individual capacities. Ward and Sheppard appeal.

II.

[1] Ward and Sheppard first contend that the district court erred in refusing their proposed jury instructions on the intracorporate conspiracy doctrine. We review jury instructions for abuse of discretion. *Johnson v. MBNA Am. Bank, NA*, 357 F.3d 426, 432 (4th Cir.2004); see also *S. Atl. Ltd. P'ship of Tenn. v. Riese*, 284 F.3d 518, 530 (4th Cir.2002). "The test of the adequacy of jury instructions is whether the jury charge, construed as a whole, adequately

states the controlling legal principle without misleading or confusing the jury." *Chaudhry v. Gallerizzo*, 174 F.3d 394, 408 (4th Cir.1999). "An error of law constitutes an abuse of discretion." *A Helping Hand, LLC v. Balt. County, Md.*, 515 F.3d 356, 370 (4th Cir.2008). However, "[w]e will not set aside a jury verdict based on an instructional error 'unless the erroneous instruction seriously prejudiced the challenging party's case.'" *Willingham v. Crooke*, 412 F.3d 553, 560 (4th Cir.2005) (quoting *College Loan Corp. v. SLM Corp.*, 396 F.3d 588, 595 (4th Cir.2005)).

*315 Under South Carolina law "[a] civil conspiracy ... consists of three elements: (1) a combination of two or more persons, (2) for the purpose of injuring the plaintiff, (3) which causes him special damage." *Lee v. Chesterfield Gen. Hosp., Inc.*, 289 S.C. 6, 344 S.E.2d 379, 382 (1986). South Carolina courts have recognized an exception to civil conspiracy liability when all the alleged members of a conspiracy are agents of a single corporate entity and act on behalf of the corporation: a so-called intracorporate conspiracy. *See McMillan v. Oconee Mem. Hosp., Inc.*, 367 S.C. 559, 626 S.E.2d 884, 886-87 (2006); *Anderson v. S. Ry. Co.*, 224 S.C. 65, 77 S.E.2d 350, 351 (1953).

The intracorporate conspiracy doctrine in South Carolina draws its origins from *Goble v. American Railway Express Co.*, where the state Supreme Court indicated that "it is impossible to conceive that a conspiracy between a corporation and its agents may be established by the act of such agents alone." 124 S.C. 19, 115 S.E. 900, 903 (1923). More recently, the South Carolina Court of Appeals held that although "a corporation, as a legal person in contemplation of law, cannot conspire with itself," "the agents of a corporation are legally capable, as individuals, of conspiracy among themselves or with third parties." *Lee*, 344 S.E.2d at 383.

The district court below interpreted the above cases as distinguishing between two types of civil conspiracies: (1) principal-agent conspiracies and (2) conspiracies between agents of a corporation. Based on its reading of South Carolina case law, the court concluded that the intracorporate conspiracy doctrine in South Carolina only applies to principal-agent conspiracies. Because the facts of this case placed it "squarely within" the latter context, the district court concluded that an instruction on civil conspiracy was unwarranted. J.A.2071.

Defendants, in contrast, assert that immunity for intracorporate conspiracy only ceases to apply when agents

or employees of a corporation step outside the course and scope of their employment and act as individuals rather than as agents of the corporation. Defendants argue that the district court erred in refusing a jury instruction on "whether or not [Defendants] were acting for the interest of their employer and in the course and scope of their employment." Appellants' Br. at 16. According to defendants, the scope of employment question is "quintessentially a factual issue" and must therefore be resolved by the jury. Appellants' Reply Br. at 4.

In *McMillan* the South Carolina Supreme Court indicated that scope of employment was relevant to the intracorporate conspiracy doctrine, holding that "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*." 626 S.E.2d at 887 (emphasis added). Other courts have similarly held scope of employment to be relevant under the doctrine. *See Garza v. City of Omaha*, 814 F.2d 553, 556 (8th Cir.1987) ("While it is true that a corporation cannot conspire with itself, an intracorporate conspiracy may be established where individual defendants are also named and those defendants act *outside the scope of their employment for personal reasons*." (emphasis added); *McAndrew v. Lockheed Martin Corp.*, 206 F.3d 1031, 1036 (11th Cir.2000) ("Simply put, under the doctrine, a corporation cannot conspire with its employees, and its employees, *when acting in the scope of their employment*, cannot conspire among themselves." *316) (emphasis added). Our circuit has recognized a similar "personal stake exception," holding that (under Virginia's civil conspiracy law) "the intracorporate immunity doctrine does not apply where a corporate officer has an independent personal stake in achieving the corporation's illegal objectives." *ePlus Tech., Inc. v. Aboud*, 313 F.3d 166, 179 (4th Cir.2002) (internal quotations omitted).

The jury verdict form in this case failed to explicitly address whether Ward and Sheppard were acting within the scope of their employment, and they made a timely objection before the district court. We conclude, however, that even if the district court erred in failing to give the requested instruction, the error was not seriously prejudicial when considered in light of the record as a whole.

The verdict form specifically required the jury to find that Ward and Sheppard had entered into an agreement "*for the*

purpose of injuring [Anthony]." J.A.2007 (emphasis added). The jury was also instructed that:

With respect to the second element [of civil conspiracy], the plaintiff must prove by a preponderance of the evidence that Mr. Ward and Mr. Sheppard specifically intended to injure the plaintiff. The primary purpose of the alleged agreement or conspiracy must be to injure the plaintiff. Mere speculation about a party's motives with respect to certain conduct does not constitute proof of conspiracy.

J.A.1965. Further, there was ample evidence adduced at trial that Ward's and Sheppard's actions toward Anthony were personally, rather than professionally, motivated. Anthony provided evidence that Ward disliked him, not for any professionally relevant reason, but because he had refused to accommodate Ward's request that he alter his After Action Report to make it more unfavorable to Bessinger. Similarly, Anthony's refusal to testify negatively about Warden Harrison during Sheppard's handling of Harrison's grievance hearing motivated Sheppard to act against Anthony's interests. Defendants' decisions to act contrary to longstanding custom, for example by declining to give Anthony advance notice of the January 2004 shakedown of Lee, is similarly suggestive of a personal, rather than a professional, motive. And finally, Anthony introduced considerable evidence at trial that wardens at other institutions in which security lapses were discovered that were comparable to those at Lee, but against whom defendants did not bear any personal grudge, were permitted to continue working or participate in the TERI program.

In sum, the finding of a specific intent to injure Anthony, coupled with the evidence that defendants had a personal stake in injuring plaintiff, leads us to conclude the error in this case was not seriously prejudicial. Thus, although the district court erred in refusing to give the requested scope of employment instruction, we conclude that this error does not necessitate a new trial.

III.

[2] Ward and Sheppard next contend that the district court erred in failing to charge the jury on immunity from suit under

the South Carolina Tort Claims Act (SCTCA). We review a court's failure to give a requested jury instruction under the abuse of discretion standard described above.

S.C.Code Ann. § 15-78-70 provides that:

(a) This chapter constitutes the exclusive remedy for any tort committed by an employee of a governmental entity.

*317 An employee of a governmental entity who commits a tort while acting within the scope of his official duty is not liable therefor except as expressly provided in subsection (b).

(b) Nothing in this chapter may be construed to give an employee of a governmental entity immunity from suit and liability if it is proved that the employee's conduct was not within the scope of his official duties or that it constituted actual fraud, actual malice, intent to harm, or a crime involving moral turpitude.

S.C.Code Ann. § 15-78-70(a), (b) (2005). Under S.C.Code Ann. § 15-78-30: " 'Scope of official duty' or 'scope of state employment' means (1) acting in and about the official business of a governmental entity and (2) performing official duties." S.C.Code Ann. § 15-78-30(i) (2005).

Defendants argue that the desire to terminate an employee cannot constitute intent to harm because "any time a supervising government employee participates in sanctioning an employee, they, by definition, intend to do that employee 'harm' in the general sense of the word." Appellants' Br. at 20. Consequently, defendants say, "intent to harm" under the SCTCA "must require a malicious or personal motivation in order for the exception to become operable." *Id.* Defendants note that malice or intent to harm must be "proved" under § 15-78-70(b), and they contend that mere allegations are therefore insufficient.

The district court concluded that the SCTCA is not intended to protect state employees from liability for intentional torts, noting that "irrespective of whether Defendants Ward and Sheppard acted outside the scope of their official duty, they are not immune from suit under the SCTCA because their conduct was proven to be intentionally tortious." J.A.2079. The court determined that

it was not necessary ... to give additional charges to the jury regarding intent to harm because the elements of civil conspiracy, an

intentional tort, already encompass such intent. The jury's finding that Defendants had civilly conspired against Plaintiff was sufficient to remove from the purview of the SCTCA's protected class of government employees.

Id. We agree. The jury was specifically required to find that defendants intentionally injured Anthony in order to award damages on the civil conspiracy claim: namely, that Ward and Sheppard entered into an agreement "for the purpose of injuring Plaintiff." J.A.2007. The jury was also instructed that it must find Anthony had proved by a preponderance of the evidence that defendants "specifically intended to injure the plaintiff" and that this was "[t]he primary purpose of the alleged agreement or conspiracy." J.A.1965. The district court therefore did not abuse its discretion in refusing to include an additional jury instruction on scope of employment under the SCTCA.

IV.

Ward and Sheppard further contend that they were entitled to judgment as a matter of law based on Anthony's failure to allege and prove special damages or, in the alternative, that the district court erred in failing to adequately charge the jury on special damages as an element of civil conspiracy. Specifically, defendants contend that Anthony neither alleged¹ nor *318 proved damages under the civil conspiracy claim over and above those alleged for the race discrimination claim.

A.

In reviewing whether plaintiff has proved special damages, we view the evidence in the light most favorable to the plaintiff as the non-moving party, drawing all reasonable inferences in his favor without weighing the evidence or credibility of the witnesses. *Baynard v. Malone*, 268 F.3d 228, 234-35 (4th Cir.2001) ("The question is whether a jury, viewing the evidence in the light most favorable to [the non-moving party], could have properly reached the conclusion reached by this jury."). "We must reverse if a reasonable jury could only rule in favor of [the movant]; if reasonable minds could differ, we must affirm." *Id.* at 235.

As noted above, the third element of a civil conspiracy in South Carolina is that the defendants' agreement to injure the plaintiff "causes special damages." *Pye v. Estate of Fox*, 369 S.C. 555, 633 S.E.2d 505, 511 (2006). According to *Pye*, "[b]ecause the quiddity of a civil conspiracy claim is the damage resulting to the plaintiff, the damages alleged must go beyond the damages alleged in other causes of action." *Id.* In *Todd v. South Carolina Farm Bureau Mutual Insurance Co.*, the South Carolina Supreme Court held that "[w]here the particular acts charged as a conspiracy are the same as those relied on as the tortious act or actionable wrong, plaintiff cannot recover damages for such act or wrong, and recover likewise on the conspiracy to do the act or wrong." 276 S.C. 284, 278 S.E.2d 607, 611 (1981) (quoting 15A C.J.S. *Conspiracy* § 33 (1967), at 718). The plaintiff in *Todd* had brought five causes of action, including four tort claims and a fifth claim for "conspiracy to so damage the plaintiff." 278 S.E.2d at 608. As the court pointed out, "[t]he fifth cause of action simply takes all the prior allegations and alleges that the acts were done in furtherance of a conspiracy among the defendants. Damages are then sought for injury resulting from the conspiracy." *Id.* at 611. The court held that "[t]he trial judge erred by overruling the demurrer to the conspiracy cause of action in the complaint, since Todd can recover no additional damages for the alleged fifth cause of action." *Id.*

The case law makes clear that the concern is with a plaintiff receiving a double recovery. See *Kuznik v. Bees Ferry Assocs.*, 342 S.C. 579, 538 S.E.2d 15, 31 (S.C.Ct.App.2000) ("An action for civil conspiracy will not lie if a plaintiff has obtained relief through other avenues."). Here, because the jury only awarded damages on one of the two claims in this case, there is no possibility that plaintiff received an impermissible double recovery. See *Peoples Fed. Sav. & Loan Ass'n of S.C. v. Res. Planning Corp.*, 358 S.C. 460, 596 S.E.2d 51, 60 (2004) ("The damages alleged in [plaintiffs] breach of fiduciary duty and conspiracy claims are similar. However, since the referee directed the verdict in favor of [defendant] on [plaintiffs] breach of fiduciary duty claim, [defendant] is not twice subject to payment for damages for the same act. There is no error."). Defendants failed to challenge the adequacy of Anthony's complaint prior to trial, and the jury awarded damages on only one of Anthony's two claims. Consequently, any deficiency in the complaint was harmless; defendants are not entitled *319 to judgment as a matter of law based on a failure to prove special damages.

B.

Ward and Sheppard also contend that the trial court erred in refusing their requests "to elaborate sufficiently to allow the jury, as laymen, to understand the element of special damages as it applies to a cause of action for civil conspiracy." Appellants' Br. at 27-28. Defendants argue that the trial court's instructions on the special damages requirement were misleading and confusing because they led the jury to believe that if Anthony was awarded no damages under the discrimination claim, any damages awarded under a civil conspiracy claim would necessarily satisfy the special damages requirement. Defendants fail, however, to indicate what alternative language they believe should have been used.²

On the issue of special damages, the judge instructed the jury as follows:

With respect to the third element [of civil conspiracy], plaintiff must prove special damages. And special damages are damages for losses that are not natural and proximate—that are not the natural and proximate result of the injury. The plaintiff must sufficiently state and claim special damages.

This element is an important element in the tort of civil conspiracy because it requires a showing of the damage resulting to plaintiff from an overt act done pursuant to the alleged conspiracy.

The damage alleged must go beyond the damages alleged in other causes of action. In other words, plaintiff must prove that he had incurred damages greater or different from the damages arising from his discrimination claim.

Different damages are damages over and above the damages he alleged he suffered from the other claim. Damages allegedly resulting from the conspiracy must not overlap with or be subsumed by the damages allegedly resulting due to the race discrimination claim.

J.A.1965-66.

We disagree with defendants that these instructions misstate the relationship between damages recoverable for the race discrimination and civil conspiracy claims. See *Pye*, 633 S.E.2d at 511. The jury was instructed that damages for the civil conspiracy must be different from those for the race

discrimination claim and that it must not award damages on the civil conspiracy claim if it concluded that these damages were merely duplicative of those in the race discrimination claim. See *Peoples Fed. Sav. & Loan*, 596 S.E.2d at 60. This is correct. We therefore conclude that the district court did not abuse its discretion with respect to the special damages instruction.

V.

[3] Ward and Sheppard next contend that they are entitled to judgment as a matter of law based on Anthony's failure to prove a "combination" between defendants *320 and because the jury verdict was contrary to the weight of the evidence presented. As explained above in part IV.A, "[w]e must reverse if a reasonable jury could only rule in favor of [the movant]; if reasonable minds could differ, we must affirm." *Baynard v. Malone*, 268 F.3d at 235.

Under South Carolina law "[a] conspiracy is actionable only if overt acts pursuant to the common design proximately cause damage to the plaintiff." *A Fisherman's Best, Inc. v. Recreational Fishing Alliance*, 310 F.3d 183, 195 (4th Cir.2002) (citing *First Union Nat'l Bank of S.C. v. Soden*, 333 S.C. 554, 511 S.E.2d 372, 383 (S.C.Ct.App.1998)). However, "[c]ivil conspiracy is an act which is, by its very nature, covert and clandestine and usually not susceptible of proof by direct evidence." *First Union*, 511 S.E.2d at 383. Consequently, "[c]onspiracy may be inferred from the very nature of the acts done, the relationship of the parties, the interests of the alleged conspirators and other circumstances." *Island Car Wash, Inc. v. Norris*, 292 S.C. 595, 358 S.E.2d 150, 153 (S.C.Ct.App.1987) (noting also that "concert of action, amounting to a conspiracy, may be shown by circumstantial as well as direct evidence").

Defendants claim that Anthony introduced "no evidence of any combination or agreement between Appellants Ward and Sheppard." Appellants' Br. at 30. They claim that "[t]here was no testimony that [Defendants] had any discussions, meetings or other communications regarding the investigation into the discrepancies in [Anthony's] official reports, or played any role in making the decision as to the appropriate level of discipline to be recommended to Director Ozmint." *Id.* at 30-31.

In response, Anthony contends that "[t]he nature of the acts committed and the relationship of Ward and Sheppard itself

is evidence of conspiracy." Appellee's Br. at 33. According to Anthony, "[t]here were numerous times that Ward and Sheppard met in discussion of Anthony, and Ward and Sheppard acted together, in concert, in a course of action that was contrary to the normal policy and procedure at SCDC, but which furthered their own personal objective to harm Anthony." *Id.*

We agree with Anthony that the jury heard sufficient evidence at trial regarding motive, opportunity, and concerted action from which to conclude that defendants reached an agreement to harm Anthony and committed civil conspiracy. With regard to motive, as discussed above in part II, Anthony provoked the enmity of both defendants by failing to cooperate with their efforts to discredit other employees in the Department. Anthony believed these efforts were inappropriate and refused to be complicit. Regarding opportunity, despite attempting to downplay the connection between himself and Sheppard, Ward conceded at trial that he had a "professional friendship" with Sheppard and that the two men ate lunch together "a couple days a week." J.A. 1052. Ward also testified that he spoke with Sheppard about Laurie Bessinger's actions during the hostage situation at Lee. And Sheppard admitted forwarding to Ward an email he received from Inspector Hair about concerns over activities in the boiler room at Lee.

The jury also heard testimony regarding adverse actions taken by the defendants against other SCDC employees they disliked. Bessinger testified that the defendants acted in a concerted manner to force his own retirement by working together to discredit him. According to Bessinger, Sheppard initiated conversations with employees under Bessinger's direct supervision to try to elicit information which could *321 be used to undermine and discredit Bessinger. Ward admitted that he asked Ozmint to "relieve" Bessinger on the night of the hostage situation. J.A. 1067. And Associate Warden Pridgen testified that on the night of the hostage incident Ward complained to him about Bessinger being a problem: "Bessinger's trying to run everything. But if you tell anybody, I'm going to tell them you are lying." J.A. 476.

Harrison, for his part, testified that Sheppard deviated from Department custom by personally serving as both investigator and then lawyer in Harrison's grievance hearing, which resulted in Harrison's demotion from warden of Kershaw. Sheppard served these roles despite the existence of a separate Office of General Counsel which acts as counsel for SCDC.

In Anthony's case, Ward admitted deviating from standard SCDC policy in failing to inform Anthony about the shakedown of Lee in January 2004, and he participated directly in the shakedown. John Near, the Human Resources Director for SCDC, testified that he does not know of any other warden who has ever been terminated or refused rehire because of an inspection-related issue. Warden Harrison also testified that he had never known of a warden losing his job either because of contraband found in an institution (absent firsthand involvement by the warden), or for failure to make inspections. Ultimately, we must conclude that reasonable minds could differ regarding the existence of a common design by Ward and Sheppard to harm Anthony. *See Baynard*, 268 F.3d at 235. Sufficient evidence was presented in this case for the jury to find that defendants conspired to bring about the forced retirement of Anthony. The jury verdict must therefore stand.

VI.

Defendants further contend that the district court erred in failing to charge the jury on the employment-at-will doctrine. Again, as explained above in part II, we review jury instructions for abuse of discretion.

Under South Carolina law "[a]t-will employment is generally terminable by either party at any time, for any reason or for no reason at all." *Prescott v. Farmers Tel. Coop., Inc.*, 335 S.C. 330, 516 S.E.2d 923, 925 (1999). South Carolina recognizes only three exceptions to this general rule: (1) an employee has recourse against his employer for termination in violation of public policy; (2) an at-will employee may not be terminated for exercising constitutional rights; and (3) an employee has a cause of action against an employer who contractually alters the at-will relationship and terminates the employee in violation of the contract. *Nelson v. Charleston County Parks & Recreation Comm'n*, 362 S.C. 1, 605 S.E.2d 744, 746 (S.C.Cl.App.2004). The South Carolina Supreme Court has held that "an at-will employee may not maintain a civil conspiracy action against her employer." *Angus v. Burroughs & Chapin Co.*, 368 S.C. 167, 628 S.E.2d 261, 262 (2006) (citing *Ross v. Life Ins. Co. of Va.*, 273 S.C. 764, 259 S.E.2d 814, 815 (1979)).

Ward and Sheppard argue that Anthony was an at-will employee and that, to the extent that defendants were acting within the scope of their employment, they are protected by the employment-at-will doctrine. Anthony counters that

he was not terminated by SCDC but was instead refused rehire under South Carolina's TERI program. More important, Anthony points out that neither defendant actually had the power to terminate him; that power resided in Jon Ozmint, the Director of SCDC. Ward merely had the power to make a recommendation to Ozmint regarding what action SCDC should take; Sheppard *322 lacked even this power. Because we agree with Anthony that his civil conspiracy claim is not against his employer, the employment-at-will doctrine is inapplicable. The district court did not abuse its discretion in failing to instruct the jury on the doctrine.

VII.

Finally, defendants urge this court to consider the combined effect of the errors committed by the district court and claim that the cumulative effect of the errors occurring during trial mandates a remand for a new trial. *See Beck v. Haik*, 377 F.3d 624, 644–45 (6th Cir.2004). Although this court has yet to determine whether the cumulative error doctrine applies in the civil context, *cf. United States v. Martinez*, 277 F.3d 517, 532–34 (4th Cir.2002) (applying the cumulative error doctrine in the criminal context), we need not make this determination in order to resolve this case. Assuming without deciding that such a doctrine is appropriate in the civil context, *see Beck*, 377 F.3d at 644–45 (adopting cumulative

error doctrine in civil context), *overruled on other grounds by Adkins v. Wolever*, 554 F.3d 650 (6th Cir.2009) (en banc); *Frymire-Brinati v. KPMG Peat Marwick*, 2 F.3d 183, 188 (7th Cir.1993) (same); *Malek v. Fed. Ins. Co.*, 994 F.2d 49, 55 (2d Cir.1993) (same); *Hendler v. United States*, 952 F.2d 1364, 1383 (Fed.Cir.1991) (same); *Gordon Mailloux Enters., Inc. v. Firemen's Ins. Co. of Newark*, 366 F.2d 740, 742 (9th Cir.1966) (same), *but see SEC v. Infinity Group Co.*, 212 F.3d 180, 196 (3d Cir.2000) (noting rejection of cumulative error doctrine in civil context), reversal would nevertheless be inappropriate in this case. The only error that occurred in this case was that the jury was not specifically asked to find that defendants acted outside the scope of their employment when they injured Anthony. As explained above, because we conclude that his error was not prejudicial, the cumulative error doctrine does nothing to alter this conclusion.

* * *

For the foregoing reasons, the judgment is

AFFIRMED.

Parallel Citations

2009 WL 1931192 (C.A.4 (S.C.))

Footnotes

- 1 Defendants devote much of their briefing to arguing that the damages sought in the race discrimination and civil conspiracy claims were largely overlapping and therefore Anthony failed to adequately allege special damages. This argument was not raised before trial and is therefore untimely. On a motion for judgment as a matter of law, the relevant question is not whether Anthony adequately alleged special damages but whether he proved special damages at trial.
- 2 We also note that defendants' counsel never made any argument based on the distinction between general and special damages. South Carolina case law is clear that damages in a civil conspiracy action must not duplicate those alleged in other causes of action. South Carolina courts have been less clear about what additional specific limitations might exist with respect to damages that may be recovered on a civil conspiracy claim. *See Gynecology Clinic, Inc. v. Cloer*, 334 S.C. 555, 514 S.E.2d 592, 593 (1999) (citing *Charles v. Texas Co.*, 199 S.C. 156, 18 S.E.2d 719, 726–29 (1942) (discussing available damages in context of unlawful conspiracy)).

2007 WL 1032440

Only the Westlaw citation is currently available.

United States District Court,
D. South Carolina,
Columbia Division.

Calvin ANTHONY, Plaintiff,
v.

SOUTH CAROLINA DEPARTMENT OF
CORRECTIONS, Robert Ward, and Charles
Sheppard, in their individual capacities, Defendants.

Civil Action No. 3:05-CV-1636--
MBS. | March 30, 2007.

Opinion

ORDER & OPINION

MARGARET B. SEYMOUR, United States District Judge.

*1 On June 9, 2005, Plaintiff Calvin Anthony filed this action against his former employer, South Carolina Department of Corrections ("SCDC"), as well as Robert Ward and Charles Sheppard, Deputy Director and Inspector General of SCDC, respectively, in their individual capacities. Plaintiff alleges that Defendants unlawfully discriminated against him based on his race in violation of Title VII of the Civil Rights Act of 1964 ("Title VII"), 42 U.S.C. § 2000(e)-2(a), and that Ward and Sheppard also engaged in a civil conspiracy to cause Plaintiff harm. Amended Complaint, 1-6 (Entry 6). Defendants moved for summary judgment on April 28, 2006. Motion for Summary Judgment (Entry 19). After having been granted an extension of time to respond, Plaintiff filed a response in opposition to Defendants' motion for summary judgment on June 16, 2006. Plaintiff's Memorandum in Opposition (Entry 26). Defendants filed a reply memorandum on June 26, 2006. Reply to Plaintiff's Memorandum in Opposition (Entry 43).

In accordance with 28 U.S.C. § 636(b) and Local Rule 73.02, D.S.C., this matter was referred to United States Magistrate Judge Bristow Marchant for pretrial handling. On February 2, 2007, the Magistrate Judge filed a Report and Recommendation in which he recommended that Defendant's motion for summary judgment be granted in part and denied in part. Report and Recommendation, 22 (Entry 46). Plaintiff filed objections to the Report on February 21, 2007. Plaintiff's

Objections to Report and Recommendations (Entry 21). Defendant SCDC filed its objections on February 22, 2007. SCDC's Objections to Report and Recommendation (Entry 52). Plaintiff filed a response to Defendant's objections on December 21, 2006. Reply to Objections (Entry 28).

The Magistrate Judge makes only a recommendation to this court. The recommendation has no presumptive weight. The responsibility for making a final determination remains with this court. *Mathews v. Weber*, 423 U.S. 261, 270 (1976). The court is charged with making a *de novo* determination of any portions of the Report and Recommendation to which a specific objection is made. The court may accept, reject, or modify, in whole or in part, the recommendation made by the Magistrate Judge or may recommit the matter to the Magistrate Judge with instructions. 28 U.S.C. § 636(b)(1).

I. FACTS

The facts of this case are detailed at length in the Report and Recommendation of the Magistrate Judge. Report and Recommendation, 1-7. In short, Plaintiff, an African-American man, is a former Warden of Lee Correctional Institution ("LCI"), a facility in SCDC's prison system. Plaintiff worked for SCDC for twenty-four years and had routinely received excellent evaluations from his supervisors. Plaintiff's Deposition Day Two, 18-19. In 2002, Plaintiff came under the supervision of Robert Ward, Deputy Director of SCDC. *Id.* at 9-10. According to Plaintiff, Ward and Sheppard, both of whom are white, exhibited bias in favor of SCDC's white wardens.¹

*2 In July 2003, Plaintiff elected to participate in the Teacher and Employee ("TERI") Program, a state retirement incentive program that allows an employee to retire and receive retirement benefits and to later be reinstated to the same position and also receive a percentage of his or her salary. Plaintiff's Deposition Day One, 88-90. Ward initially encouraged Plaintiff to participate in the program. *Id.* at 89. On April 30, 2004, Plaintiff signed a TERI Program form indicating that he wished to retire effective June 30, 2004 and be rehired under the program. SCDC Retiree Temporary Employment Form, 1.

On January 29, 2004, Sheppard ordered a shakedown of LCI based on a report that Maintenance Supervisor James Goff² was inappropriately giving inmates access to the cafeteria pantry and allowing them to smoke marijuana while

working in the boiler room. Affidavit of Karen Hair, 2 (Entry 19-9). Although it is routine practice to give a warden advance notice that a shakedown is going to occur, Plaintiff was not notified.³ Plaintiff's Deposition Day One, 25-27. The shakedown was conducted by an investigator from the Office of Inspector General and agents from South Carolina Law Enforcement Division ("SLED"). SCDC Investigative Activity Report, 7 (Entry 19-9). The investigators found unsupervised inmates in the boiler room in possession of keys to secured areas, unauthorized computer equipment, and cafeteria food. Affidavit of Karen Hair, 2-3. No drugs or weapons were found in the boiler room.⁴

After the shakedown and subsequent investigation, Ward charged Plaintiff with gross negligence and falsification of official inspection reports on June 16, 2004. Affidavit of John Near, 3 (Entry 19-11). Ward alleged that Plaintiff misrepresented the extent of his own boiler room inspections. Ward Deposition, 180-81. Plaintiff avers that the first he learned of any investigation after the shakedown was when he received notice of Ward's charges against him. Plaintiff's employee review meeting to discuss the charges with Ward was held on June 22, 2004. Ward Deposition, 179. Plaintiff states that Ward informed him that SCDC would not rehire him under the TERI Program after his retirement and that, if Plaintiff did not retire, Ward would terminate his employment. Plaintiff's Deposition Day One, 126. Plaintiff gave notice of his retirement on June 23, 2004. Ward Deposition, 176.

Plaintiff filed a charge of discrimination with the South Carolina Human Affairs Commission ("SCHAC") on August 30, 2004. After receiving a right to sue letter, Plaintiff filed this action, alleging that Defendants discriminated against him on the basis of his race and retaliated against him for opposing SCDC's racially discriminatory policies. Amended Complaint, 3-5. Plaintiff also raised a state law civil conspiracy claim against Ward and Sheppard. *Id.* at 5-6. The Magistrate Judge recommended that the court grant summary judgment as to Plaintiff's claims for retaliation and civil conspiracy, finding that Plaintiff had failed to raise the retaliation charge in his SCHAC charge and had not sufficiently proven that Ward and Sheppard ever conspired against him.⁵ Report and Recommendation, 17-21. The Magistrate Judge also recommended that the court deny summary judgment with respect to Plaintiff's claim for racial discrimination, finding that Plaintiff had established a prima facie case of discrimination under Title VII. *Id.* at 1-17.

II. DISCUSSION

*3 Rule 56(c) of the Federal Rules of Civil Procedure provides that summary judgment shall be rendered when a moving party has shown "[that] the pleadings, depositions, answers to interrogatories, and admissions on file, together with the affidavits, if any, show that there is no genuine issue as to any material fact and that the moving party is entitled to judgment as a matter of law." Fed.R.Civ.P. 56(c). The court must determine whether the evidence presents a sufficient disagreement to require submission to a jury or whether it is so one-sided that one party must prevail as a matter of law. *Anderson v. Liberty Lobby, Inc.*, 477 U.S. 242, 251-52 (1986). Nonetheless, in deciding a motion for summary judgment, "the judge's function is not [herself] to weigh the evidence and determine the truth of the matter but to determine whether there is a genuine issue for trial." *Id.* at 249. Summary judgment should only be granted in those cases where it is perfectly clear that there remains no genuine dispute as to material fact and inquiry into the facts is unnecessary to clarify the application of the law. *McKinney v. Bd. of Trustees of Mayland Cmty. College*, 955 F.2d 924, 928 (4th Cir.1992).

A. Race Discrimination Claim

Plaintiff alleges race discrimination under Title VII. Title VII prohibits an employer from discharging an individual because of his race, gender, or national origin. 42 U.S.C. § 2000e-2(a). In order to prevail in a discrimination claim, a plaintiff must first establish a prima facie case of discrimination. *McDonnell Douglas Corp. v. Green*, 411 U.S. 792, 802 (1973); *Causey v. Balog*, 162 F.3d 795, 802 (4th Cir.1998). Once a plaintiff makes out a prima facie case of discrimination, an inference of impermissible discrimination is established, and the burden then shifts to the defendant to articulate some legitimate, nondiscriminatory reason for the plaintiff's termination. *McDonnell Douglas*, 411 U.S. at 802. If the defendant articulates such a reason, the plaintiff bears the ultimate burden of persuasion and must show, by a preponderance of the evidence, that the defendant's proffered reason for the dismissal is pretextual. *Id.* at 804.

1. Prima Facie Case

SCDC contends that the Magistrate Judge incorrectly found that Plaintiff established a prima facie case for discrimination. SCDC's Objections to Report and Recommendation, 2, 14-24. Specifically, Defendant states that the "Magistrate

Judge erred in finding and concluding that similarly situated employees outside the Plaintiff's class received more favorable treatment." *Id.* at 2. The court disagrees.

Generally, the prima facie case for a discrimination claim under Title VII requires a plaintiff to show that: (1) he is a member of a protected class; (2) he suffered adverse employment action; (3) he was performing his job duties at a level that met his employer's legitimate expectations at the time of the adverse employment action; and (4) the position remained open or was filled by similarly qualified applicants outside the protected class. *Hill v. Lockheed Martin Logistics Mgt., Inc.*, 354 F.3d 277, 285 (4th Cir.2004) (quoting *Reeves v. Sanderson Plumbing Prods., Inc.*, 530 U.S. 133, 143 (2000)). However, these elements may vary depending on what type of discrimination a plaintiff alleges. See *Emis v. Nat'l Ass'n of Bus. & Educ. Radio, Inc.*, 53 F.3d 55, 58 (4th Cir.1995) (stating that the precise elements of a prima facie case are flexible and depend on the factual situation and claim alleged).

*4 To establish a prima facie case of race discrimination in cases involving the enforcement of employee disciplinary measures, the four-prong prima facie model set forth in *Hill* is "less useful." *Moore v. Charlotte*, 754 F.2d 1100, 1105-06 (4th Cir.1985). In the disciplinary context, a plaintiff must demonstrate that: (1) he is a member of a protected class, (2) he "engaged in prohibited conduct similar to that of a person of another race, color, sex, religion, or national origin," and (3) "disciplinary measures enforced against the plaintiff were more severe than those enforced against the other person." *Id.* The "relevant comparison should not center around similarly situated employees, rather, the court should compare offenses which are comparable in seriousness to the plaintiff's misconduct." *Burwell v. Philip Morris*, 1994 U.S.App. LEXIS 35247, *7-8 (4th Cir. Dec. 15, 1994). Accordingly, "the focus is on similar offenses, not similar employees." *Id.* Such a "comparison will never involve precisely the same set of work-related offenses occurring over the same period of time and under the same set of circumstances." *Cook v. CSX Transp. Corp.*, 922 F.2d 507, 511 (4th Cir.1993); thus, exact sameness between a plaintiff and the other person is not necessary. See *Harrison v. Metro. Gov't of Nashville & Davidson County*, 80 F.3d 1107, 1115 (6th Cir.1996) ("[I]n comparing employment discipline decisions, 'precise equivalence in culpability between employees' is not required. Rather, the plaintiff must simply show that the employees were engaged in misconduct of 'comparable seriousness.'" (quoting *McDonald v. Santa*

Fe Trail Transp. Co., 427 U.S. 273, 283 n. 11 (1976) (internal quotations omitted)).

Plaintiff has provided sufficient evidence to establish a prima facie case of discrimination under *Moore*. It is undisputed that he is a member of a protected class. Viewing the evidence in a light most favorable to Plaintiff, a reasonable jury could find that Plaintiff committed violations similar to those of SCDC employees of another race, but was subject to harsher disciplinary action. Plaintiff has provided various examples of white wardens within SCDC who experienced problems at their institutions similar to those at LCI, but were not terminated from their employment as Plaintiff was. See, e.g., Plaintiff's Deposition Day One, 130 (George Hagan, white warden at Allendale Correctional Institution, was not disciplined after a 2004 shakedown of his facility revealed that inmates had access to computers and smuggled firearms, which were used to shoot two inmates); *Id.* at 122-23 (Rick Smith, white warden at Tyger River Correctional Institution, was not disciplined and was allowed to participate in the TERI Program after inmates were discovered using scrap materials to build a secret hideaway recreation space).

Just as the LCI shakedown revealed inmates with access to unauthorized areas and in possession of contraband, similar investigations at both the Allendale and Tyger River prisons revealed almost identical deficiencies; however, the wardens of those facilities were not punished in contrast to Plaintiff, who was forced to retire early and not allowed to participate in the TERI Program. The record also indicates that Ward made both decisions. Ward Deposition, 189-90 (stating that Ward did not include any report of the Allendale incident in Hagan's file, nor did he take any action against Smith). See *Smith v. Xerox Corp.*, 196 F.3d 358, 370-71 (2d Cir.1999) ("Because intent is the critical issue, only a comparison between persons evaluated by the same decisionmaker is probative of discrimination."). Plaintiff's alleged violation of SCDC policy was, at minimum, comparable in seriousness to the misconduct by white wardens, yet the disciplinary action enforced against him was more severe. For purposes of summary judgment, the Magistrate Judge properly found that the evidence is sufficient to create a question of fact as to whether Plaintiff's misconduct was comparably serious (and, in some cases, more serious, see Report and Recommendation, 12-14) to that of white wardens supervised by Ward who were treated more leniently. Accordingly, Defendant's objection is without merit.⁶

2. Non-Disciplinary Disparate Treatment Claims⁷

*5 SCDC asserts that the Magistrate Judge improperly concluded that SCDC conceded that Plaintiff could establish the first three prongs of the prima facie test as set forth in *Hill*. SCDC's Objections to the Report and Recommendation, 24-26. SCDC states that "[a]lthough [SCDC's] motion for summary judgment did rely upon the cited case of *Moore* ... [SCDC] did not concede the issues covered by the first three prongs of the typical prima facie case analysis." *Id.* Again, the court disagrees.

Plaintiff's complaint lists various incidents which Plaintiff avers constitute race discrimination. Amended Complaint, 3-4. Aside from Plaintiff's claims arising out of the 2004 shakedown and subsequent investigation, many of Plaintiff's claims addressed other ways in which Defendants discriminated against him during his employment with SCDC. *See id.* at 3 ("Ward became Plaintiff's supervisor and began to subject the plaintiff to disparate terms and conditions of employment"); *id.* ("Ward and Sheppard ... exhibited racial animus toward the plaintiff by deliberately bypassing him to talk and interact with lower level white personnel at the facility"). Plaintiff did not limit his complaint to incidents surrounding the shakedown; rather, he specifically stated that "the above actions constitute unlawful race discrimination." *Id.* at 4.

Defendants did not address Plaintiff's non-disciplinary disparate treatment claims in their motion for summary judgment; nor did Defendants set forth or analyze those claims under the elements as set forth in *Hill*. While SCDC states that it "clearly argued in the motion for summary judgment, the memorandum, and the reply that evidence did not support any argument that ... Plaintiff had met the burden setting forth a prima facie case," *id.*, Defendants' own pleadings belie this assertion. *See* Memorandum in Support for Motion for Summary Judgment, 21-24 (Entry 19-2) (discussing only the prima facie case as set forth in *Moore*); *id.* at 24-25 (explaining the pretext standard in the context of disciplinary actions); Reply to Plaintiff's Memorandum in Opposition, 2 ("focus[ing] on clarifying [unsupported or incorrect] allegations [made by Plaintiff in his memorandum in opposition]"); *id.* at 12 (concluding that "Plaintiff has not established a prima facie case of racial discrimination or retaliation because he has not rebutted [SCDC's] that a nondiscriminatory reason motivated Mr. Ward's decision to discipline Mr. Anthony and give him the option of retiring or being terminated."). These pleadings indicate that Defendants

failed to move for summary judgment on Plaintiff's non-disciplinary disparate treatment claims. As such, Defendant's objection is without merit.⁸

3. Pretext

SCDC objects to the Magistrate Judge's conclusion that Plaintiff established pretext as to SCDC's legitimate, non-discriminatory reasons for terminating Plaintiff's employment. SCDC's Objections to Report and Recommendation, 2. However, SCDC does not raise any specific objection to the Magistrate Judge's findings; rather, SCDC simply restates arguments made in its motion for summary judgment. *Compare, e.g., id.* at 8-14 (describing shakedown on January 29, 2004, the subsequent investigation, the corrective action taken against Plaintiff) with Memorandum in Support of Motion for Summary Judgment, 3-14, 15-17 (same). Even if the court construed these statements as objections to the Report, at most, they would constitute the type of general and conclusory objections that do not warrant the court's response. *See Orplano v. Johnson*, 687 F.2d 44, 47-48 (4th Cir.1982) (when a party makes only general and conclusory objections that do not direct the court to a specific error in the Magistrate Judge's proposed finding and recommendations, the court need not conduct a *de novo* review).

B. Civil Conspiracy

*6 Plaintiff objects to the Magistrate Judge's recommendation that the court grant summary judgment as to his civil conspiracy claim against Defendants Ward and Sheppard in their individual capacities. Plaintiff's Objections to the Report and Recommendations, 1. Plaintiff argues that the "record is replete with facts, as well as inferences to show that the individual defendants conspired to bring about [Plaintiff's] forced retirement." *Id.* The court finds that Plaintiff has alleged a civil conspiracy claim against Ward and Sheppard sufficient to survive summary judgment.

The tort of civil conspiracy contains three elements: (1) a combination of two or more persons, (2) for the purpose of injuring the plaintiff, (3) causing plaintiff special damage. *Kuznik v. Bees Ferry Assoc.*, 538 S.E.2d 15, 31 (S.C.Ct.App.2000). "A claim for civil conspiracy must allege additional acts in furtherance of a conspiracy rather than re-allege other claims." *Robinson v. Melts*, 86 F.Supp.2d 557, 563 (D.S.C.1997) (citing *Todd v. S.C. Farm Bureau Mut. Ins. Co.*, 278 S.E.2d 607 (S.C.1981)). Such a claim may exist "even though respondents committed no unlawful

act and no unlawful means were used." *LaMotte v. Punch Line of Columbia, Inc.*, 370 S.E.2d 711, 713 (S.C.1988). To be actionable, "overt acts pursuant to the common design proximately cause damage to the party bringing the action." *Future Group, II v. Nattonasbank*, 478 S.E.2d 45, 51 (S.C.1996).

A plaintiff may bring a civil conspiracy cause of action against the employees of a corporation in their individual capacities. *Lee v. Chesterfield Gen. Hosp., Inc.*, 344 S.E.2d 379, 383 (S.C.1986). It is clear from the face of the complaint that Plaintiff has specifically sued Ward and Sheppard "in their individual capacities" rather than in their official capacities. Amended Complaint, 1. In essence, Plaintiff alleges that Ward and Sheppard conspired against him to do a surprise shakedown and subsequent investigation, which Plaintiff was not aware of until he received notice of the charges that resulted from the investigation. Plaintiff has further alleged that Ward's and Sheppard's actions were motivated by Plaintiff's refusal to assist Ward and Sheppard in misrepresenting the conduct of another SCDC official, Laurie Bessinger, in a report concerning a riot that took place at LCI. Plaintiff's Deposition Day Two, 86.⁹

The record also indicates that Ward and Sheppard met on different occasions with regard to the shakedown, *see, e.g.* Ward Deposition, 90-93 (discussing conversations between Ward and Sheppard about the logistics of the shakedown operation); and Plaintiff's participation in the TERI Program, *see e.g.*, Bessinger Deposition, 17 ("Mr. Ward ... had given [Plaintiff] reason to believe that he was going to support him in the rehire program. Mr. Sheppard sabotaged ... that with Mr. Ward because then Mr. Ward changed his mind on that, and the only reason I could think of would be that Mr. Sheppard ... pretty much convinced Mr. Ward that he shouldn't be in favor of it."). *See LaMotte*, 370 S.E.2d 711, 713 n. 1 (considering that the defendants "held meetings and circulated correspondence allegedly containing misrepresentations" about plaintiffs in finding that defendants were not entitled to granting summary judgment to defendants). The unusual circumstances surrounding the shakedown and Ward's refusal to allow Plaintiff's participation in the TERI Program raise genuine issues of

material facts as to whether a civil conspiracy to injure Plaintiff existed between Ward and Sheppard.

*7 Plaintiff's disputed status as an at-will employee does not change this finding. Even assuming that Plaintiff's employment was terminable at the will of SCDC, Defendants' assertion that "an at-will employee is precluded from maintaining an action for civil conspiracy to terminate his employment" is unpersuasive. Memorandum in Support of Motion for Summary Judgment, 33. It is well-settled in South Carolina that at-will employees may not sustain actions for civil conspiracy against their employers. *See Angus v. Burroughs & Chapin Co.*, 628 S.E.2d 261, 262 (S.C.2006) ("[A]n at-will employee may not maintain a civil conspiracy action against her employer." (citing *Ross v. Life Ins. Co. of Va.*, 259 S.E.2d 814, 815 (S.C.1979))). In the instant case, however, Plaintiff has not raised a civil conspiracy claim against SCDC. Thus, his status as an at-will employee does not bar his claim for civil conspiracy against Ward and Sheppard. *See Lee*, 344 S.E.2d at 383 ("[A]gents of a corporation are legally capable, as individuals, of conspiracy among themselves or with third parties."). Accordingly, Defendants are not entitled to summary judgment as to Plaintiff's civil conspiracy claim.

III. CONCLUSION

The court has accepted all of Plaintiff's factual allegations as true. After thoroughly reviewing the Report and Recommendation in its entirety and the evidence in this case and after examining the applicable case law, the court denies Defendants' motion for summary judgment as to Plaintiff's civil conspiracy claim, and the court declines to adopt the Magistrate Judge's recommendation with respect to that claim. The court adopts the remainder of the Report and Recommendation of the Magistrate Judge and denies the motion for summary as to Plaintiff's race discrimination claim and grants the motion as to Plaintiff's retaliation claim.

IT IS SO ORDERED.

Footnotes

- 1 *See, e.g.*, Plaintiff's Deposition Day One, 44 (Plaintiff was not placed on any institution management committees or task forces); *id.* at 51-53 (Ward visited LCI less frequently than he visited institutions run by white wardens); *id.* at 56-57 (Sheppard unnecessarily

- criticized LCI and gave unwarranted praise to facilities with white wardens); Plaintiff's Memorandum in Opposition, 2 (Ward failed to annually evaluate Plaintiff during the two years Plaintiff served under Ward).
- 2 Goff is responsible for the boiler room, and he was supervised by Tom Morrow, Maintenance Director. Plaintiff's Memorandum in Opposition, 5. Morrow's Supervisor was Major John Brooks. *Id.* Brooks was supervised by Associate Warden Henry Pridgen, who reported to Plaintiff. *Id.*
- 3 Ward states that Plaintiff was not advised of the shakedown because Pridgen was suspected of wrongdoing and Pridgen's close relationship with Plaintiff might have caused "word [to] get back to the individual in the boiler room"; nevertheless, Ward is unable to recall any prior occasion in which Plaintiff gave Pridgen confidential information. Ward Deposition, 74-77.
- 4 During a search of the rest of the facility, investigators found weapons, drugs, and alcohol in the residential area. Ward Deposition, 70-73. According to Ward, finding such material in a prison is not an unusual occurrence. *Id.*
- 5 Plaintiff did not object to the Magistrate Judge's recommendation that summary judgment be granted as to his retaliation claim. In the absence of objections to the Report and Recommendation of the Magistrate Judge, this court is not required to give any explanation for adopting the recommendation. *Cumby v. Davis*, 718 F.2d 198, 199 (4th Cir.1983). The court has thoroughly reviewed the Report and concurs in the Magistrate Judge's finding that summary judgment should be granted with respect to the retaliation claim.
- 6 SCDC's assertion that "Plaintiff must point to the employer's own classification of disciplinary offenses in its assessments of comparable seriousness" is unfounded. SCDC's Objections to Report and Recommendation, 15-16. SCDC incorrectly relies on *Moore* in support of that proposition. In *Moore*, the Fourth Circuit stated that the "district court [which had conducted a bench trial] ignored the department's own classification of disciplinary offenses in its assessments of comparable seriousness." *Moore*, 754 F.2d at 1106. At no point in the opinion does the court require all plaintiffs to cite to a specific classification of a disciplinary offense, nor does the opinion indicate that the court should require any such proof at the summary judgment stage.
- 7 Insofar as SCDC objects to the Magistrate Judge's finding that Plaintiff had sufficiently proven that his forced retirement constituted an adverse employment action for Plaintiff's constructive discharge claim, the objection is moot. See Plaintiff's Memorandum in Opposition, 8 n. 4 (stating that "[n]o such claim [for constructive discharge] is made and any arguments relating thereto are misplaced").
- 8 Even if the court did consider SCDC's argument that Plaintiff has not established a prima facie case under *McDonnell Douglas*, SCDC's argument would fail. SCDC argues that, to establish pretext, a plaintiff must show that the employer's decision was motivated by retaliatory animus. *Id.* at 24-25 (citing *Reeves v. Sanderson Plumbing Prods., Inc.*, 197 F.3d 688 (5th Cir.1999), *overruled by* 530 U.S. 133 (2000)). Under current Title VII jurisprudence, a plaintiff is no longer required to show discriminatory animus to satisfy his burden of proving pretext. See *Reeves*, 530 U.S. at 147 (stating that a plaintiff may show pretext by either: (1) persuading the court that a discriminatory reason more likely motivated the employer, or (2) showing that the employer's proffered explanation is unworthy of credence since, "[i]n appropriate circumstances, the trier of fact can reasonably infer from the falsity of the explanation that the employer is dissembling to cover up a discriminatory purpose."). Accordingly, SCDC's assertion that the facts "relied on by the Magistrate Judge for an inference of racial bias or animus are not supported by the record" is without merit. SCDC Objections to the Report and Recommendation, 26.
- 9 According to Plaintiff, Ward requested that Plaintiff put false information about Bessinger's handling of the riot into a report and to make false allegations during a grievance proceeding against Bessinger. *Id.* at 86-87.

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Dr Randall

IN THE UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF SOUTH CAROLINA
FLORENCE DIVISION

FILED

MAR 1 2004

U.S. CLERK
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Jerome M. Guanciale, D.O.,

Plaintiff,

vs.

C.A. No. 4:02-3001-25

McLeod Regional Medical Center of
the Pee Dee, Inc., d/b/a Saint Eugene
Community Hospital,

Defendant.

ENTERED
MAR 8 2004

ORDER

The plaintiff, Jerome M. Guanciale, D.O., brought this action against the defendant, McLeod Regional Medical Center of the Pee Dee, Inc. (d/b/a Saint Eugene Community Hospital), alleging EM'ALA Whistleblower protections, defamation, civil conspiracy, interference with contractual rights, interference with prospective business advantage, breach of contract, misrepresentation, and violation of the Unfair Trade Practices Act. This matter is now before the Court upon the defendant's motion for summary judgment pursuant to Rule 56 of the Federal Rules of Civil Procedure. In its motion, the defendant argues that it is entitled to judgment as a matter of law because: 1) the defendant is entitled to immunity from damages under federal law pursuant to the Health Care Quality Improvement Act of 1986, 42 U.S.C. §§11101 - 11152 ("HCQIA"); 2) the plaintiff's common law claims fail to state a cause of action; and 3) the defendant is a private hospital and has the right to regulate conduct in its facility. The plaintiff has filed a memorandum opposing

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only the defendant's motion for summary judgment based on HCQIA immunity.¹

I. Background²

In 1995, Saint Eugene Community Hospital ("Saint Eugene") recruited Jerome M. Guanciale, D.O. ("Guanciale") to move to Dillon, South Carolina, and serve as a surgeon. Guanciale remained a member of the medical staff of Saint Eugene Hospital from 1995 until 2001. During his tenure, Guanciale filed a number of complaints with hospital administrators regarding what he believed to be problems with staffing and supplies at Saint Eugene. Ultimately, Guanciale submitted a report to the federal government alleging that the hospital violated the Emergency Medical Treatment and Active Labor Act ("EMTALA").

In August of 2000, Guanciale was involved in two incidents that resulted in his summary suspension on August 14, 2000. These two incidents are the subject of the suspension in the pending lawsuit. The first incident occurred on August 5, 2000, when a dispute arose between Guanciale and Dr. Wallace over emergency surgery for a patient. Guanciale chose not to treat the patient and Dr. Wallace arranged for the patient to be transported to another hospital. Shortly after the patient was transferred, Guanciale and Dr. Wallace met in the main hallway of the hospital near the lobby. The discussion between the doctors became heated over Guanciale's justification for refusing to treat the patient. Reportedly, the dispute created a disturbance in the hospital. The second incident that led

¹ The plaintiff is given twenty (20) days to respond to the defendant's two remaining arguments in support of its motion for summary judgment.

² The facts are viewed in the light most favorable to the plaintiff and are specifically relevant to the issue of immunity under HCQIA. The facts relating to the underlying claims or the allegations prior to Guanciale's August 14 suspension are not discussed in detail.

to the summary suspension occurred on August 9, 2000, when Guanciale was called to Saint Eugene's Emergency Department to treat a patient. After examining the patient, Guanciale decided not to perform surgery and the patient was transferred to another hospital.³

The administrator of Saint Eugene, Donald D. Sandoval ("Sandoval"), investigated the incidents of August 5 and August 9. As part of his review, he spoke to and collected written statements from the primary witnesses to the August 5 incident. The record does not clearly reflect that Sandoval interviewed Guanciale about the August 9 incident. Upon review, Sandoval determined that Guanciale's behavior was disruptive to Saint Eugene, not in the best interest of the patient care, and could adversely affect the health and welfare of patients in the hospital. On August 13, 2000, Sandoval met with Guanciale and informed him that he was summarily suspended as of 7:00 a.m. on Monday, August 14, 2000. Sandoval handed Guanciale a letter signed by Sandoval and J. Bruce Barragan, President and CEO of McLeod Health. The letter stated that "...all of your admitting and clinical privileges are summarily suspended. Furthermore, we have requested that the Medical Executive Committee⁴ of Saint Eugene Medical Center revoke your medical staff membership and admitting and clinical privileges." The letter also set forth the prior letter of reprimand, the reasons for the suspension, and Guanciale's right to appeal.⁵ It is clear that the action taken by Sandoval and Barragan was significant.

³ There may be factual discrepancies in regards to the August 5 and August 9 incidents. However, the factual discrepancies are not relevant to whether Saint Eugene properly complied with the statutory provisions that would entitled the hospital to immunity pursuant to HCQIA.

⁴ Hereafter referred to as the "MEC."

⁵ This letter was originally dated August 14, 2000, but was corrected in hand-writing to August 13, 2000.

The following morning, Guanciale returned to the hospital and had contact with some members of the MEC in the hospital cafeteria. One of the individuals present appears to have been Dr. Dwight A. Jacobus, Chief of Staff of Saint Eugene at the time. Guanciale states in his affidavit that Dr. Jacobus and Dr. Wallace, both MEC members, were present in the cafeteria. However, the affidavit submitted by Dr. Jacobus states that he did not recall any such discussions in the cafeteria on August 14. The record is unclear as to who was present in the hospital cafeteria and what was discussed. Importantly, Dr. Jacobus also served as the Chairman of the MEC which met to discuss the summary suspension of Guanciale by Sandoval.

On August 15, 2000, the MEC held a special meeting to discuss the summary suspension of Guanciale. The minutes of the MEC meeting indicate that Sandoval appeared before the committee and presented documentation pertaining to the alleged inappropriate behavior by Guanciale on August 5 and August 9. After hearing Sandoval's presentation, the MEC reinstated Guanciale's privileges but agreed to the summary suspension. Specifically, the minutes of the MEC meeting that were distributed over Dr. Jacobus' signature stated the following:

After much discussion, the Committee agreed that the 48-hour summary suspension was appropriate. This offense was reported to the South Carolina State Board of Medical Licensure. Further inappropriate behavior from Dr. Guanciale could result in termination of all privileges and medical staff membership. This was voted as the second warning to Dr. Guanciale on his inappropriate behavior by this Committee. The Committee decided to reinstate Dr. Guanciale's privileges as of 3:00 p.m. on August 15, 2000, but, also agreed with the summary suspension.

The MEC found, without hearing from Guanciale, that a 48-hour suspension which would

be reported to the South Carolina Board of Medical Licensure was appropriate. Regarding the issue of whether the MEC gave Guanciale an opportunity to provide information to the Committee, Dr. Jacobus stated in his submitted affidavit, "Dr. Guanciale was not offered an opportunity by the Medical Executive Committee or the hospital administrator to present any information to the Committee prior to or during the August 15th meeting." As to the manner in which the administration viewed Guanciale, Dr. Jacobus states in his affidavit:

Prior to August 15, 2000, I overheard on more than one occasion hospital administrators, including Ron Webb and Don Sandoval, instruct nurse supervisors and other personnel to document everything possible regarding Dr. Guanciale's conduct.

Without a question in my mind, the hospital administration was imposing a higher standard of conduct on Dr. Guanciale and documenting any activities by him, which did not meet the standard in an effort to force Dr. Guanciale to leave.

(Second Declaration of D.A. Jacobus, D.O.)

On August 15, 2000, a letter signed by Dr. Jacobus was presented to Guanciale outlining the decision by the MEC to uphold the summary suspension for 48-hours and to reinstate his privileges as of 3:00 p.m. that day.

On August 9, 2002, Guanciale filed an eight-count complaint against Saint Eugene alleging BMTALA Whistleblower protections, defamation, civil conspiracy, interference with contractual rights, interference with prospective business advantage, breach of contract, misrepresentation, and violation of the Unfair Trade Practices Act. Saint Eugene has now moved for summary judgment based primarily on the immunity afforded to hospitals pursuant to HCQIA.

II. Summary Judgment Standard

Summary judgment shall be granted when the "pleadings, depositions, answers to interrogatories, and admissions on file, together with the affidavits, if any, show that there is no genuine issue as to any material fact and that the moving party is entitled to a judgment as a matter of law." Fed.R.Civ.P. 56(c). The moving party bears the burden of showing that there is no genuine issue of material fact and that it is entitled to judgment as a matter of law. *Celotex Corp. v. Catrett*, 477 U.S. 317, 323 (1986). If the moving party carries its burden of showing that there is an absence of evidence to support a claim, then the non-moving party must demonstrate by affidavit, depositions, answers to interrogatories, and admissions on file that there is a genuine issue of material fact for trial. *Id.* at 324-25. An issue of fact is "genuine" when the evidence is such that a reasonable jury could return a verdict for the non-moving party. *Anderson v. Liberty Lobby, Inc.*, 477 U.S. 242, 248 (1986). An issue of fact is "material" only if establishment of the fact might affect the outcome of the lawsuit under the governing substantive law. *Id.* When determining whether there is an issue for trial, the court must view the inferences to be drawn from the underlying facts in the light most favorable to the non-moving party. *Perini Corp. v. Perini Constr., Inc.*, 915 F.2d 121, 123-24 (4th Cir.1990). The non-moving party may not rely on beliefs, conjecture, speculation, or conclusory allegations to defeat a motion for summary judgment. *Baber v. Hosp. Corp. Of Am.*, 977 F.2d 872, 874-75 (4th Cir. 1992).

HCQIA immunity is a question of law that is properly decided by the Court at summary judgment. *Bryan v. James E. Holmes Reg'l. Med. Ctr.*, 33 F.3d 1318, 1332-33 (11th Cir. 1994).

III. Analysis

A. Immunity Under HCQIA

Congress enacted HCQIA "to improve the quality of medical care by encouraging physicians to identify and discipline physicians who are incompetent or who engage in unprofessional behavior." *Matthews v. Lancaster General Hosp.*, 87 F.3d 624, 632 (3rd Cir. 1996) (quoting H.R. Rep. No. 903, 99th Cong., 2d Sess. 2 (1986)). An entity qualifying for HCQIA immunity "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. §11151(a)(1). Specifically, HCQIA provides a "professional review body"⁶ with immunity from damages whenever a "professional review action"⁷ is taken in accordance with the requirements of the statute.

In order for HCQIA immunity to apply, a professional review action must have been taken:

⁶ The term "professional review body" means a health care entity and the governing body or any committee of a health care entity which conducts professional review activity, and includes any committee of the medical staff of such an entity when assisting the governing body in a professional review activity. 42 U.S.C. § 11151(11).

⁷ The statute defines "professional review action" as an action or recommendation of a professional review body which is taken or made in the conduct of professional review activity, which is based on the competence or professional conduct of an individual physician (which conduct affects or could affect adversely the health or welfare of a patient or patients); and which affects (or may affect) adversely the clinical privileges, or membership in a professional society, of the physician. Such term includes a formal decision of a professional review body not to take an action or make a recommendation described in the previous sentence and also includes professional review activities relating to a professional review action. 42 U.S.C. § 11151(9).

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

improper
notice & hearing
facts into
reasons. belief
that action was
warranted based
on facts

42 U.S.C. §11112(a).

The statute further provides that "[a] professional review action shall be presumed to have met the preceding standards [§11112(a)(1-4)] necessary for the protection set out in §11111(a) of this title unless the presumption is rebutted by a preponderance of the evidence." *Id.* Under this unconventional standard, Guanciale bears the burden of proving by a preponderance of evidence that the defendant's peer review process did not satisfy §11112(a). Thus, Saint Eugene is entitled to summary judgment unless "a reasonable jury, viewing all facts in a light most favorable to [the plaintiff], could conclude that he had shown, by a preponderance of the evidence, that [the] action fell outside the scope of §11112(a)." *Gabaldoni v. Washington County Hosp. Assoc.*, 250 F.3d 255, 260 (4th Cir. 2001).

The undersigned finds, for the reasons set forth below, that Guanciale has satisfied his burden by showing that Saint Eugene failed to meet the third and fourth provisions of the "safe-harbor" statute outlined in §11112(a). Therefore, Saint Eugene is not entitled to immunity based on the "safe-harbor" provisions. Additionally, Saint Eugene argues that if it failed to meet the "safe-harbor" provisions, then it is still entitled to immunity based on the exceptions to the notice and hearing requirements outlined in 42 U.S.C. §11112(c)(1)

and (2). For the reasons stated below, this Court concludes that the exceptions do not apply. The undersigned will address each of the "safe-harbor" provisions, and the applicable exceptions, in turn.

(1) Action Taken in Furtherance of Quality Health Care

Guanciale first argues that Saint Eugene failed to meet the first "safe-harbor" provision because the action taken was not in furtherance of quality health care. The facts in the record do not persuasively support this claim. There is evidence in the record that physicians and other hospital staff documented complaints against Guanciale for "disruptive behavior." In addition, there is evidence in the record that Guanciale did not perform a surgical procedure on a patient in an emergency condition and that he did not answer a call that resulted in a patient being unnecessarily transferred to another hospital. The burden is on Guanciale to present sufficient evidence to rebut the presumption that the action taken in this case was in furtherance of quality health care. Guanciale has failed to rebut the presumption on the first provision.

(2) Reasonable Effort to Obtain the Facts of the Matter

Second, Guanciale argues that Saint Eugene failed to meet the second "safe-harbor" provision because it did not make a reasonable effort to obtain the facts of the matter. HCQIA does not require the ultimate decision maker to investigate a matter independently, but requires only a reasonable effort to obtain the relevant facts. *Gabaldoni*, 250 F.3d at 261. Saint Eugene's administration received several accounts of the incidents leading to the professional review action and discussed the events with several witnesses. Again, Guanciale has the burden and he has failed to present sufficient evidence to rebut the

presumption that Saint Eugene made a reasonable effort to obtain the facts of the matter.

(3) Adequate Notice and Hearing Procedures or Other Procedures Fair Under the Circumstances

Third, Guanciale argues that Saint Eugene failed to provide "adequate notice and hearing procedures" under §11112(a)(3). Paragraph (3) also provides for immunity if "such other procedures as are fair to the physician under the circumstances" are afforded to the physician against whom action is taken.

The Court must first determine if Saint Eugene provided Guanciale with "adequate notice and hearing procedures" in relation to his 48-hour suspension. A suspension of a physician's clinical and admitting privileges is a significant action. There are consequences that flow from a suspension. All suspensions of doctors, regardless of the term, must be reported to the South Carolina Board of Medical Examiners pursuant to the South Carolina Hospital Reporting Act.⁸ It is also vitally important that hospitals have the power to protect patients and to suspend physicians who are unable to appropriately care for and properly treat patients. Congress recognized the necessity of providing immunity to hospitals, administrators, and doctors who are involved in the disciplinary process when action is taken against an offending physician. However, Congress also recognized the importance of procedural safeguards by including a "due process" component requiring "adequate notice and hearing procedures" in the statutory framework. It is apparent from this language that Congress intended to ensure that physicians facing disciplinary action have an opportunity

⁸ Saint Eugene notified the South Carolina Board of Examiners of Guanciale's suspension on August 17, 2000.

to present a response to such action. If the hospital complies with the "due process" requirements of the statute, then the physician who is disciplined is barred from pursuing legal action against the hospital. The hospital, upon compliance with the statutory requirements, has the benefit of the shield of immunity, even if its disciplinary decision is inappropriate or improper. With compliance, there is no second-guessing or judicial review of the hospital's disciplinary decision.

Again, the statute requires that "adequate notice and hearing procedures are afforded to the physician" facing disciplinary action. Use of the terms "notice" and "hearing procedures" are significant. Congress chose these terms for good reason and the use of these terms indicate the hospital must meet at least a minimal "due process" requirement if the hospital gets the benefit of the shield of immunity. Inherent in basic due process is the right to be heard. "The right to be heard, which is so essential to due process in an adversary system of adjudication, [can] be vindicated only by affording a defendant an opportunity to testify before the fact-finder." *Sexton v. French*, 163 F.3d 874, 881 (4th Cir. 1998).

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In this case, the issue of notice to Guanciale does not appear to be in dispute. On August 13, Sandoval met with Guanciale to inform him that he would be suspended starting the next morning at 7:00 a.m. and provided notice that the MEG would meet on August 15 to consider the case. During the initial meeting, Sandoval gave Guanciale a letter that included the reasons for the suspension and his right to appeal. Thus, the record indicates that Guanciale received adequate notice under §11112(a)(3).

While notice was adequate in this case, Guanciale has presented sufficient evidence

to rebut the presumption that Saint Eugene provided adequate "hearing procedures" under the statute. Saint Eugene argues that it complied with the statute because the members of the MEC heard Guanciale's position in at least three ways: (1) Guanciale's interview with Sandoval; (2) Guanciale's contact with some doctors on the MEC in the hospital cafeteria on the morning of August 14; and (3) the official meeting of the MEC on August 15. The undersigned concludes that these are not adequate "hearing procedures" as required by the statute.

First, Saint Eugene argues that Sandoval's investigation of the incidents that resulted in Guanciale's suspension was an adequate "hearing procedure." Shortly after the incidents in question, Sandoval interviewed all relevant parties including Guanciale. As an administrator at the hospital, it was certainly appropriate for Sandoval to investigate reports of alleged misconduct that impacted on patient welfare. HCQIA does not require the ultimate decision-maker to investigate a matter independently, but requires only a reasonable effort to obtain the facts. See *Gabaldoni*, 250 F.3d at 261. However, the fundamental principle of HCQIA is for peer-review of physicians. In this case, the MEC was the peer-review body that had the power to accept, reject, reduce, or continue the summary suspension. After his investigation, Sandoval presented the evidence to the MEC that he relied on in imposing the summary suspension on Guanciale. The information gathered during the investigation does not equate with Guanciale's "due process" rights under the statute to present his version of the incident to the ultimate decision-maker. Again, the plain language of the statute requires an adequate "hearing procedure." Sandoval's investigation of the incident does not constitute a "hearing procedure" afforded to

Guanciale. Therefore, while Sandoval's investigation was warranted and proper, it does not equate with or amount to the "hearing procedures" contemplated by the statute.

Second, Saint Eugene argues that the contact in the cafeteria between Guanciale and some members of the MEC on the morning of August 14 was an adequate "hearing procedure" under HCQIA. What can best be described as an "informal meeting" occurred in the hospital cafeteria when Guanciale apparently had some contact with Dr. Wallace and Dr. Jacobus and asked to speak with them regarding his suspension. Guanciale submitted an affidavit of Dr. Jacobus, Chairman of the MEC. Dr. Jacobus states that he did not recall any discussions relating to Guanciale's suspension during the contact in the cafeteria on August 14. Importantly, Dr. Jacobus states in his affidavit that "Dr. Guanciale was not offered an opportunity by the Medical Executive Committee or the hospital administrator to present any information to the Committee prior to or during the August 15th meeting." Hence, clearly Guanciale was not given an opportunity to appear before the MEC considering his case. He was given no opportunity to present his version of the facts, offer his position on the suspension, or respond to the presentation of what happened delivered by Sandoval.

It is reasonable to conclude that Dr. Jacobus, the Chairman of the MEC, had reservations about a process that gave Guanciale no opportunity to appear or present information on his behalf. Again, in his affidavit, Dr. Jacobus states: "Without a question in my mind, the hospital administration was imposing a higher standard of conduct on Dr. Guanciale and documenting any activities by him, which did not meet the standard in an effort to force Dr. Guanciale to leave." Also, Dr. Jacobus notes that he heard Sandoval, who

presented the results of his investigation to the MEC, "instruct nurse supervisors and other personnel to document everything possible regarding Dr. Guanciale's conduct." This implies that Dr. Jacobus believed Sandoval possibly had a bias against Guanciale. This also is why a hearing procedure that does not give a suspended physician the opportunity to present his position in some manner is not "adequate." For the reasons set forth above, the undersigned concludes that the procedure followed in this case was not sufficient under the statute. Accordingly, the undersigned finds that the affidavit submitted by Dr. Jacobus, Chairman of the MEC, and the relevant facts noted are sufficient for Guanciale to rebut the presumption that the informal gathering in the hospital cafeteria equated to adequate "hearing procedures."

Third, Saint Eugene argues that the official MEC meeting held on August 15 was an adequate "hearing procedure" under the statute. Again, Guanciale was afforded notice that the MEC would meet to review his suspension. As noted, there is no indication that the plaintiff was given an opportunity to appear or present his position to the MEC on the summary suspension. Only Sandoval, the administrator who summarily suspended the plaintiff, appeared before the MEC to present the results of his investigation and to discuss Guanciale's suspension. Again, Dr. Jacobus indicates in his affidavit that Sandoval may have been biased against Guanciale. There is no transcript of the proceeding in the record to determine what consideration the MEC gave to Guanciale's position nor is there any indication that Guanciale was allowed to appear or even present a written statement setting forth his position regarding the suspension and to respond to Sandoval's presentation. Adequate "hearing procedures" requires that the physician be given some opportunity,

through a written statement, personal appearance, or counsel, to present a position prior to MEC action. Otherwise, the term "hearing procedures" has no real significance and could lead to a one-sided review or possible slanted presentation of evidence related to a summary suspension by a hospital administrator. In fact, Congress was very specific when it drafted into the statute what rights it believed a physician should be afforded under the "adequate notice and hearing procedures" section. Regarding a hearing procedure, the statute specifically states:

(C) in the hearing the physician involved has the right-

- (i) to representation by an attorney or other person of the physician's choice,
- (ii) to have a record made of the proceedings, copies of which may be obtained by the physician upon payment of any reasonable charges associated with the preparation thereof,
- (iii) to call, examine, and cross-examine witnesses,
- (iv) to present evidence determined to be relevant by the hearing officer, regardless of its admissibility in a court of law, and
- (v) to submit a written statement at the close of the hearing; and

(D) upon completion of the hearing, the physician involved has the right-

- (i) to receive the written recommendation of the arbitrator, officer, or panel, including a statement of the basis for the recommendations, and
- (ii) to receive a written decision of the health care entity, including a statement of the basis for the decision.

42 U.S.C. § 11112(b)(3)(C) & (D).

While the statute also states that a professional review body's failure to meet the conditions described in this subsection shall not, in itself, constitute failure to meet the standards of subsection (a)(3), it does clearly indicate what type of hearing procedure should be afforded to a physician facing disciplinary action.

This Court concludes that giving a physician facing suspension and termination of privileges the opportunity to appear personally before a professional review body would surely comply with the statutory requirements. A personal appearance would likely assure a hospital that it would gain the full benefit of the immunity shield. A written statement from the physician facing disciplinary action may even be sufficient to afford immunity. As well, the undersigned recognizes that a hospital is not expected to be the equivalent of the courthouse where adherence to due process is expected and required. However, in this case, there was no appearance by the plaintiff nor any indication that he was given the opportunity to submit a statement regarding his position before the MEC made the suspension decision. The record does not reflect what consideration the MEC gave to the plaintiff's position prior to upholding the suspension. On August 15, Dr. Jacobus wrote a letter to the plaintiff simply stating that it was the decision of the MEC to uphold the summary suspension of 48-hours. Further, the record does not reflect what evidence the MEC relied on in reaching its decision. A simple hearing afforded to Guanciale would suffice under the paragraph (3) of the "safe-harbor" provision. However, based on the record before it, this Court concludes that Guanciale presented sufficient evidence to rebut the presumption that Saint Eugene complied with the adequate "hearing procedures" section of the statute.

However, the inquiry does not end here. Paragraph (3) also provides for the grant of immunity if the hospital follows "such other procedures as are fair to the physician under the circumstances." Saint Eugene argues that, at the very least, the process afforded to Guanciale was fair under the circumstances. Again, in the affidavit submitted by Dr.

Jacobus, the MEC Chairman states, "[w]ithout a question in my mind, the hospital administration was imposing a higher standard of conduct on Dr. Guanciale and documenting any activities by him, which did not meet the standard in an effort to force Dr. Guanciale to leave." In light of this statement by Dr. Jacobus, the fact that Guanciale was not afforded an opportunity to present any information to the MEC, and the statutory language, the undersigned concludes that the procedure in this case was not fair under the circumstances.

(4) Reasonable Belief That Action Was Warranted By The Facts Known

The fourth "safe-harbor" provision requires that a professional review action must be taken "in the reasonable belief that the action was warranted by the facts known after such reasonable effort to obtain facts and after meeting the requirement of paragraph (3)." 42 U.S.C. §11112(a)(4). As stated above, the undersigned has concluded that Guanciale presented sufficient evidence to rebut the presumption that Saint Eugene complied with the "due process" requirement set forth in paragraph (3). Accordingly, Saint Eugene has failed to meet the requirements of §11112(a)(4) as well.

The hospital argues that the unpublished Fourth Circuit decision in *Wieters v. Roper Hospital*⁹ is controlling here. Initially, the undersigned notes that unpublished opinions are not binding in this circuit. See Rule 36(c) of the Federal Rules of Appellate Procedure. However, the undersigned concludes that *Wieters* is distinguishable for the following reasons. In the *Wieters* case, the District Court granted the hospital's motion for summary

⁹ *Wieters v. Roper Hosp., Inc.*, 58 Fed.Appx. 40 (4th Cir. 2003) (Unpublished).

judgment because it held that the physician failed to rebut the presumption that the hospital complied with §11112(a) of HCQIA. The facts of that case, however, are distinguishable to the case at bar. In *Wieters*, the physician was afforded an opportunity to personally appear, with a lawyer, before an Ad Hoc Committee and present his objections to the summary suspension. In this case, Saint Eugene never afforded Guanciale an opportunity to appear or be heard regarding his suspension. Unlike *Wieters*, there is insufficient evidence in the record that Guanciale was allowed the opportunity to set forth his objections to the MEC in person, in writing, or through a third party. This Court is unable to conclude that Congress intended for this statute to authorize action by a hospital without any input from the sanctioned physician. Such an interpretation would effectively write out the "due process" component of the statute. Therefore, *Wieters* is distinguishable from the current action on these grounds.

B. Exception to the Adequate Notice and Hearing Procedures

Saint Eugene also argues that if it failed to meet the "due process" requirement of §11112(a)(3), then it is still entitled to immunity based on the exceptions to notice and hearing procedures set forth in the statute. Specifically, Saint Eugene relies on §11112(c) which states:

For purposes of section 11111(a) of this title, nothing in this section shall be construed as--

(1) requiring the procedures referred to in subsection (a)(3) of this section--

(A) where there is no adverse professional review action taken, or

(B) in the case of a suspension or restriction of clinical privileges, for a period of not longer than 14 days, during which an investigation is being conducted to determine the need for a professional review action; or

(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)

Clearly, the exception cited in §11112(c)(1)(A) is not appropriate because the 48-hour suspension was an adverse professional review action. The exception cited in §11112(c)(1)(B) applies only if the suspension or restriction of clinical privileges does not exceed 14 days "during which" an investigation is "being conducted" to determine the "need for" a professional review action. There are two primary components to the (c)(1)(B) subsection: (1) a suspension must not exceed 14 days; and (2) the suspension is imposed while an investigation is being conducted to determine the need for a professional review action.

The facts in the record do not support application of this special exception to the notice and fair hearing procedures required by §11112(a)(3). Sandoval provided formal notice to the plaintiff of the suspension in a letter dated August 13, 2000. That letter states, "all of your admitting and clinical procedures are summarily suspended effective immediately. Furthermore, we have requested that the MEC revoke your staff medical staff membership and admitting and clinical privileges." Read literally, this correspondence does not limit the suspension or investigation to 14 days or less. The letter indicates the hospital administration was seeking, in addition to summary suspension of privileges, a revocation of staff membership and admitting and clinical privileges. The MEC limited the suspension to 48-hours after its August 15 meeting. The action by the MEC, therefore, limited the

suspension to 2 days, meeting the requirement of less than 14 days for the exception to apply.

However, for the exception to apply, if the suspension is less than 14 days, the hospital is required to show that during the suspension period an investigation was "being conducted" to determine the "need for" a professional review action. There are no facts in the record that support a conclusion that an investigation was being conducted to determine the need for a professional review action. The letter from Sandoval dated August 13 to Guanciale references no investigation being conducted to determine the need for professional review action. The correspondence is clear – the plaintiff was "summarily suspended effective immediately" and "we have requested that the MEC . . . revoke your medical staff membership and admitting and clinical privileges." This language does not support the position that an investigation was being conducted "to determine the need for a professional review action." It is clear that the decision had already been made to seek professional review action at the time of the suspension. There is no factual support for the position that an investigation was being conducted to decide whether or not there was a need for a professional review action.

Saint Eugene also argues that the "emergency provision" of HCQIA outlined in §11112(c)(2) relieved the hospital from the notice and fair hearing requirements of §11112(a)(3). The "emergency provision" specifically permits summary suspensions "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). Courts have held that HCQIA's emergency provision "does not

require imminent danger to exist before a summary restraint is imposed. It only requires that the danger may result if the restraint is not imposed." *Fobbs v. Holy Cross Health Sys. Corp.*, 29 F.3d 1439, 1443 (9th Cir. 1994). There are facts in the record to support a conclusion by Sandoval that continued behavior by Guanciale could result in danger to a patient. However, like paragraph (3) of the "safe-harbor" provisions, the "emergency provision" requires minimal "due process." Specifically, the statute provides that after suspension of a physician pursuant to subsection (2), the hospital must provide "subsequent notice and hearing or other adequate procedures." As discussed above, Dr. Jacobus' affidavit states that Guanciale was not offered an opportunity to appear or present any information to the MLC with respect to his suspension. It was acceptable for Sandoval, as he did, to summarily suspend Guanciale if there was, or could be, any danger to an individual. However, once the suspension is imposed, the statute requires a "hearing or other adequate procedures" that meet a minimal "due process" standard. The undersigned concludes that, as Dr. Jacobus' affidavit and the relevant facts show, Guanciale did not receive minimal "due process" as required by the language of the "emergency provision" of HCQIA.

IV. Conclusion

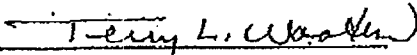
For the reasons stated above, the undersigned concludes that Saint Eugene is not entitled to immunity under HCQIA.

Therefore, it is **ORDERED** that the defendant's motion for summary judgment based on HCQIA immunity (Doc. #20-1) be **DENIED**.

It is further **ORDERED** that the defendant's motion for attorneys fees (Doc. #20-2) be **DENIED**.

The plaintiff has twenty (20) days to respond to the defendant's two remaining arguments in support of its motion for summary judgment.

IT IS SO ORDERED.


TERRY L. WOOTEN
UNITED STATES DISTRICT JUDGE

March 8, 2004
Florence, South Carolina

STATE OF SOUTH CAROLINA)
)
COUNTY OF YORK) IN THE COURT OF COMMON PLEAS
) SIXTEENTH JUDICIAL CIRCUIT

Robert Randall, M.D.,)
)
) Civil Action No. 2012-CP-46-167
)
) Plaintiff,)
)
) v.)
) **DEFENDANTS' REPLY TO**
) **MEMORANDUM IN**
) **OPPOSITION TO MOTION FOR**
Amisub of South Carolina, Inc. d/b/a)
Piedmont Medical Center, Nathaniel)
Edwards, M.D., and Richard Patterson,)
M.D.,)
)
) Defendants.)

Defendants submit this reply to the memorandum in opposition to summary judgment filed by Dr. Randall.

ARGUMENT

I. DEFENDANTS SHOULD RECEIVE DAMAGES IMMUNITY

Under the Health Care Quality Improvement Act ("HCQIA"), Defendants are entitled to damages immunity if Dr. Randall's peer review action 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. §§ 11111(a) & 11112(a).

Dr. Randall's peer review action is *presumed under the law* to comply with each of the four HCQIA standards. 42 U.S.C. § 11112(a). This statutory presumption results in Defendants' summary judgment motion prevailing *unless* Dr. Randall establishes non-compliance with the HCQIA standards by a preponderance of the evidence. *Moore v. Williamsburg Reg. Hosp.*, 560 F.3d 166, 180 (4th Cir. 2009); *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); *Gnanciale 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).")(attached to Randall Mem.).

Defendants do not rely upon HCQIA's statutory presumption alone to establish that Dr. Randall's peer review action complies with the HCQIA standards. With their memorandum, Defendants submitted evidence in the form of meeting minutes, notices, hearing testimony, hearing panel findings, reports from the appellate review process, and deposition testimony showing compliance with all four of the HCQIA standards.

Dr. Randall has now submitted his memorandum in opposition to summary judgment, and it does not contest Defendants' compliance with standards one, two, or four of HCQIA. Dr. Randall's memorandum does offer several arguments ostensibly

aimed at standard three of HCQIA. Randall Mem. at 10.¹ For the reasons set forth below, Dr. Randall's arguments regarding this standard should be rejected.

A. Dr. Randall has not established non-compliance with HCQIA standard three

Standard three differs from the other HCQIA standards in that it provides a list of specific procedures. If these procedures are provided to the physician, 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.").

HCQIA standard three provides in relevant part:

A health care entity is *deemed to have met the adequate notice and hearing requirement of subsection (a)(3)* of this section with respect to a physician if the following conditions are met (or are waived voluntarily by the physician):

¹ Although Dr. Randall's memo notes in passing that there is a "question of fact" as to whether Defendants can meet "the third and fourth provisions of the [HCQIA] statute," the memorandum contains no argument or legal authority with respect to the fourth prong. Randall Mem. at 10-13. Furthermore, whether a "question of fact" exists regarding compliance with the HCQIA standards is not the appropriate inquiry. Summary judgment for the peer reviewers is appropriate unless a reasonable jury, viewing the facts in the best light for the physician, could conclude that the physician has shown by a preponderance of evidence that the peer review action failed to satisfy the HCQIA standards. Defs. Mem. at 15. Simply put, the existence of a mere "question of fact" regarding compliance with the HCQIA standards cannot defeat a motion for summary judgment seeking damages immunity. *Id.*

(1) Notice of proposed action

The physician has been given notice stating—

- (A) (i) that a professional review action has been proposed to be taken against the physician,
- (ii) reasons for the proposed action,
- (B) (i) that the physician has the right to request a hearing on the proposed action,
- (ii) any time limit (of not less than 30 days) within which to request such a hearing, and
- (C) a summary of the rights in the hearing under paragraph (3).

(2) Notice of hearing

If a hearing is requested on a timely basis under paragraph (1)(B), the physician involved must be given notice stating—

- (A) the place, time, and date of the hearing, which date shall not be less than 30 days after the date of the notice, and
- (B) a list of the witnesses (if any) expected to testify at the hearing on behalf of the professional review body.

(3) Conduct of hearing and notice

If a hearing is requested on a timely basis under paragraph (1)(B)—

- (A) subject to subparagraph (B), the hearing shall be held (as determined by the health care entity)—
 - (i) before an arbitrator mutually acceptable to the physician and the health care entity,
 - (ii) before a hearing officer who is appointed by the entity and who is not in direct economic competition with the physician involved, or
 - (iii) before a panel of individuals who are appointed by the entity and are not in direct economic competition with the physician involved;
- (B) the right to the hearing may be forfeited if the physician fails, without good cause, to appear;
- (C) in the hearing the physician involved has the right—
 - (i) to representation by an attorney or other person of the physician's choice,

- (ii) to have a record made of the proceedings, copies of which may be obtained by the physician upon payment of any reasonable charges associated with the preparation thereof,
- (iii) to call, examine, and cross-examine witnesses,
- (iv) to present evidence determined to be relevant by the hearing officer, regardless of its admissibility in a court of law, and
- (v) to submit a written statement at the close of the hearing; and

(D) upon completion of the hearing, the physician involved has the right—

- (i) to receive the written recommendation of the arbitrator, officer, or panel, including a statement of the basis for the recommendations, and
- (ii) to receive a written decision of the health care entity, including a statement of the basis for the decision.

42 U.S.C. § 11112(b)(emphasis added). 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 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”).

1. Standard three does not provide for a pre-suspension hearing

Dr. Randall claims that his peer review action violates HCQIA standard three because he was not provided notice and a hearing *prior to* the suspension of his surgical privileges. Randall Mem. at 10-11. 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 absence of a pre-suspension hearing in Dr. Randall’s peer review action cannot establish non-compliance with standard three.

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 as she languished in critical care, Defs. Mem. at 7-8. This case, coming on the heels of the other bad cases that had been reviewed, caused the Chief of Staff, and thereafter the MEC, to reasonably believe that a suspension was necessary to protect Piedmont's patients from potential imminent harm. *Id.* at 8-9. After the suspension was imposed, Dr. Randall received the "subsequent notice and hearing" provided for by section 11112. *Id.*

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 Dr. Randall's claim of non-compliance with standard three should be rejected.

Dr. Randall contends that the Federal District Court's order in *Guanciale v. McLeod Regional Medical Center* supports his claim that a pre-suspension hearing was required in his peer review action. Randall Mem. at 10-13. 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. *Defs. Mem.* at 9-11. Before that, Dr. Randall was permitted to submit written statements and to make two personal appearances before the MEC. *Defs. Mem.* at 8. The utter 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.

2. Standard three does not apply to MEC meetings

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, and Dr. Patterson allegedly made misstatements at the MEC meeting regarding the bylaws and Dr. Randall's patient care. *Randall Mem.* at 11-12. 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 conduct² at MEC meetings do not implicate any of the procedures in section 11112(b)'s safe harbor, these allegations cannot establish a lack of compliance with HCQIA standard three.

3. Standard three does not provide for peer review hearings within 90 days

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. Randall Mem. at 7-8. Simply put, 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). Therefore, that Dr. Randall's peer review hearing was not convened 90 days after the MEC decision to continue his suspension cannot establish non-compliance with HCQIA standard three.³

4. Standard three does not require that the hearing panel members practice in the reviewed physician's specialty area

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. Randall Mem. at 6-7. 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. §

² Though it is entirely irrelevant to the standard three analysis, Dr. Randall's allegations that Dr. Patterson misrepresented procedural options and facts about Dr. Randall's patient care at an MEC meeting is unsupported by the evidence in this case. Baker Dep. at 65, L.20 - 67, L.4 (Ex. A).

³ Dr. Randall makes this 90-day claim because he disagreed with the Hearing Panel's decision to postpone his hearing when the MEC's expert unexpectedly declined to attend the hearing on the previously scheduled date. Defs. Mem. at 10, n.6.

11112(b). Dr. Randall's hearing panel did not include a general surgeon with laparoscopic experience, but because this claim, like Dr. Randall's other claims, does not implicate a safe harbor procedure, it too fails.

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;

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

5. Conclusion

Defendants submitted overwhelming evidence showing that Dr. Randall's peer review action provided all the safe harbor 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, the presumption that Dr. Randall's peer review action complies with HCQIA standard three should become a finding of compliance.

B. Dr. Randall makes no arguments and cites no authority to establish non-compliance with HCQIA standard four

HCQIA standard four is satisfied unless Dr. Randall establishes, by a preponderance of the evidence, "that the facts relied upon by the Board were so obviously mistaken or inadequate as to make reliance upon them unreasonable." *Hein-*

Muniz v. Aiken Reg. Med. Ctrs, 2013 WL 3359277 **3 (4th Cir. 2013)(quoting *Meyers v. Columbia/HCA Healthcare Corp.*, 341 F.3d 461, 471 (6th Cir. 2003)).

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, the transcript from the peer review hearing, and the written submissions from counsel for Dr. Randall and the MEC. Defs. Mem. at 11. These materials were replete with facts and expert opinions regarding Dr. Randall's patient care.

Dr. Randall's memorandum cites no authority and makes no arguments to establish that the materials relied upon by the Board were inadequate or obviously mistaken. Because Defendants have offered both argument and evidence regarding standard four, and Dr. Randall did neither, the Court should find that Dr. Randall's peer review action complies with HCQIA standard four.

II. DR. RANDALL'S ARGUMENTS REGARDING HIS INDIVIDUAL CAUSES OF ACTION ARE WITHOUT MERIT

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

As demonstrated above, Dr. Randall's arguments that his peer review action did not comply with HCQIA fail as a matter of law. Defendants are, therefore, entitled to HCQIA damages immunity.

Dr. Randall seeks damages pursuant to his conspiracy and defamation causes of action. As HCQIA damages immunity has eliminated Dr. Randall's ability to recover

damages pursuant to his causes of action, these claims are no longer viable, and summary judgment on them is proper.

B. Dr. Randall's conspiracy claim still fails

In response to Defendants' assertion that the intra-corporate immunity doctrine defeats Dr. Randall's conspiracy claim, Dr. Randall contends 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. Randall Mem. at 14. Dr. Randall is mistaken.

In *Anthony*, the Fourth Circuit Court of Appeals actually 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).

Dr. Randall also contends that Defendants' assertion of the intra-corporate immunity doctrine fails because of the personal stake exception. Randall Mem. at 14. The personal stake exception is a narrow and limited exception to the doctrine of intra-corporate immunity that only applies "where a co-conspirator possesses a personal stake *independent of his relationship to the corporation.*" *ePlus Tech., Inc. v. Aboud*, 313 F.3d 166, 179 (4th Cir. 2002)(emphasis added). The personal stake exception has further been limited to situations where the offending party stood to gain financially or economically from participation in the conspiracy. See, e.g., *ePlus Tech., Inc.*, 313

F.3d at 179-80 ("personal stake exception" applied where defendant stood to "personally profit" financially from conspiracy); *Holter v. Moore and Co.*, 702 F.2d 854, 857 n. 8 (10th Cir. 1983)(finding that "independent personal stake" exception applies only "when the officer has an outside economic interest such as ownership of a competing corporation, through which he will benefit from the restraint").

Dr. Randall has not identified any independent economic benefit that Dr. Patterson, a non-practicing surgeon, or Dr. Edwards, a cardiologist, stood to gain by participating in an alleged conspiracy to revoke Dr. Randall's abdominal surgery privileges. There was no overlap between these physicians' areas of practice and no allegation that they were in direct competition with each other in any way. Therefore, this narrow exception does not apply here because Dr. Patterson and Dr. Edwards had no personal stake in the decision to revoke Dr. Randall's privileges. *Oksanen v. Page Mem'l Hosp.*, 945 F.2d 696, 704-05 (4th Cir. 1991).

At most, Dr. Randall has alleged personal animosity or a personal bias on the part of Dr. Edwards against Dr. Randall. This type of subjective independent motive has not been held to qualify for the narrowly construed "personal stake exception." *Hartman v. Bd. of Trustees of Community Coll. Dist. No. 508*, 4 F.3d 465, 470 (7th Cir. 1993)(where the court concluded that the intra-corporate conspiracy doctrine "is not avoided simply by showing that corporate employees were motivated in part by personal bias" because such an interpretation would render the doctrine meaningless).

Finally, in *Oksanen*, the Fourth Circuit made clear that any independent interest is irrelevant to the antitrust analysis when the individual could not single-handedly cause the restraint to be imposed and the corporation would have taken the same action

anyway. 945 F.2d at 705 ("To give advice when asked by the decisionmaker is not equivalent to being the decisionmaker itself.")(internal quotations and citations omitted). Because neither Dr. Edwards nor Dr. Patterson could unilaterally revoke Dr. Randall's privileges, and because their actions were taken within the scope of the peer review process, Dr. Randall's invocation of the personal stake exception fails as a matter of law. *Wuchenich v. Shenandoah Mem'l Hosp.*, 215 F.3d 1324, *12 (4th Cir. 2000)(holding the personal stake exception did not apply in part because revocation of the plaintiff physician's medical staff privileges was subject to review by the hospital, and because decision making authority in the plaintiff physician's case was dispersed among a number of individuals).

C. Dr. Randall's defamation claims still fails

Dr. Randall contends that a mere insinuation of a false statement is actionable as defamation. Randall Mem. at 16. However, Dr. Randall fails to identify any false statement actually insinuated by the defendants.

Dr. Randall cites *Wuchenich v. Shenandoah Mem'l Hosp.*, 215 F.3d 1324 (4th Cir. 2000), a case which is factually distinguishable and thus inapplicable. In *Wuchenich*, a physician's medical staff privileges were initially suspended and later reinstated. *Id.* at *5. The hospital failed to notify the National Practitioner's Data Bank ("NPDB") of the voided suspension in a timely manner and the NPDB did not remove all mention of the suspension until approximately one year later. *Id.* Therefore, applying Virginia substantive law, the Fourth Circuit remanded the physician's defamation claim only with respect to the ongoing publication in the NPDB of the suspension after the hospital had reinstated the physician's privileges. *Id.* at *16. The

district court's dismissal of the physician's remaining defamation allegations was affirmed. *Id.*

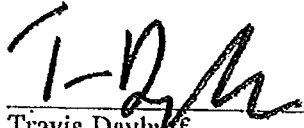
At the time of the publication in *Wuchenich*, the hospital's report to the NPDB was partially false, because although the report had been true at one time, the report was no longer true. There is no similar allegation regarding the falsity of the report in the present case. Dr. Randall's privileges were, in fact, suspended. Dr. Randall's privileges have not been subsequently reinstated. Indeed, Dr. Randall testified during his deposition that the report Piedmont made to the NPDB is factually accurate. Randall Dep. at 181, L.9 - 183, L.13 (Ex. B). Because substantial truth is an absolute defense to defamation, Dr. Randall's defamation claim fails as a matter of law. *Parker v. Evening Post Pub. Co.*, 317 S.C. 236, 245, 452 S.E.2d 640, 645-46 (Ct. App. 1994).

CONCLUSION

For the reasons set forth above and in Defendants' memorandum in support of the motion for summary judgment, Defendants respectfully request summary judgment in their favor on HCQIA immunity and summary judgment in their favor as to all of Dr. Randall's causes of action.

Respectfully submitted,

NELSON MULLINS RILEY &
SCARBOROUGH LLP

By: 

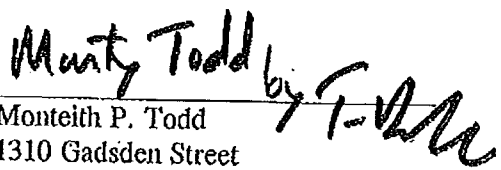
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November 21, 2013

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Attorney for Nathaniel Edwards, M.D.

Columbia, South Carolina

November 21, 2013

EXHIBIT A

State of South Carolina	)	
	)	
County of York	)	
	)	
Robert Randall, M.D.,	)	2012-CP-46-167
	)	
Plaintiff,	)	
	)	
vs.	)	Deposition
	)	
Amisub of South	)	of
Carolina, Inc. d/b/a/	)	
Piedmont Medical Center,	)	Robert Wayne Baker,
Nathaniel Edwards, M.D.,	)	MD
and Richard Patterson,	)	
M.D.,	)	
	)	
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

1 that.

2 MR. GRIFFIN: Let me take a quick break. I'm
3 about through.

4 (Off the record from 3:31 p.m. until
5 3:32 p.m.)

6 MR. GRIFFIN: Dr. Baker, I do not have any
7 further questions for you.

8 THE DEPONENT: All right, sir.

9 MR. GRIFFIN: This gentleman --

10 EXAMINATION

11 BY MR. DAYHUFF:

12 Q Dr. Baker, we've met before.

13 A Yes, sir.

14 Q My name is Travis Dayhuff. For the record, I
15 represent the defendants that have been sued in
16 this action. That includes Piedmont Medical
17 Center, Dr. Edwards, and Dr. Patterson --

18 A Yes, sir.

19 Q -- as I recall.

20 I'm going to start with where we left off,
21 which is discussion of the summary suspension of
22 Dr. Randall's privileges.

23 A Yes, sir.

24 Q The -- take a look at Exhibit 9 in your pack there,
25 which is, I believe, a letter to Dr. Randall about

1 his summary suspension. I can find it, if you'd
2 like. There's --

3 A This is it.

4 Q --- Number 9.

5 A Yes, sir.

6 Q And this is to Dr. Randall; it's dated October
7 15th, 2010; is that right?

8 A Yes, sir.

9 Q If you'd look down at the penultimate paragraph,
10 "The medical executive committee will take action
11 on this summary restriction within 14 days in
12 accordance with the bylaws. The MEC may modify,
13 continue for a definite or indefinite period, or
14 terminate the summary restriction." Does that
15 sentence reflect your understanding of the options
16 the MEC had available to it when you got together
17 to consider Dr. Randall's summary suspension?

18 A Yes. I mean, I -- I -- we would have the option --
19 yes.

20 Q Okay. I ask because Ms. --

21 A That wasn't in her notes.

22 Q -- West's notes seem to say you could uphold it,
23 continue it, or modify it.

24 A Right. Obviously, to -- to overturn it was an
25 option.

1 Q Okay. Good. So that's -- you understood that that
2 was an option available --

3 A Yes, sir.

4 Q -- to you?

5 Okay. Good. At that meeting, why -- you
6 voted in favor of upholding the summary
7 restriction?

8 A Yes, sir.

9 Q Why did you do that?

10 A I think at point there was enough concern expressed
11 about safety of patients.

12 Q Okay. And were you comfortable that those of your
13 colleagues that were participating in this
14 deliberation and decision-making -- that they were
15 motivated by the same concern that you had?

16 A That would be my assumption, yes, sir.

17 Q Okay. All right. Did you observe anything that
18 caused you to have a concern that your colleagues
19 were motivated by some desire to retaliate against
20 Dr. Randall?

21 A No, sir.

22 Q All right. Did you observe anything that would
23 cause you to believe that they were motivated by
24 some sort of bias against Dr. Randall?

25 A No, sir.

EXHIBIT B

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

COMPUSCRIPTS, INC.
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Post Office Box 7172
Columbia, South Carolina 29202
803-988-0086
1-888-988-0086
compuscripts.com

1 A. Yeah.

2 Q. Fair enough. But you're right, the timing
3 makes some sense.

4 What were the other one, oh, Clark, that
5 deposition was --

6 A. No, that's not -- that's not the --

7 Q. That deposition was last month?

8 A. Right. Right.

9 Q. Okay. All right. Do you know what the NDB
10 report on you says? Have you seen it?

11 A. I've seen it. I don't recall what it states
12 there.

13 Q. Okay. I've got part of it, I think. I don't
14 know that I have the whole thing. I'll show it to you.

15 A. Okay.

16 (DEFT. EXH. 5, Adverse Action Report,
17 PRIV-PREPROD00000184 and 185, was marked for
18 identification.)

19 BY MR. DAYHUFF:

20 Q. All right. I want to take that look at the
21 text of it. It's on the second page of, what is this,
22 5?

23 A. Yeah.

24 Q. It says -- I'm sorry, it begins on the prior
25 page. "The abdominal surgery privileges of Robert

1 Randall, Jr., M.D., were summarily suspended by
2 Piedmont Medical Center on October 15, 2010, on the
3 grounds that surgical judgment and techniques exhibited
4 by Dr. Randall fell below the standard of care of the
5 medical staff and to ensure there would be no imminent
6 danger to patients who might receive such services."

7 Now, certainly that's accurate. The MEC did
8 summarily suspend you on that date, right?

9 A. I don't argue, I mean, the facts as presented
10 here. It's the whole process.

11 Q. I got you. I got you. Well, so that's true,
12 that's what they did and the reasons they said they did
13 it?

14 A. Correct.

15 Q. You just disagree that they are right?

16 A. Yeah. With that there, it ended any
17 possibility of me functioning as a surgeon anywhere,
18 anytime.

19 Q. Then it describes the privileges that were
20 suspended, and that goes all the way down to almost the
21 very end to adrenal. Do you see that?

22 A. Yeah.

23 Q. So that's true, those are the privileges they
24 suspended, right, that's the same list that's on the
25 list of the letter?

1 A. Correct.

2 Q. Then it says, "The summary suspension extends
3 to the provision of consultation that relates to
4 those." That's true, they suspended everything that
5 related to it, right?

6 A. Right.

7 Q. "All other privileges remain unrestricted,"
8 that's true?

9 A. What's left, yeah.

10 Q. What's left. I hear you. "Dr. Randall
11 denies all allegations and has requested a hearing to
12 review and challenge the findings." That's true?

13 A. Correct.

14 MR. DAYHUFF: Jim, do we have the rest of the
15 NPDB, the one that's on the revocation? Do you have
16 any idea?

17 MR. GRIFFIN: Where did this come from? Did
18 this come from you?

19 MR. DAYHUFF: Yeah, we produced this, but I
20 assumed you guys had it just because you get a copy if
21 you're the practitioner.

22 MR. GRIFFIN: He's not provided it to us.

23 THE WITNESS: No, I don't.

24 BY MR. DAYHUFF:

25 Q. Have you ever received a copy of one of these

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:

**DEFENDANTS' REPLY TO MEMORANDUM IN
OPPOSITION TO MOTION FOR SUMMARY JUDGMENT
(UNDER SEAL)**

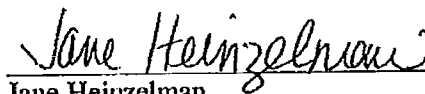
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Jane Heinzelman
Administrative Assistant

November 21, 2013

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.

CERTIFICATE OF COUNSEL

The undersigned certifies that the Record on Appeal contains all material proposed to be included by any of the parties and not any other material, and that Appellant has complied with the August 13, 2007 Order of the Supreme Court on Personal Data Identifiers.



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Ariail E. King

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Columbia, South Carolina

October 15, 2014

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
Appellate 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.

PROOF OF SERVICE

I, Jaime Harmon, the undersigned employee of Lewis Babcock & Griffin L.L.P, attorney for Robert Randall, M.D., do hereby certify that I have served a copy of the Corrected Record on Appeal on October 17, 2014, by causing a copy of same to be deposited in the U.S. Mail, proper postage prepaid addressed as follows:

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OCT 17 2014

SC Court of Appeals

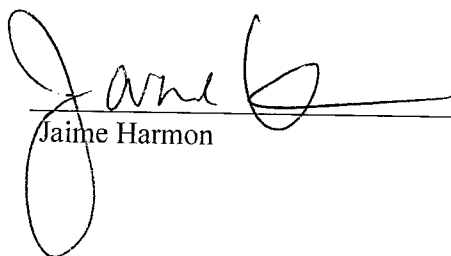
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NOV 06 2014

SC Court of Appeals

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Jaime Harmon

This 17th day of October, 2014.

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
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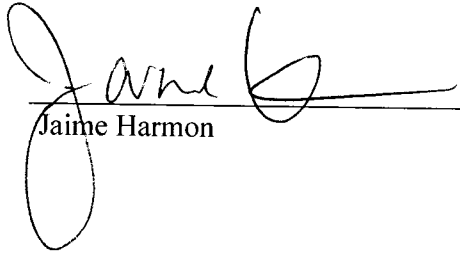
Respondents.

PROOF OF SERVICE

I, Jaime Harmon, the undersigned employee of Lewis Babcock & Griffin L.L.P, attorney for Robert Randall, M.D., do hereby certify that I have served a copy of the Corrected Record on Appeal on October 17, 2014, by causing a copy of same to be deposited in the U.S. Mail, proper postage prepaid addressed as follows:

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Jaime Harmon

This 17th day of October, 2014.