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THE STATE OF SOUTH CAROLINA
In The Court of Appeals

Appeal From Laurens County Court of Common Pleas

Eugene C. Griffith, Jr., Circuit Court Judge

Appellate Case No. 2017-001064

Chris Katina McCord, Christopher McCord,
Janice Sherfield, and Jerry Sherfield ********** Appellants

v.

Laurens County Health Care System and
Greenville Health System ********** Respondents

RECORD ON APPEAL

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SEP 14 2017
SC Court of Appeals

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FORM 4

STATE OF SOUTH CAROLINA
COUNTY OF LAURENS
IN THE COURT OF COMMON PLEAS

JUDGMENT IN A CIVIL CASE

CASE NO. 2014-CP-30-0250

Chris Katina McCord, Christopher McCord, Janice Sherfield, and Jerry Sherfield	Laurens County Health Care System and Greenville Health System
PLAINTIFF(S)	DEFENDANT(S)

Submitted by: The Honorable Eugene C. Griffith, Jr.	Attorney for : ☐ Plaintiff ☐ Defendant or ☐ Self-Represented Litigant

DISPOSITION TYPE (CHECK ONE)

☐ **JURY VERDICT.** This action came before the court for a trial by jury. The issues have been tried and a verdict rendered.

☒ **DECISION BY THE COURT.** This action came to trial or hearing before the court. The issues have been tried or heard and a decision rendered. ☐ See Page 2 for additional information.

☐ **ACTION DISMISSED** (*CHECK REASON*): ☐ Rule 12(b), SCRCP; ☐ Rule 41(a), SCRCP (Vol. Nonsuit); ☐ Rule 43(k), SCRCP (Settled); ☐ Other

☐ **ACTION STRICKEN** (*CHECK REASON*): ☐ Rule 40(j), SCRCP; ☐ Bankruptcy; ☐ Binding arbitration, subject to right to restore to confirm, vacate or modify arbitration award; ☐ Other

☐ **STAYED DUE TO BANKRUPTCY**

☐ **DISPOSITION OF APPEAL TO THE CIRCUIT COURT** (*CHECK APPLICABLE BOX*): ☐ Affirmed; ☐ Reversed; ☐ Remanded; ☐ Other

NOTE: ATTORNEYS ARE RESPONSIBLE FOR NOTIFYING LOWER COURT, TRIBUNAL, OR ADMINISTRATIVE AGENCY OF THE CIRCUIT COURT RULING IN THIS APPEAL.

IT IS ORDERED AND ADJUDGED: ☐ See attached order (formal order to follow) ☒ Statement of Judgment by the Court:

After careful review of the memoranda submitted by the plaintiffs and defendant, the plaintiffs' Motion to Alter or Amend Judgement under Rule 59(e) SCRCP is respectfully denied.

LAURENS COUNTY CLERK OF COURT
2017 APR 13 A 9:25
LYNN W. LANCASTER

ORDER INFORMATION

This order ☒ ends ☐ does not end the case.
Additional Information for the Clerk:

INFORMATION FOR THE JUDGMENT INDEX

Complete this section below when the judgment affects title to real or personal property or if any amount should be enrolled. If there is no judgment information, indicate "N/A" in one of the boxes below.

Judgment in Favor of (List name(s) below)	Judgment Against (List name(s) below)	Judgment Amount To be Enrolled (List amount(s) below)
		$
		$
		$

If applicable, describe the property, including tax map information and address, referenced in the order:

The judgment information above has been provided by the submitting party. Disputes concerning the amounts contained in this form may be addressed by way of motion pursuant to the SC Rules of Civil Procedure. Amounts to be computed such as interest or additional taxable costs not available at the time the form and final order are submitted to the judge may be provided to the clerk. **Note: Title abstractors and researchers should refer to the official court order for judgment details.**
E-Filing Note: In E-Filing counties, the Court will electronically sign this form using a separate electronic signature page.

J C Griffith Jr. | 2154 | 4-4-17

Eugene C. Griffith, Jr., Presiding Judge | **Judge Code** | **Date**

For Clerk of Court Office Use Only

This judgment was entered on the day of , 20 and a copy mailed first class or placed in the appropriate attorney's box on this day of , 20 to attorneys of record or to parties (when appearing pro se) as follows:

Joseph G. Wright, Esq.
P.O. Box 1778
Anderson, SC 29622
ATTORNEY(S) FOR THE PLAINTIFF(S)

Kenneth N. Shaw, Esq.
P.O. Box 2048
Greenville, SC 29602
ATTORNEY(S) FOR THE DEFENDANT(S)

CLERK OF COURT

Lynn W. Lancaster
Laurens County CCCP & GS

A TRUE COPY OF ORIGINAL

Court Reporter:

E-Filing Note: In E-Filing counties, the date of Entry of Judgment is the same date as reflected on the Electronic File Stamp and the clerk's entering of the date of judgment above is not required in those counties. The clerk will mail a copy of the judgement to parties who are not E-Filers or who are appearing pro se. See Rule 77(d), SCRCP.

ADDITIONAL INFORMATION REGARDING DECISION BY THE COURT AS REFERENCED ON PAGE 1.

This action came to trial or hearing before the court. The issues have been tried or heard and a decision rendered.

FORM 4

STATE OF SOUTH CAROLINA
COUNTY OF LAURENS
IN THE COURT OF COMMON PLEAS

JUDGMENT IN A CIVIL CASE

CASE NO. 2014 CP- 30-250

Chris Katina McCord, Christopher McCord, Janice Sherfield, and Jerry Sherfield
PLAINTIFF(S)

Laurens County Health Care System and Greenville Health System
DEFENDANT(S)

Submitted by: The Honorable Eugene C. Griffith, Jr.	Attorney for : ☐ Plaintiff ☐ Defendant or ☐ Self-Represented Litigant

DISPOSITION TYPE (CHECK ONE)

☐ **JURY VERDICT.** This action came before the court for a trial by jury. The issues have been tried and a verdict rendered.

☒ **DECISION BY THE COURT.** This action came to trial or hearing before the court. The issues have been tried or heard and a decision rendered. ☐ See Page 2 for additional information.

☐ **ACTION DISMISSED** (*CHECK REASON*): ☐ Rule 12(b), SCRCP; ☐ Rule 41(a), SCRCP (Vol. Nonsuit); ☐ Rule 43(k), SCRCP (Settled); ☐ Other

☐ **ACTION STRICKEN** (*CHECK REASON*): ☐ Rule 40(j), SCRCP; ☐ Bankruptcy; ☐ Binding arbitration, subject to right to restore to confirm, vacate or modify arbitration award; ☐ Other

☐ **STAYED DUE TO BANKRUPTCY**

☐ **DISPOSITION OF APPEAL TO THE CIRCUIT COURT** (*CHECK APPLICABLE BOX*): ☐ Affirmed; ☐ Reversed; ☐ Remanded; ☐ Other

NOTE: ATTORNEYS ARE RESPONSIBLE FOR NOTIFYING LOWER COURT, TRIBUNAL, OR ADMINISTRATIVE AGENCY OF THE CIRCUIT COURT RULING IN THIS APPEAL.

IT IS ORDERED AND ADJUDGED: ☒ See attached order (formal order to follow) ☐ Statement of Judgment by the Court:

ORDER INFORMATION

This order ☒ ends ☐ does not end the case.
Additional Information for the Clerk :

LAURENS COUNTY CLERK OF COURT
2017 MAR -6 A 10:4
LYNN W. LANCASTER

INFORMATION FOR THE JUDGMENT INDEX

Complete this section below when the judgment affects title to real or personal property or if any amount should be enrolled. If there is no judgment information, indicate "N/A" in one of the boxes below.

Judgment in Favor of (List name(s) below)	Judgment Against (List name(s) below)	Judgment Amount To be Enrolled (List amount(s) below)
		$
		$
		$

If applicable, describe the property, including tax map information and address, referenced in the order.

A TRUE COPY OF ORIGINAL
Lynn W. Lancaster
Laurens County CCCP & GS

The judgment information above has been provided by the submitting party. Disputes concerning the amounts contained in this form may be addressed by way of motion pursuant to the SC Rules of Civil Procedure. Amounts to be computed such as interest or additional taxable costs not available at the time the form and final order are submitted to the judge may be provided to the clerk. **Note: Title abstractors and researchers should refer to the official court order for judgment details.**
E-Filing Note: In E-Filing counties, the Court will electronically sign this form using a separate electronic signature page.

Circuit Court Judge | **Judge Code** 2154 | **Date** 3-1-17

SCRCP Form 4C (02/2017)

For Clerk of Court Office Use Only

This judgment was entered on the day of , 20 and a copy mailed first class or placed in the appropriate attorney's box on this day of , 20 to attorneys of record or to parties (when appearing pro se) as follows:

ATTORNEY(S) FOR THE PLAINTIFF(S)

ATTORNEY(S) FOR THE DEFENDANT(S)

CLERK OF COURT

Court Reporter:

E-Filing Note: In E-Filing counties, the date of Entry of Judgment is the same date as reflected on the Electronic File Stamp and the clerk's entering of the date of judgment above is not required in those counties. The clerk will mail a copy of the judgement to parties who are not E-Filers or who are appearing pro se. See Rule 77(d), SCRCP.

ADDITIONAL INFORMATION REGARDING DECISION BY THE COURT AS REFERENCED ON PAGE 1.

This action came to trial or hearing before the court. The issues have been tried or heard and a decision rendered.

STATE OF SOUTH CAROLINA COUNTY OF LAURENS Chris Katina McCord, Christopher McCord, Janice Sherfield, and Jerry Sherfield, Plaintiffs, v. Laurens County Health Care System and Greenville Health System, Defendants.	IN THE COURT OF COMMON PLEAS C.A. No.: 2014-CP-30-250 ***ORDER GRANTING SUMMARY JUDGMENT***

LAURENS COUNTY
CLERK OF COURT
2017 MAR -6 A 10: 1
LYNN W. LANCASTER

This matter came before the Court on January 6, 2016 for oral argument on Plaintiffs' motion to amend their complaint and Defendants' motion for summary judgment. After carefully reviewing the entire factual record, the memoranda of law submitted by the parties, listening to oral arguments, and reading the salient case law, for the reasons more fully explained below, the Court hereby grants Defendants' motion for summary judgment on the grounds that the Court finds that there is no material question of fact to be presented to a jury and Defendants owed no duty to Plaintiffs to ensure that Plaintiffs' physician had medical malpractice liability insurance coverage for their claims against him.[1]

[1] At the hearing, the Court heard Plaintiffs' motion to amend first and orally granted leave for Plaintiffs to file their Second Amended Complaint; however, there are a couple of reasons why that does not affect the Court's ruling on Defendants' motion for summary judgment. First, when faced with a properly supported motion for summary judgment, as is the case here, Rule 56(e), SCRCP , expressly provides that Plaintiffs may not rest on the allegations in their pleadings. See e.g., Humana Hospital Bayside v. Lightle, 305 SC 214, 216, 407 S.E.2d 637, 638 (1991); Klippel v. Mid-Carolina Oil Inc., 303 S.C. 127, 129, 399 S.E.2d 163, 164 (Ct. App. 1990). In other words, on a motion for summary judgment, what matter is not what is alleged in the underlying complaint, but whether there are any facts in the record which create a genuine issue of material fact. Hayes v. City of Charlotte, 10 F.3d 210, 215 (4th Cir. 1993) (the non-moving party is "required at the summary judgment stage to go beyond its pleadings and come forward with specific facts in support of its claim "). Second, the court has carefully considered the facts alleged in the Second Amended Complaint, and they simply do not create a genuine issue of material fact or change the Court's determination that no duty was owed.

1/10

Introduction

While Plaintiffs' Complaint contains numerous allegations, the crux of their claim is they contend that Laurens and/or GHS[2] should be liable for default judgments they obtained in separate medical malpractice actions filed against Dr. Byron Brown and his OB/GYN practice. Plaintiffs have been unable to collect on those judgments, because Dr. Brown no longer resides in the country and his medical malpractice carriers denied coverage. Plaintiffs allege that Laurens should be held liable for those judgments on the theory that Laurens owed them a duty to ensure there was medical malpractice coverage for their claims against Dr. Brown.

Facts

This case arises out of surgeries that were performed on Plaintiffs Chris Katina McCord and Janice Sherfield at Laurens County Hospital ("Hospital") from December 2008 to May 2009 by Dr. Byron Brown. It is undisputed that at the time of the surgeries, Dr. Brown had surgical privileges at the Hospital, but he was not employed by the Hospital.[3] Dr. Brown had his own practice with an office located offsite from the Hospital. It is undisputed that pursuant to the Hospital Medical Staff Bylaws ("Bylaws"), Dr. Brown had to maintain medical malpractice insurance in order to retain privileges at the Hospital. And, it is undisputed that at the time of the surgeries, he was in compliance with the Bylaws, as Dr. Brown had a claims-made medical malpractice liability insurance policy through Joint Underwriting Association ("JUA") with coverage limits of $200,000 per claim and $600,000 annual aggregate. In addition, Dr. Brown

[2] GHS is named as a defendant solely upon the basis that Plaintiffs allege that subsequent to the acts giving rise to the causes of action, Laurens entered into an agreement of consolidation or merger with GHS in which GHS may have assumed Laurens's liabilities. (Sec. Am. Compl. ¶ 3.)

[3] There was a February 14, 2002 Agreement between Dr. Brown and Laurens whereby Laurens agreed to subsidize Dr. Brown's practice for three years (hereinafter "Subsidy Contract), because the Hospital felt there were an insufficient number of OB/GYN physicians in the area. However, the Subsidy Contract made clear that Dr. Brown was an independent contractor who was free to admit patients at any hospital and maintain privileges to perform surgeries at any hospital.

RM 2/10

had excess coverage through Patients' Compensation Fund, which pushed his total coverage up to $1,000,000 per claim and $3,000,000 annual aggregate.

A few months after the surgeries on Mrs. McCord and Mrs. Sherfield, in July, 2009, Dr. Brown decided to switch his medical malpractice insurance from JUA to MAG Mutual. He bought a claims-made policy from MAG Mutual, which covered claims arising on or after July 9, 2009. When he made the change he declined to purchase either "tail" or "prior bad acts" coverage, which meant there would be no coverage for previously unreported claims that occurred prior to July 9, 2009. As a result, since neither Mrs. McCord nor Mrs. Sherfield put Dr. Brown, or anyone else, on notice that they planned to file a claim against him until well after July 9, 2009, there was no insurance coverage for either of their claims.

Following their surgeries, both Mrs. McCord and Mrs. Sherfield continued to experience incontinence issues and both had to seek additional medical care in an attempt to resolve those issues. As a result, they both decided to pursue legal actions against Dr. Brown. The McCords filed their Complaint against Dr. Brown and his practice on December 9, 2011. They did not name Laurens as a defendant in that action or assert any allegations against Laurens. The Sherfields filed their Complaint against Dr. Brown and his practice on September 25, 2012. Like the McCords, they did not name Laurens or assert any allegations against Laurens.

While those actions were pending, Dr. Brown moved out of the country and refused to continue participating in the defense of the actions. As a result, both the McCords and Sherfields were ultimately able to obtain default judgments against Dr. Brown and his practice. (See C.A. No. 11-CP-30-1141, March 11, 2014 Judgment in the amount of $1,480,457 for Chris Katina McCord and $50,000 for Christopher McCord and C.A. No. 12-CP-30-753, March 11, 2014 Judgment in the amount of $1,468,580 for Janice Sherfield and $50,000 for Jerry Sherfield.)

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Shortly thereafter on March 26, 2014, Plaintiffs filed the instant action.

Summary Judgment Standard

Summary judgment is appropriate when it is clear that there is no genuine issue of material fact and the conclusions and inferences to be drawn from the facts are undisputed. Calvert v. House Beautiful Paint and Decorating Ctr., Inc., 313 S.C. 494, 443 S.E.2d 398 (1994). "The purpose of summary judgment is to expedite the disposition of cases which do not require the services of a fact finder." Dawkins v. Fields, 354 S.C. 58, 69, 580 S.E.2d 433, 438 (2003) (quoting George v. Fabri, 345 S.C. 440, 452, 548 S.E.2d 868, 874 (2001)). When a plaintiff cannot establish facts to meet all the elements of the cause of action, summary judgment is appropriate. Bessinger v. Bi-Lo, Inc., 329 S.C. 617, 496 S.E.2d 33 (Ct. App. 1997); Hunter v. Dixie Home Stores, 101 S.E.2d 262, 232 S.C. 139 (1957). A party may not rely upon an issue of fact that is not genuine or an inference which is not reasonable to rebut a motion for summary judgment. Main v. Corley, 281 S.C. 525, 316 S.E.2d 406 (1984).

In order to prevail on either of their causes of action, Plaintiffs must establish that Defendants breached a legal duty owed to them. "A legal duty is that which the law requires to be done or forborne with respect to a particular individual or the public at large." Byerly v. Connor, 301 S.C. 441, 443 415 S.E.2d 796, 798 (1992). A legal duty may be created by statute, a contractual relationship, status, property interest, or some other special circumstance. Madison v. Babcock Ctr., Inc., 371 S.C. 123, 136, 638 S.E.2d 650, 656 (2007). The court must determine, as a matter of law, whether the law recognizes a particular duty. Id. If there is no duty, then the defendant is entitled to summary judgment as a matter of law. Id.

Legal Analysis

I. **No Contractual Duty Owed**

Plaintiffs' first cause of action is breach of contract. In ruling on a motion for summary

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judgment, it is the court's duty to interpret and enforce the contract the parties actually made for themselves and the court cannot, under the guise of interpretation, create a better or different contract than the one the parties actually made. See Sphere Drake Ins. Co. v. Litchfield, 313 S.C. 471, 438 S.E.2d 275, 277 (Ct. App. 1993) (court "is limited to interpretation of the contract made by the parties" and "is without authority to alter a contract by construction or to make a new contract for the parties"); Chan v. Thompson, 302 S.C. 285, 395 S.E.2d 731, 734 (Ct. App. 1990) ("The rights of the parties must be measured by the contract which the parties themselves made, regardless of its wisdom, reasonableness, or failure of the parties to guard their rights carefully") (citations omitted). If the contract is unambiguous, it must be construed according to the terms the parties have used, and the terms are to be interpreted in their plain, ordinary, and popular sense. Litchfield, supra.

The document that Plaintiffs contend forms the basis of their breach of contract claim is the Conditions of Admission form which they executed prior to each of their surgeries (hereinafter "the Contract"). Specifically, Plaintiffs point to the first sentence of the paragraph titled "Financial Agreement" which states,

> "The undersigned agrees he signs as agent or as patient that in consideration of the services to be rendered to that patient, he hereby individually obligates himself to pay the account of the hospital, in accordance with the regular rates and terms of the hospital."

Plaintiffs contend that sentence created a duty on the part of the Hospital to ensure that Dr. Brown had medical malpractice insurance coverage for their claims against him; however, the Court finds Plaintiffs' contentions unavailing.

First, taking the terms in their plain, ordinary and popular sense, the purpose of the sentence is unambiguous. It simply obligates patients to pay the bills they receive for the services rendered to them by the Hospital. "Services to be rendered," in the context of that

SM 5/10

paragraph, refers to those services that the Hospital actually provides and bills for, such as room charges, medications, and meals, not ensuring that an independent physician has medical malpractice insurance.

Plaintiffs contend that the "services to be rendered" include: compliance with state and federal laws and regulations; compliance with the Bylaws, and; compliance with the contracts between the Hospital and privileged physicians. However, those things aren't actually services rendered by the Hospital. At most, they go toward the standard of care for how services should be rendered by the Hospital. In essence, Plaintiffs seem to be contending that the Contract implies that services will be rendered in a certain manner; however, South Carolina does not recognize a cause of action for breach of an implied contract in the context of medical care. Banks v. Medical Univ., 314 S.C. 376, 444 S.E.2d 519 (1994).

In addition, Plaintiffs' interpretation is unreasonable, because it requires one to ignore the plain and unambiguous language contained in other parts of the Contract. The paragraph entitled "Medical and Surgical Consent" states,

> The patient's care is under the direction of the attending physicians and the hospital is not responsible for any act or omission of the physicians.... The undersigned recognizes that most medical staff members furnishing services to the patient, including the radiologists, pathologist, anesthesiologists, and the like (are) independent contractors and not employees of the hospital.

That paragraph should have made it clear to Plaintiffs that the Hospital was not responsible for any acts or omissions of Dr. Brown. To the extent that Dr. Brown's failure to purchase tail coverage could be construed as a violation of the Bylaws, it would be his violation of the Bylaws, not the Hospitals'. It cannot be reasonably argued that the Hospital promised to ensure that Dr. Brown maintained medical malpractice insurance when the Hospital clearly stated that it was not responsible for anything Dr. Brown did or failed to do.

SKY 6/10

II. No Other Basis for a Duty Owed

Plaintiffs also assert a negligence cause of action against Defendants, but to the extent Plaintiffs are alleging the duty owed to them arose under contract, their claims must be redressed under the terms of the contract, and a tort action will not lie. *See Tommy L. Griffin Plumbing & Heating Co. v. Jordan, Jones, & Goulding, Inc.*, 320 S.C. 49, 54-55, 463 S.E.2d 85, 88 (1995). In an effort to sustain both their contract and negligence causes of action, Plaintiffs' argue that the Contract created a "special relationship" between the parties and that distinct and separate tort duties arose from that relationship (Pl. Mem. In Opp., pp. 16-21); however, the Court finds that assuming, without deciding, that there was a special relationship between the parties, the relationship did not create a duty on the part of Laurens to ensure that Dr. Brown had medical malpractice insurance to cover Plaintiffs' claims.

Plaintiffs contend that Laurens owed them a duty to ensure that Dr. Brown complied with the terms and conditions of the Bylaws and the Subsidy Contract. As an initial matter, there is no evidence in the record that Dr. Brown failed to comply with the requirements of the Bylaws and/or the Subsidy Contract. It is undisputed that at the time of the surgeries on Plaintiffs, Dr. Brown had the required insurance. Plaintiffs contend that he fell out of compliance when he switched policies in July of 2009 and failed to purchase tail coverage; however, there is nothing in the Bylaws or the Subsidy Contract that specifically required Dr. Brown to purchase tail coverage, nor is there any evidence in the record that Laurens considered Dr. Brown to be in violation of the Bylaws or in breach of the Subsidy Contract by his failure to purchase tail coverage.

Nevertheless, even if the Bylaws and/or the Subsidy Contract required Dr. Brown to purchase tail coverage, that requirement would not inure to the benefit of Plaintiffs. Plaintiffs contend they were intended beneficiaries of the requirement that Dr. Brown maintain insurance,

JCH 7/10

but there is nothing in either the Bylaws or the Subsidy Contract that states that the insurance requirement is there for the benefit of patients, and Plaintiffs' contention is inconsistent with South Carolina law. See Trancik v. USAA Ins. Co., 354 S.C. 549, 581 S.E.2d 858 (Ct. App. 2003) ("Third-party-liability-insurance contracts are generally indemnity contracts whereby the insurer, or the first party, agrees to pay the insured, or the second party, the amount of any damages the insured may become legally liable to pay a third party; thus, the third party, or the incidental beneficiary, does not have a contractual relationship with the insurer and cannot maintain an action against the insurer for breach of the insurance contract.") At most, Plaintiffs would be incidental beneficiaries of the Medical Staff Bylaws and Subsidy Contract, but that would not give them standing to bring an action to enforce those documents. Id.

Regardless, even if Plaintiffs were intended beneficiaries, such status would only give them standing to sue Dr. Brown as the promisor, not Laurens as the promisee. Under the terms of both the Bylaws and the Subsidy Contract, the obligation to maintain insurance belonged to Dr. Brown. To the extent his failure to purchase tail coverage meant he had not fulfilled his obligations, Plaintiffs would, at best, have been able to sue Dr. Brown for breach of the Bylaws and Subsidy Contract, but that would not give them the right to sue Laurens. See Sullivan v. U.S., 625 F.3d 1378 (Fed. Cir. 2010) (holding plaintiffs could not maintain a breach of contract action against Postal Service for failing to enforce a contract with a transportation company, and noting that the contract provision requiring the contractor to purchase liability insurance for its vehicles was intended to protect the Postal Service from potential risk and plaintiffs were at best incidental beneficiaries); Hesse v. Long and Foster Real Estate, Inc., No. 1:11cv506, 2012 WL 1427793 (E.D.Va.2012) (noting that no jurisdiction recognizes a theory of liability whereby a third party to a contract can sue the non-breaching party for failure to enforce the contract).

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Finally, Plaintiffs make several allegations regarding medical malpractice incidents in the United States, (Sec. Am. Compl. ¶¶ 5-8), and essentially make a public policy argument for the Court to find a duty in this case; however, it is the job of the legislature, not the judiciary, to consider such arguments and enact laws accordingly. Holman v. Bulldog Trucking Co., 311 S.C. 341, 348, 428 S.E.2d 889, 893 (Ct. App. 1993) ("When the Legislature has enacted a rule embodying a particular policy choice, the courts have no power to annul the Legislature's judgment by substituting their own views of sound public policy."); see also Henderson v. Evans, 268 S.C. 127, 232 S.E.2d 331 (1977) (It is not the province of the courts to perform legislative functions.) Plaintiffs' contentions in this case are inconsistent with the public policy of South Carolina as currently set forth by the legislature. Plaintiffs argue that Laurens is mandated by South Carolina law to comply with certain requirements for licensing and operating a hospital (Pl. Mem. In Opp. to Sum. J., pp. 8-11); however, there is no law in South Carolina that requires doctors to maintain medical malpractice insurance, much less any law that puts the burden on hospitals to ensure that doctors maintain medical malpractice insurance.

Further, Laurens and GHS are both governmental entities subject to the South Carolina Tort Claims Act, S.C. Code Ann. § 15-78-10, et seq. (1976, as amended), and they and their agents and employees are, therefore, entitled to all rights, privileges, defenses, limitations, and immunities afforded by the Act and afforded by the doctrine of sovereign immunity, as is retained by the Act. See Murphy v. Richland Mem. Hosp., 317 S.C. 560, 455 S.E.2d 688 (1995) (citing Benton v Roger C Peace, 313 S.C. 520, 443 S.E.2d 537 (1994)). Pursuant to the Act, a governmental entity cannot be held liable for the acts or omissions of an independent contractor. S.C. Code § 15-78-60(20); see also Smith v. Reg'l Med. Ctr., 394 S.C. 110, 713 S.E.2d 656 (Ct. App. 2011) (holding governmental hospital could not be held liable for the negligent acts of an

SCH 9/10

independent contractor physician). Therefore, it is the public policy of this State and the intent of the legislature that Laurens cannot be held liable for Dr. Brown's failure to have insurance coverage for Plaintiffs' claims. To hold otherwise under the facts of this case would be an unreasonable expansion of the law. *See Huggins v. Citibank*, 355 S.C. 329, 333, 585 S.E.2d 275, 277 (2003) ("The concept of duty in tort liability will not be extended beyond reasonable limits.")

CONCLUSION

The Court finds that Defendants owed no legal duty to Plaintiffs regarding Dr. Brown's medical malpractice insurance. Defendants also set forth proximate cause and statute of limitations arguments in favor of summary judgment; however, in light of the Court's finding that no duty was owed, the Court need not address those arguments.

For the reasons stated herein,

IT IS HEREBY ORDERED, ADJUDGED AND DECREED that Defendants' motion for summary judgment is granted, and all of Plaintiffs' claims against Defendants are hereby dismissed with prejudice.

AND IT IS SO ORDERED.

The Honorable Eugene C. Griffith, Jr.
Eighth Judicial Circuit

Feb. 28th, 2017

A TRUE COPY OF ORIGINAL
Lynn W. Lancaster
Laurens County CCCP & GS

SCJ 10/10

STATE OF SOUTH CAROLINA COUNTY OF LAURENS Chris Katina McCord, Christopher McCord, Janice Sherfield, and Jerry Sherfield, ☒ Plaintiff v. Laurens County Health Care System And Greenville Health System, ☐ Defendant.	)	IN THE COURT OF COMMON PLEAS CASE NO. 2014-CP-30-0250 MOTION AND ORDER INFORMATION FORM AND COVER SHEET

Plaintiff's Attorney:	Defendant's Attorney:
Joseph G. Wright, Bar No. 6239 Address: P. O. Drawer 1778, Anderson, SC 29622 phone: 864-225-6228 fax: 864-231-9031 e-mail: jwright@mcgowanhood.com other:	Kenneth N. Shaw, Bar No. Address: P.O. Box 2048, Greenville, SC 29602 phone: 864-240-3200 fax: 864-240-3300 e-mail: kshaw@hsblawfirm.com other:

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

SECTION I: Hearing Information

Nature of Motion: Rule 59(e) Motion to Alter or Amend Judgment
Estimated Time Needed: 30 minutes Court Reporter Needed: ☒ YES / ☐ NO

SECTION II: Motion/Order Type

☒ Written motion attached
☐ Form Motion/Order

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

Signature of Attorney for ☒ Plaintiff / ☐ Defendant — March 7, 2017 Date submitted

LAURENS CLERK OF COURT 2017 MAR 10 P 1:1

LYNN W. LANCASTER

SECTION III: Motion Fee

☒ PAID – AMOUNT: $25.00
☐ EXEMPT: (check reason)
☐ Rule to Show Cause in Child or Spousal Support
☐ Domestic Abuse or Abuse and Neglect
☐ Indigent Status ☐ State Agency v. Indigent Party
☐ Sexually Violent Predator Act ☐ Post-Conviction Relief
☐ Motion for Stay in Bankruptcy
☐ Motion for Publication ☐ Motion for Execution (Rule 69, SCRCP)
☐ Proposed order submitted at request of the court; or,
reduced to writing from motion made in open court per judge's instructions
Name of Court Reporter:
☐ Other:

JUDGE'S SECTION	
☐ Motion Fee to be paid upon filing of the attached order. ☐ Other:	_____ JUDGE CODE: _____ Date: _____

CLERK'S VERIFICATION

Collected by: _____ Date Filed:

☐ MOTION FEE COLLECTED: _____

SCCA/233 (11-03)

STATE OF SOUTH CAROLINA	)	IN THE COURT OF COMMON PLEAS
	)	
COUNTY OF LAURENS	)	C.A. FILE NO. 14-CP-30-250
Chris Katina McCord, Christopher McCord, Janice Sherfield, and Jerry Sherfield,	)	
Plaintiffs,	)	PLAINTIFFS' RULE 59(e) MOTION TO ALTER OR AMEND JUDGMENT (*Rule 59(e), SCRCP*)
vs.	)	
Laurens County Health Care System and Greenville Healthcare System,	)	
Defendants.	)	

LAURENS COUNTY
CLERK OF COURT
2017 MAR -9 A 9:
LYNN W. LANCASTER

Plaintiffs, Chris Katina McCord, Christopher McCord, Janice Sherfield, and Jerry Sherfield, by and through undersigned counsel, respectfully move this Court pursuant to *Rule 59(e),* of the *South Carolina Rules of Civil Procedure* to alter or amend its judgment rendered February 28, 2017, granting Defendants' Motion for Summary Judgment.

In support of this motion, Plaintiffs rely on the Second Amended Complaint and Demand for Jury Trial, Plaintiffs' Memorandum in Opposition to Motion for Summary Judgment, Plaintiffs' Supplement to Memorandum in Opposition to Motion for Summary Judgment, Attachments to Memorandums, filed affidavits and depositions, and Plaintiffs' Memorandum in Support of Plaintiffs' Motion to Alter or Amend Judgment. (Memorandum).

As set forth in the Memorandum, the Court failed to consider or misapprehended the law in that:

1) The Order erroneously finds that:
"...the crux of their claim is they contend that Laurens and/or GHS should be liable for default judgments they obtained in separate medical malpractice actions filed against Dr. Byron Brown and his OB/GYN practice."

2) The Order fails to find that:
the contracts between Plaintiffs and Laurens County Health Care System ("Laurens County Hospital or Hospital") were ambiguous because the "services to be rendered to the patient" were not defined in the four corners of the contract;

3) The Order fails to find that:
a reasonable interpretation of "services to be rendered to the patient" is for Laurens County Hospital to require privileged physicians, including Byron A. Brown, MD ("Dr. Brown"), to comply with Hospital Bylaws and the Subsidy Contract including maintaining valid professional liability insurance coverage;

4) The Order fails to find that:
Laurens County Hospital breached the contract with Plaintiffs by failing to require Dr. Brown to comply with Hospital Bylaws and the Subsidy Contract by maintaining valid professional liability insurance coverage;

5) The Order fails to find that:
a special relationship creating a duty of due care arose between Laurens County Hospital and Plaintiffs by Laurens County Hospital providing services for surgeries performed in the hospital and Plaintiffs agreeing to undergo and pay for services rendered by Laurens County Hospital; and

6) The Order fails to find that:
Laurens County Hospital failed to exercise due care in monitoring, supervising or requiring Dr. Brown to comply with Hospital Bylaws and the Subsidy Contract by maintaining valid professional liability insurance coverage.

Plaintiffs respectfully request that the Court's Order and Judgment of February 28, 2017 be vacated and that this matter be scheduled for trial on the merits.

Respectfully submitted,

MCGOWAN, HOOD & FELDER, LLC

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ATTORNEYS FOR THE PLAINTIFFS

March 7, 2017
Anderson, South Carolina

STATE OF SOUTH CAROLINA COUNTY OF LAURENS	IN THE COURT OF COMMON PLEAS C.A. FILE NO. 14-CP-30-250
Chris Katina McCord, Christopher McCord, Janice Sherfield, and Jerry Sherfield, Plaintiffs, vs. Laurens County Health Care System and Greenville Healthcare System, Defendants.	MEMORANDUM IN SUPPORT OF PLAINTIFFS' RULE 59(e) MOTION TO ALTER OR AMEND JUDGMENT

LAURENS COUNTY
CLERK OF COURT
2017 MAR -9 A 10:
LYNN W. LANCASTER

Plaintiffs respectfully request that this Court reconsider and alter or amend its Order dated February 28, 2017 and the findings and rulings contained therein, as follows:

1) The Order erroneously finds that:
"...the crux of their claim is they contend that Laurens and/or GHS should be liable for default judgments they obtained in separate medical malpractice actions filed against Dr. Byron Brown and his OB/GYN practice."

2) The Order fails to find that:
the contracts between Plaintiffs and Laurens County Health Care System ("Laurens County Hospital or Hospital") were ambiguous because the "services to be rendered to the patient" were not defined in the four corners of the contract;

3) The Order fails to find that:
a reasonable interpretation of "services to be rendered to the patient" is for Laurens County Hospital to require privileged physicians, including Byron A. Brown, MD ("Dr. Brown"), to comply with Hospital Bylaws and the Subsidy Contract including maintaining valid professional liability insurance coverage;

4) The Order fails to find that:

Laurens County Hospital breached the contract with Plaintiffs by failing to require Dr. Brown to comply with Hospital Bylaws and the Subsidy Contract by maintaining valid professional liability insurance coverage;

5) The Order fails to find that:
a special relationship creating a duty of due care arose between Laurens County Hospital and Plaintiffs by Laurens County Hospital providing services for surgeries performed in the hospital and Plaintiffs agreeing to undergo and pay for services rendered by Laurens County Hospital; and

6) The Order fails to find that:
Laurens County Hospital failed to exercise due care in monitoring, supervising or requiring Dr. Brown to comply with Hospital Bylaws and the Subsidy Contract by maintaining valid professional liability insurance coverage.

The grounds for the request of Plaintiffs to reconsider and alter or amend the Order are set forth below:

1) **The Order erroneously finds that:**
"...the crux of their claim is they contend that Laurens and/or GHS should be liable for default judgments they obtained in separate medical malpractice actions filed against Dr. Byron Brown and his OB/GYN practice."

The findings referenced above and any similar findings in the Order are erroneous. Plaintiffs do not allege that the Hospital is liable for the default judgments entered against Dr. Brown under a third-party liability claim. Rather, Plaintiffs allege that the Hospital is liable for failures by its own employees in two ways. First, Plaintiffs allege the Hospital breached an express contract between itself and Plaintiffs in failing to enforce its own Medical Staff Bylaws ("Bylaws"). Second, Plaintiffs allege the Hospital breached the duty of due care in hospital administration that arises in the special relationship between hospital and patient by failing to enforce its own Bylaws. These failures by Hospital employees resulted in damages to Plaintiffs of the value of the insurance coverage lost of $1,000,000 per claim/$3,000,000 limit that would have

been available absent the breaches of contract and/or failure to adhere to the standard of due care in hospital administration by Hospital employees as detailed below (Paragraphs 71, 73 of Second Amended Complaint). The amount of insurance coverage that would have been available for Mrs. McCord, absent Laurens County Hospital's breaches of contract, amounts to $1,740,392.75 and $58,787.40 for Mr. McCord, plus interest from March 11, 2014 and $1,000,000 for Mrs. Sherfield, plus interest from March 11, 2014.[1]

Accordingly the above-referenced finding is erroneous.

2) **The Order fails to find that:**
the contracts between Plaintiffs and Laurens County Health Care System ("Laurens County Hospital") were ambiguous because the "services to be rendered to the patient" were not defined in the four corners of the contract.

Plaintiffs allege and Defendants admit that Laurens County Hospital and Plaintiffs entered into four separate contracts (paragraphs 21, 22, 25, 26, 31, 70, 72 Second Amended Complaint and Attachment 1- Request for Admission #5). It is also undisputed that Laurens County Hospital owed a duty to Plaintiff to adhere to the terms of these four contracts. Thus, Plaintiffs are in privity of contract with Laurens County Hospital and can maintain an action for breach of contract and recover any damages resulting from the breach. *Fabian v. Lindsay*, 765 S.E.2d 132, 139 (S.C. 2014).

The contracts include written documents entitled "Conditions of Admission". (Attachment 1 and Attachment 5). The written documents provide that "in consideration

[1] Dr. Brown committed malpractice during each of the three surgeries, i.e., 12/18/09, 2/19/09, and 4/17/09, he performed on Mrs. McCord (see *McCord, et al v. Byron A. Brown, MD, et al;* C.A. File No. 11-CP-30-1141). This constituted three separate acts of negligence claims under the claims made policy with a limit of $1,000,000 each claim. Mrs. McCord would be entitled to recover on two claims up to $1,000,000 each and Mrs. Sherfield would be entitled to recover on the third claim $1,000,000 plus interest.

of the services to be rendered to the patient, he hereby individually obligates himself to pay the account of the hospital, in accordance with the regular rates and terms of the hospital."

The "services to be rendered" are not limited by contract to those services for which separate charges are made or limited to those charges on a rate sheet. For example, the charges to Mrs. McCord and Mrs. Sherfield contain general categories like "OR Services, Anesthesia, respiratory therapy and recovery room". (Attachment 2). Obviously, additional services that are not separately listed are included.

The Order found that services to be rendered "refers to those services that the Hospital actually provides and bills for, such as room charges, medications, and meals, not ensuring that an independent physicians has medical malpractice insurance." (Order, page 6). This could be one construction of the contract language; but, it is not the only construction as a matter of law, especially when viewed in a light most favorable to Plaintiffs.

There are other vital services performed by the hospital for patients which the hospital does not bill separately. South Carolina law requires each hospital to have a "single organized medical staff that has overall responsibility for the quality of medical care provided to patients". (Attachment 29 - *§44-7-260(D) S.C. Code*). Further, the medical staff shall "with the approval of the hospital governing body, adopt bylaws, rules and regulation to govern its operation as an organized medical staff." (Attachment 30 – DHEC Regulations Chapter 3 – Medical Staff. Section 301. Appointments)

The services of the hospital medical staff are critically important to the life and well-being of the patient. For example, one important service is to properly privilege the

physicians practicing in the hospital. The costs to the hospital for providing such service is not paid for by a direct charge to the patient but is paid out of the general income received from patient fees.

Neither the "services to be rendered" nor the services that were rendered by Laurens County Hospital can be determined from the four corners of the contract. The CEO of Laurens County Hospital agreed when he testified as follows:

> Q. ... the conditions of admission state that services are to be rendered by the hospital to the patient?
> A. Right.
> Q. my question to you, quite simply, is the range of services to be rendered to the patient is not listed in this document, correct?
> A. Yes
> Q. Is that correct?
> A. Yes
> (Attachment 32 – D'Alberto deposition 44:19-23)[2]

Since the scope of the services language in the contract, i.e., "services to be rendered", cannot be determined within the four corners of the contract, then the term "services" is ambiguous. *Carolina Ceramics, Inc. v. Carolina Pipeline Co.*, 161 S.E.2d 179, 181 (S.C. 1968) (holding that a contract is ambiguous if it is capable of being understood in more senses than one, if the agreement is obscure in meaning, or has indefiniteness of expression, or has a double meaning.) "Summary judgment is improper where the motion presents a question as to the construction of a written contract, and the contract is ambiguous because the intent of the parties cannot be gathered from the four corners of the contract." *H.K. New Plan Exchange Property Owner 1, LLC v. Cohen*, 649 S.E.2d 181, 184 (S.C. App. 2007)(citations omitted).

[2] The attachments to the Supplement to Memorandum In Opposition to Motion for Summary Judgment which were not numbered have been numbered 28 through 34 to assist in referencing.

The *Rule 30(b)(6), SCRCP* designee for Laurens County Hospital, Sandra Thompson, testified that the Conditions of Admission forms were prepared by Laurens County Hospital, that the forms had been used by Laurens County Hospital for at least 15 years prior to the surgeries, and that the forms were used in all the McCord and Sherfield surgeries. (Attachment 6 – Thompson deposition, 48:19-50:17). Additionally, it is apparent that Laurens County Hospital is the sophisticated party in this transaction. Thus, the terms of the contract are to be liberally construed in favor of plaintiffs and any reasonable interpretation of "services to be rendered" favorable to patients would be mandated. *Contracts §206, Restatement 2d of Contracts.*

Mrs. McCord testified that it was her intent and understanding that part of the "services to be rendered" by the hospital was the compliance with the Medical Staff Bylaws, compliance with the contracts with physicians who directly or indirectly affected her medical care, and compliance with Rules and Regulations of South Carolina Department of Health and Environmental Control. (Attachment 35 - McCord deposition 105:19 to 106:18).

The testimony of Mrs. Sherfield was similar. She also testified that it was her intention that the hospital would comply with all state and federal laws, for the hospital to require that all its privileged surgeons, specifically Dr. Brown, comply with the hospital rules and regulations, for the hospital to require its surgeons to comply with any contract they may have with the hospital about patient protection, and that she considers the hospital requirement that doctors maintain professional liability insurance is protection to her. (Attachment 36 - Sherfield deposition 67:20 to 68:12). Also, Mrs. Sherfield knew, at the time of execution of the contract, that Laurens County Hospital required any

doctor privileged there to have professional liability insurance. (Attachment 36 - Sherfield Deposition 71:5 to 72:9).

The scope and meaning of the term "services to be rendered" is disputed by the parties. Since the intent of the parties and the construction of the term "services to be rendered" is different and cannot be gathered from the four corners of the contract, the contract is ambiguous.

The construction of an ambiguous contract is a question of fact to be determined by the jury. *Café Associates, Ltd. V. Gerangross*, 406 S.E.2d 162 (1991); *Peoples v. South Carolina Power Co*, 164 S.E. 605 (1932).

The failure to include the above finding in the Order is error. Such finding would raise a fact question which would preclude the granting of summary judgment.

3) **The Order fails to find that:**
a reasonable interpretation of "services to be rendered to the patient" is for Laurens County Hospital to require privileged physicians, including Byron A. Brown, MD ("Dr. Brown"), to comply with Hospital Bylaws and the Subsidy Contract including maintaining valid professional liability insurance coverage.

Laurens County Hospital is required by the South Carolina Department of Health and Environmental Control to appoint a medical staff responsible to the governing authority for the clinical work of the hospital and to require the medical staff to adopt bylaws, rules, and regulations to govern the operation of the hospital. (Attachment 30 - *DHEC Regulation 61-16; §44-7-260(A) S.C. Code of Laws*). This agency is charged with promoting and protecting the state's public health. Thus, the requirement of Hospitals to adopt and adhere to bylaws, rules, and regulations are designed to protect the health and safety of patients in South Carolina hospitals.

The medical staff of Laurens County Hospital adopted bylaws that required members of the medical staff to "**maintain** valid professional liability insurance coverage in the amounts deemed necessary by the Board from time to time ... for continuing appointment to the medical staff." (emphasis added) (Attachment 8 – Section 3.21(e) of Medical Staff Bylaws) The amount of professional liability insurance coverage required by the Board of Trustees of Laurens County Hospital was "malpractice insurance coverage limits as defined by Joint Underwriters Association and Patient's Compensation Fund, or coverage limits of one million/three million dollars." (Attachment 31 - Answer to Interrogatory 21).

Also, Laurens County Hospital entered into contracts with physicians that would affect individual rights and benefits of the patients. On February 14, 2002, Laurens County Hospital and Dr. Brown entered into a contract in which Laurens County Hospital agreed to subsidize and guarantee his net practice collection of $27,000 per month for 36 months and then to be repaid prorata over the next ten years. (Attachment 9 – Subsidy Contract). The total amount disbursed to Dr. Brown in subsidy payments was $644,447. The payments were to be repaid by being forgiven on a prorated basis over ten years at $5370 per month beginning July 2005 until June 2015, as long as Dr. Brown complied with all provisions of the Medical Staff Bylaws and the Subsidy Contract which included maintaining professional liability insurance with minimum limits of $1,000,000/$3,000,000 aggregate. (Attachment 10 – Subsidy Contract Repayment/Forgiveness Schedule; Attachment 9 – Article II, IV, V, VI Subsidy Contract).

As noted earlier, the medical staff of Laurens County Hospital was required to adopt medical staff bylaws to govern the operation of the hospital. The bylaws adopted required the medical staff to ensure that the Licensed Independent Practitioners, i.e., the physicians privileged to practice in Laurens County Hospital, "shall maintain valid professional liability insurance coverage". Further, the Subsidy Contract between Laurens County Hospital and Dr. Brown required Dr. Brown to maintain professional liability insurance "in a minimum amount of $1,000,000 per claim/$3,000,000 aggregate of JUA/PCF coverage". (Attachment 9 – Exhibit. 29, Article VI Subsidy Contract).

The CEO of Laurens County Hospital testified that monitoring physicians compliance with that portion of the medical staff bylaws that requires physicians practicing in the hospital to maintain valid professional liability insurance would be a function of medical staff leadership. (Attachment 32 - D'Alberto deposition 32:5-17). As noted above, both Mrs. McCord and Mrs. Sherfield testified that part of their decision in choosing to undergo their elective procedures at Laurens County Hospital instead of another institution was their understanding that the Hospital would follow its own rules set up to protect the health and safety of its patients.

The expert witness in hospital administration for Plaintiffs, John C. Hyde, II, PhD, MSHA, BS, testified that the requirement for doctors practicing in the hospital to maintain professional liability insurance has been the prevailing standard in American hospitals since the "late 70's" and that he had never heard of a hospital allowing physicians to "go, quote, bare", i.e., without professional liability insurance coverage. (Attachment 33 - Hyde deposition pages 25:14-17; 47:23-25).

Also, the expert witness in hospital administration for Defendants, James Weiss, MSHA, MBA, FACHE, testified that:

* it was common practice in 2008 and 2009 to require physicians to carry and maintain medical malpractice insurance (58:4-8);

* "it's a requirement standard in the industry that the governing body required medical staff to have ... to mandate that the .... the practitioners have medical malpractice " (62:45 to 63:2); and

* the patient benefits from the medical malpractice insurance because there is a sum of money that can pay the patient (59:25 to 60:10)
(references to Attachment 28 - Weiss deposition)

There is a sound and valid basis for hospitals to require physicians to maintain professional liability insurance coverage. The hospital experts for both Plaintiffs and Defendants acknowledged that two major medical articles were reliable authorities that related to preventable injuries and deaths of patients in hospitals. (Attachment 28 - Weiss deposition 46:16-20; 46:8-15; Attachment 33 - Hyde deposition 197:2-4; 196:23 to 197:1). The medical articles are "*To Err is Human*" published by the Institute of Medicine (Attachment 11) and "*Adverse Events in Hospitals: National Incidences Among Medicare Beneficiaries*" published by the United States Department of Health and Human Services. (Attachment 12).

The number of preventable deaths in American hospitals each year was estimated by the Institute of Medicine to be between 44,000 and 98,000 – the lower figure exceeded the deaths caused by motor vehicle wrecks and breast cancer. The Institute of Medicine characterized this as "the nation's epidemic of medical errors." The Inspector General's report is even more alarming. The report shows, in part, that an estimated 180,000 Medicare patients die each year from adverse medical events and

that an estimated 13.5% of hospitalized Medicare beneficiaries experienced adverse events during their hospital stay.

These respected studies by the Institute of Medicine and the United States Department of Health and Human Services confirm the wisdom of hospitals adopting bylaws requiring physicians practicing in the hospital to maintain professional liability insurance as a service to the patients.

Plaintiffs submit that this requirement in the hospital bylaws is further evidence to support the position that a reasonable interpretation of the term "services to be rendered" includes the requirement of Laurens County Hospital to ensure compliance by Dr. Brown with the Medical Staff Bylaws and Subsidy Contract. Based on the testimony of the expert witnesses for the parties, Dr. Hyde and Mr. Weiss, the prevailing standard for hospitals in America is to require physicians who practice in the hospital to maintain professional liability insurance.

The Order correctly states that "there is no law in South Carolina that requires doctors to maintain medical malpractice insurance". (Order, page 9). However, the decision of Laurens County Hospital for its medical staff to be responsible for physicians practicing in the hospital to maintain professional liability insurance does not need legislative approval – it is a service to the patients that Laurens County Hospital and, according to Dr. Hyde and Mr. Weiss, the vast majority of hospitals in America have undertaken for the benefit of their patients.

Thus, Plaintiffs submit that a reasonable interpretation of "services to be rendered" would include Laurens County Hospital requiring Dr. Brown to adhere to the

Hospital bylaws, rules, and regulations including maintaining professional liability insurance.

The failure to include the above finding in the Order is error. Such finding would raise a fact question which would preclude the granting of summary judgment.

4) **The Order fails to find that:**
Laurens County Hospital breached the contract with Plaintiffs by failing to require Dr. Brown to comply with Hospital Bylaws and the Subsidy Contract by maintaining valid professional liability insurance coverage.

Dr. Brown failed "to maintain professional liability insurance coverage in compliance with the Medical Staff Bylaws (Attachment 8 - §3.2.1(e) Medical Staff Bylaws) and the Subsidy Contract (Attachment 11 – Article VI Subsidy Contract).

The insurance policy in effect during the one year term beginning July 9, 2008 was a JUA Claims-Made policy with policy number JBC 00041. (Attachment 15). The three claims of medical malpractice against Dr. Brown by Mrs. McCord arising out of her surgeries and the claim of medical malpractice against Dr. Brown by Mrs. Sherfield were covered under the Claims-Made policy during the term from July 9, 2008 to July 9, 2009. (Attachment 4, Attachment 15, Attachment 16).

The JUA policy was not renewed after July 9, 2009. The insurance for year July 9, 2009 to July 9, 2010 was provided by MAG Mutual Insurance Company ("MAG Mutual") which was also a claims-made policy. (Attachment 20 – paragraphs 3 and 4 Affidavit of Brent S. Reece). Thus, in order to maintain coverage for the claims of Mrs. McCord and Mrs. Sherfield, either Extended Reporting Period Endorsement or Prior Acts coverage needed to be obtained. (see Attachment 16). Dr. Brown was given over six months from July 9, 2009 to January 14, 2010 to exercise the option to purchase

Extended Reporting Endorsement from JUA. (Attachment 17). Dr. Brown did not purchase Prior Acts Coverage from MAG Mutual (Attachment 20 – paragraphs 3 and 4 Affidavit of Brent S. Reece).

Laurens County Hospital failed to require Dr. Brown to maintain the professional liability insurance that covered the claims of Mrs. McCord and Mrs. Sherfield. Plaintiffs allege this failure to maintain professional liability insurance was a violation of the Medical Staff Bylaws and the Subsidy Contract.(paragraph 58 Second Amended Complaint). The grounds for this allegation, in part, are that the employee of Laurens County Hospital solely responsible for making sure the physicians had professional liability insurance, namely Lynn Reeves, did not make any effort or attempt to require Dr. Brown to maintain valid professional liability insurance. Mrs. Reeves was not trained or educated concerning medical malpractice insurance policies as partially evidenced by the fact that she:

* did not know what a claims-made policy was;
* did not know what an occurrence policy was; nor
* was she familiar with tail coverage or extended coverage.
(Reeves deposition 15:17-22; 2:11 to 23:8; 37:6-10; 41:7-10)

Mrs. Reeves further testified that "it was not part of my responsibility" to inform patients nor inform any other employee of Laurens County Hospital, including the Credentialing Committee, if she knew that a claim needed to be filed because of a change in insurance. (Reeves deposition 34:7-19)

It is undisputed that professional liability insurance was not maintained on the McCord and Sherfield claims for the remaining time that Dr. Brown had privileges at Laurens County Hospital. (see Attachment 26 – privileges in effect until at least

February 17, 2010). Plaintiffs contend that this is a clear violation of the Medical Staff Bylaws and Subsidy Contract that Laurens County Hospital failed to enforce.

The Order erroneously characterizes this action as a third party action by Plaintiffs. For example, the Order states "At most, Plaintiffs would be incidental beneficiaries of the Medical Staff Bylaws and Subsidy Contract, but that would not give them standing to bring an action to enforce those documents." (Order, page 8). Also, citing Virginia case *Hearse v. Long and Foster Real Estate, Inc.* "noting that no jurisdiction recognizes a theory of liability whereby a third-party to a contract can sue the non-breaching party for failure to enforce the contract." (Order, page 8).

The complaint alleges that Laurens County Hospital breached the contract with the McCords and Sherfields in seven separate particulars for failures of Laurens County Hospital employees. (paragraph 73, Second Amended Complaint). There is no allegation of an action for a third-party claim. Further, it is correct that "at the time of the surgeries on Plaintiffs, Dr. Brown had the required insurance." (Order, page 7). However, the inquiry does not stop there because, as the Order notes "It is undisputed that pursuant to the Hospital Medical Staff Bylaws ("Bylaws"), Dr. Brown had **to maintain** (emphasis added) medical malpractice insurance in order to retain privileges at the Hospital." (Order, page 2). It is also undisputed that during the six months from July 9, 2009 to January 14, 2010 that Dr. Brown was privileged at Laurens County Hospital, he did not "maintain professional liability insurance" covering the claims of Mrs. McCord and Mrs. Sherfield. Further, Laurens County Hospital took no action to require Dr. Brown to comply with the Medical Staff Bylaws or the Subsidy Contract.

Plaintiffs submit that Laurens County Hospital clearly breached the contract with Plaintiffs or, at the very least, a factual issue is presented as to the intentions of the parties in applying the requirement "to maintain professional liability insurance" to the claims of Plaintiffs.

Thus, Plaintiffs submit that failure to find a breach of contract by Laurens County Hospital or to find the existence of a factual issue as to the intentions of the parties was error. Such finding would raise a fact question which would preclude the granting of summary judgment.

5) **The Order fails to find that:**
a special relationship creating a duty of due care arose between Laurens County Hospital and Plaintiffs by Laurens County Hospital providing services for surgeries performed in the hospital and Plaintiffs agreeing to undergo and pay for services rendered by Laurens County Hospital.

Plaintiffs allege that the providing of services by Laurens County Hospital related to surgeries performed by Dr. Brown at Laurens County Hospital had a serious effect on the quality of life and life expectancy of Mrs. McCord and Mrs. Sherfield and created a special relationship between Laurens County Hospital and its patients undergoing surgery. (paragraph 80, Second Amended Complaint).

This is the same relationship that exists between patients and hospitals throughout the United States. The patients elect to undergo surgery that could have serious consequences to their health and life expectancy. The patients elect to use the hospital and pay the hospital fees. The hospital agrees to provide the services to operate the hospital according to state and federal laws and regulations and to protect the patient, in part, by requiring the physicians to comply with the hospital policies and

procedures, medical staff by-laws, and any contracts between the hospital and physicians.

The Patients elected to undergo surgery that could have serious consequences to their health and life expectancy. The hospital provides certain services such as independently determining the scope of practice and types of surgeries each physician can perform in the hospital and protecting the patients by operating the hospital in accordance with state law and regulations. (See paragraphs 13, 41, and 80 of Second Amended Complaint). The patient is virtually putting his life in the hands of the hospital employees. It is difficult to imagine anyone arguing that the relationship between a hospital and a patient is not a special relationship.

The South Carolina Supreme Court issued three significant opinions recognizing that a special relationship creating a duty of due care can arise out of the relationship between two parties.

The South Carolina Supreme Court in *Meddin v. Southern Ry-Carolina Division, et al.*, 62 S.E.2d 109 (SC 1950), quoted with approval the United States Supreme Court, *Atlantic & Pacific R. Co. v. Laird*, 164 US 393 (1896) as follows:

> if the relation of the plaintiff and defendants be such that a duty arises from that relationship, irrespective of contract, to take due care, and the defendants are negligent, then the action is one of tort.
> *Id.* 62 S.E. at 112

Further, the court held that "the negligent and willful failure to perform certain legal duties, not arising out of the particular contract between the plaintiffs and this defendant, but arising out of the relationship created by the contract..." *Id.* 62 S.E.2d at 113.

The South Carolina Supreme Court, in a case presenting a certified question from the Fourth Circuit Court of Appeals, held that a consulting firm owed a duty to the South Carolina State Ports Authority to exercise due care to accurately report objective factual data concerning the Charleston Port if it knew or should have known that the report was to also be used by a competitor. The duty of the tort-feasor arises from the relationship to the injured party. *South Carolina Ports Authority v. Borg-Allen & Hamilton, Inc.*, 346 S.E.2d 324, 325-326.

The court further held that a cause of action is met if the following are proved:

1) the existence of a duty on the part of the defendant to **protect** the plaintiff (because of the special relationship) (emphasis added);
2) the failure of defendant to discharge that duty; and
3) injury to the plaintiff resulting from the defendant's failure to perform.

Id. 436 S.E.2d at 325

The South Carolina Supreme Court issued an opinion in *Tommy L. Griffin Plumbing and Heating Co. v. Jordan, Jones and Goulding, Inc.* 463 S.E.2d 85 (1995) to a novel question in South Carolina – whether design professionals incur tort liability to a contractor for purely economic loss. At the time, a tort action for economic loss was not recognized. However, the South Carolina Supreme Court noted:

> In the last few years, a growing number of states have refused to apply the "economic loss" rule to actions against design professionals when there is a "special relationship" between the design professional and the contractor.
> (*Id.* 463 S.E.2d 87)

Also, the Supreme Court noted:

> applying these concepts (i.e., a special relationship creating a duty of care outside the terms of the contract) to professional liability, we have long held lawyers and accountants liable in tort for malpractice (citations omitted). These professionals owe a duty to the client ... which arises separate and distinct from the contract for services. (citations omitted).

> We see no logical reason to insulate design professionals from liability when the relationship between design professionals and the plaintiff is such that the design professional owes a professional duty to the plaintiff arising separate and distinct from any contractual duties between the parties or with third parties. (citations omitted). Whether such duty exists will depend on the facts and circumstances of each case.
> (*Id.* 463 S.E.2d 89

The Supreme Court in *Meddin v. Southern Ry-Carolina Division, et al.* and *Tommy L. Griffin Plumbing and Heating Co. v. Jordan, Jones and Goulding, Inc.* held that a duty of due care arising from a special relationship existed between the parties. As noted in *Griffin*, "(W)hether such a duty exists will depend on the facts and circumstances of each case." *Tommy L. Griffin Plumbing and Heating Co. v. Jordan, Jones and Goulding, Inc.* 463 S.E.2d at 89. Likewise, the Supreme Court in *Cullum Mechanical Construction, Inc. v. South Carolina Baptist Hospital, et al.*, 463 S.E.2d 838, 842, cited *Griffin* noting "whether the design professional owes a duty depends on the facts and circumstances of each case" and further "(W)e find it is a factual issue whether these circumstances give rise to a special relationship between architect and Cullum." Thus, the existence of the special relationship and the duties that arise from that relationship would be a factual issue. Factual issues are to be determined by the jury and preclude summary judgment.

The Court found "that assuming, without deciding, that there was a special relationship between the parties". This finding, i.e., assuming a special relationship, established a duty of Laurens County Hospital to Plaintiffs. Once a duty has been established, it is further the function of the court to formulate the standard of conduct to which the duty requires the defendant to conform. *J. Doe v. WAL-MART Stores, Inc., et al.*, 711 SE2d 908, 912 (S.C. 2011).

After the standard of conduct has been established, it then becomes the function of the fact finder to determine if the standard of conduct has been breached.

> The fact finder may consider relevant standards of conduct from various sources in determining whether a defendant breached a duty owed in a negligence case. *Madison ex rel. Bryant v. Babcock Center, Inc.*, 638 S.E.2d 650, 659 (S.C. 2006). The standard of care in a given case may be established and defined by the common law, statutes, administrative regulations, industry standards, or a **defendant's own policies and guidelines**. (emphasis added)
> (*id.* 711 S.E.2d at 912)

As noted earlier, the experts for both Plaintiffs and Defendants agree that the prevailing standard is for hospitals to require physicians practicing in the hospital to maintain professional liability insurance. (Attachment 33 – Hyde deposition 25:14-17, 47: 23-25; Attachment 28 – Weiss deposition 58:4-8, 62:45 to 63:2, 59:25 to 60:10). Laurens County Hospital adopted Medical Staff Bylaws that mandate physicians that are granted privileges to maintain professional liability insurance. (Attachment 8 - §3.2.1(e) Medical Staff Bylaws).

Plaintiffs submit that a factual issue exists whether the standard of conduct was breached because Laurens County Hospital did not follow its own "policies and guidelines" to require Dr. Brown to maintain professional liability insurance covering the claims of Plaintiffs.

Plaintiffs further respectfully submit that the Court erred in determining that "the relationship did not create a duty on the part of Laurens to ensure that Dr. Brown had medical malpractice insurance to cover Plaintiffs' claims." The basis for this ruling appears to be that "at the time of the surgeries on Plaintiffs, Dr. Brown had the required insurance." (Order – page 7). However, it is undisputed that the professional liability insurance coverage of Plaintiffs claims was not maintained even though the plain

language of the Medical Staff Bylaws requires that valid professional liability insurance be maintained.

Further, it appears that another basis of the Court's opinion is "there is nothing in the Bylaws or the Subsidy Contract that specifically required Dr. Brown to purchase tail coverage, nor is there any evidence in the record that Laurens considered Dr. Brown to be in violation of the Bylaws or in breach of the Subsidy Contract by his failure to purchase tail coverage." While it is accurate that there is nothing in the Bylaws or the Subsidy Contract that specifically required Dr. Brown to purchase tail coverage, it is also accurate to state that the only way for Dr. Brown to comply with the requirement "to maintain valid professional liability insurance coverage" is to purchase either tail or extended coverage. Plaintiffs submit that the intent to maintain insurance coverage is the primary consideration rather than specific instructions how the intent is to be accomplished. Also, it is accurate to state that there is not any evidence in the record that Laurens County Hospital considered Dr. Brown to be in violation. The reason Laurens County Hospital did not know Dr. Brown was in violation is because the person responsible, Lynn Reeves, was not trained or educated to even know what a claims-made policy or an occurrence policy was. (Attachment 22 - Reeves deposition 15:17-22, 21:11 to 23:8). The failure to know that which should be known is not a valid defense.

Further, it appears that another basis of the Court's opinion is "Plaintiffs contend they are intended beneficiaries of the requirement that Dr. Brown maintain insurance ..." The Plaintiffs do not make such contention nor allege that they are third party beneficiaries; rather, Plaintiffs allege that Defendants breached the contract between

Plaintiffs and Defendants – a first party contract. (paragraph 73 Second Amended Complaint).

Plaintiffs content that the Motion for Summary Judgment should be denied because a factual issue has been established to determine if the standard of conduct has been breached by Laurens County Hospital.

6) **The Order fails to find that:**
Laurens County Hospital failed to exercise due care in monitoring, supervising or requiring Dr. Brown to comply with Hospital Bylaws and the Subsidy Contract by maintaining valid professional liability insurance coverage.

South Carolina law requires that "(E)ach hospital must have a single organized medical staff that has overall responsibility for the quality of medical care provided to the patients." (Attachment 29 – *Section 44-7-269(D) South Carolina Code of Laws*). Additionally, state law requires that the medical staff, with approval of the hospital governing authority, adopt "bylaws, rules and regulations to govern its operation as an organized medical staff." (Attachment 30 – Section 301. Appointment DHEC Regulation).

Laurens County Hospital adopted Medical Staff Bylaws that required Licensed Independent Practitioners, i.e., privileged physicians, "shall maintain valid professional liability insurance coverage in amounts deemed necessary by the Board from time to time" during the time of their "continuing appointment to the Medical Staff." (Attachment 8 – Section 3.2.1(e) Medical Staff Bylaws).

Additionally, Laurens County Hospital, in the Subsidy Contract, required that Dr. Brown must maintain "professional liability insurance in a minimum amount of

$1,000,000 per claims/$3,000,000 aggregate or JUA/PCF coverage. (Attachment 9 – Article VI. Professional Liability Insurance Subsidy Contract).

To perform its functions specified in the state statute, DHEC regulation, and medical staff bylaws Laurens County Hospital was required to monitor and supervise physicians privileged by Laurens County Hospital to maintain the "quality of medical care provided to the patients." (Attachment 29 - *§44-7-260(D) S.C. Code)*

The hospital staff exercised its responsibility to monitor and supervise the quality of medical care being rendered by Dr. Brown during the period July 9, 2009 until after January 14, 2010. It was discovered that Dr. Brown was potentially committing malpractice on numerous occasions during surgeries on patients. The evidence of malpractice during this period is partially demonstrated by the Affidavit of Sandra Thompson, who was Risk Manager of Laurens County Hospital, as follows:

* concerns arose regarding the October 27, 2009 surgery by Dr. Brown on Dixie Mitchell as being malpractice;
* concerns were raised by Rufus Watkins, MD and Dr. Brown himself about Dr. Brown properly performing the surgeries;
* in early December 2009, eleven charts of patients of Dr. Brown were sent for review by Dr. Madis who submitted his report to the hospital;
* Dr. Stribling, the Chief of Surgery of Laurens County Hospital, raised concerns about a surgical complication caused by Dr. Brown that occurred on December 11, 2009;
* Dr. Stribling raised concerns to Dr. Brian Weaver, Chief of Staff, on December 14, 2009 that resulted in Dr. Brown voluntarily relinquishing certain privileges on a temporary basis on December 15, 2009.

(Attachment 23 – Affidavit of Thompson)

The memo dated January 22, 2010 by Dr. R.W. Watkins sets forth that it was common knowledge among all eleven Scrub Techs that Dr. Brown injured numerous patients during surgeries. The memo stated, in part, that:

> There was a general concern that there were an inordinate number of inadvertent injuries to the bladder, bowel, and ureters, especially with the sling procedure. There was (sic) concerns that when performed by this MD the procedure was dangerous and it was stated there were injuries in "almost every case" and that the procedures "caused more harm than good."
>
> (Attachment 24 – Report of R.W. Watkins)

The December 2009 letter from the Chief of Surgery, Dr. Stribling, to the Chief of Staff, Dr. Weaver, sets forth the gravity of concern the medical staff had about the surgical performance of Dr. Brown. Dr. Stribling states "a situation that is of great concern to me. I worry greatly about what appears to be a continuing pattern of surgical misadventures by Dr. Byron Brown. ..... Because of what appears to me to me (sic) a worrisome pattern of complications, I will, as Chief of Surgery, respectfully ask Dr. Brown to temporarily relinquish his privileges to do all pelvic surgery..." (Attachment 25 – Letter from Dr. Stribling).

The next day, Dr. Brown relinquished his privileges at Laurens County Hospital to perform hysterectomies, anterior and posterior repairs, and urethral slings until the beginning of 2010. (Attachment 21 – letter from Dr. Brown resigning certain privileges). Two months later, Dr. Brown voluntarily entered into an agreement with Laurens County Hospital to significantly reduce the gynecological surgeries he was allowed to perform and agreed to take a leave of absence from the hospital staff positions he held. (Attachment 26 – Agreement between Laurens County Hospital and Dr. Brown).

The September 15, 2011 Memorandum of MAG Mutual documents that Dr. Brown self-reported ten separate claims (two for Mitchell for separate surgeries) against his insurance policy. (Attachment 27 – Memo of MAG Mutual).

The foregoing is substantial evidence that officials at Laurens County Hospital knew that Dr. Brown was causing serious injuries to patients during surgeries at Laurens County Hospital. The injuries were discovered during the time period from July 9, 2009 to January 14, 2010.

Thus, Laurens County Hospital had knowledge of numerous potential claims of malpractice by Dr. Brown for surgeries performed at Laurens County Hospital. Plaintiffs allege that Laurens County Hospital failed to exercise due care to require Dr. Brown to maintain valid professional liability insurance either by obtaining Extended Reporting Coverage or Prior Acts coverage knowing that numerous patients of Dr. Brown were victims of his malpractice. (paragraphs 81, 82, 83 Second Amended Complaint).

A factual issue has been presented to determine if Laurens County Hospital failed to exercise due care in monitoring, supervising, or requiring Dr. Brown to maintain valid professional liability insurance. This factual issue precludes summary judgment.

CONCLUSION

Plaintiffs respectfully request that the Court alter or amend its Order and deny the Motion for Summary Judgment.

Respectfully submitted,

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ATTORNEYS FOR THE PLAINTIFFS

March 7, 2017
Anderson, South Carolina

STATE OF SOUTH CAROLINA	)	IN THE COURT OF COMMON PLEAS
	)	
COUNTY OF LAURENS	)	C.A. FILE NO. 14-CP-30-250
Chris Katina McCord, Christopher McCord, Janice Sherfield, and Jerry Sherfield,	)	
Plaintiffs,	)	CERTIFICATE OF SERVICE
vs.	)	
Laurens County Health Care System and Greenville Healthcare System,	)	
Defendants.	)	

LAURENS COUNTY
CLERK OF COURT
2017 MAR -9 A 8:22
LYNN W. LANCASTER

I, Terry D. Allen, am an employee with the law firm of McGowan, Hood & Felder, LLC, attorneys for the Plaintiff. I do hereby certify that I have served all counsel in this action with a copy of the documents herein specified by mailing a copy of the same by U.S. Postal Service with first class postage paid as follows:

PLEADINGS: Plaintiffs' Rule 59(e) Motion to Alter or Amend Judgment and Memorandum in Support of Plaintiffs' Rule 59(e) Motion to Alter or Amend Judgment

COUNSEL SERVED:

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DATE OF MAILING: March 7, 2017

McGowan, Hood & Felder, LLC

Terry D. Allen, Paralegal

March 7, 2017

STATE OF SOUTH CAROLINA COUNTY OF LAURENS Chris Katina McCord, Christopher McCord, Janice Sherfield, and Jerry Sherfield, Plaintiffs, v. Laurens County Health Care System and Greenville Health System, Defendants.	IN THE COURT OF COMMON PLEAS C.A. No.: 2014-CP-30-250 ***DEFENDANTS' MEMORANDUM IN OPPOSITION TO PLAINTIFFS' MOTION TO ALTER OR AMEND JUDGMENT***

In response to the Court's February 28, 2017 Order granting summary judgment on behalf of Defendants, Plaintiffs have filed a motion to alter or amend the judgment. Much of Plaintiffs memorandum is focused on the same arguments they put forth in their original memorandums in opposition to summary judgment. Defendants do not feel it necessary to address those arguments again as the Court has already fully considered them and should deny Plaintiffs' motion to alter or amend for the same well thought out reasons that are set forth in the Order.

However, now in their instant motion, Plaintiffs also appear to be changing their position or attempting to set forth a few new arguments that Defendants feel compelled to address. As an initial matter, Plaintiffs' attempt to introduce new evidence into the record and/or make new arguments is inappropriate as it is well established that a party cannot use a motion to alter or amend to present an issue to the court that the party could have raised prior to judgment but did not. *Gartside v. Gartside*, 383 S.C. 35, 677 S.E.2d 621 (Ct. App. 2009). Regardless, for the reasons set forth below, Plaintiffs' new arguments should not have any impact on the Court's prior decision to grant summary judgment for Defendants.

1. Plaintiffs Change Their Damages Claim

Plaintiffs begin by arguing that, contrary to the Court's finding, they are not seeking to hold Defendants liable for the default judgments they obtained against Dr. Brown. (Pl. Mem. pp. 2-3.) In so doing, Plaintiffs allege that they are merely attempting to recover the amount of insurance coverage they contend should have been available for each of their claims. While Defendants appreciate that Plaintiffs now admit their alleged damages are not equal to the default judgments, this is the first time they have admitted as much. In fact, in their Seconded Amended Complaint, which was filed after the motion for summary judgment hearing, they continued to allege damages equal to the default judgments they received against Dr. Brown. (See Sec. Am. Compl. pp. 22-23.) Regardless, Plaintiffs' new position on their alleged damages is still erroneous.

As an initial matter, it is unclear how many claims Plaintiffs believe Mrs. McCord was entitled to make[1], but it is clear from the JUA policy in effect at the time that her three surgeries would have been treated as one claim subject to a single $1,000,000 limit. (See JUA Policy pp. 7 and 12, attached hereto as Exhibit A.) Therefore, at most, there would have been a total of $1,000,000 in coverage for both the McCords and the Sherfields.

However, as Defendants previously noted in their Reply Memorandum in Support of Summary Judgment, it is purely speculative to say that, even if there had been coverage, Plaintiffs would have definitely been able to recover. Dr. Brown's policy had a $3,000,000 annual aggregate, and it is certainly a possibility that, in light of the other claims which were made against Dr. Brown in 2009, there may have been very little or no coverage left by the time

[1] In footnote 1 on page 3 of Plaintiffs' memorandum, Plaintiffs initially state that Mrs. McCord would have a claim for each of her three surgeries; however, later in the same footnote they state that she would be entitled to recover on two claims. On page 12 of the Memorandum, they again allege that she would have three claims of medical malpractice.

McCord and Sherfield made their claims. In addition, the testimony from Plaintiffs' insurance expert confirmed that Dr. Brown's move out of the country and subsequent refusal to participate in the defense of the case could have provided grounds for his carrier to deny coverage for the claims altogether. (See Dep. Of James M. Carson, Ph.D., July 7, 2016, pp. 18-19, attached as Exhibit A to Defendants' Reply Mem. in Supp. of Sum. Judg.)

2. Plaintiffs' Subjective Interpretation of the Contracts is Irrelevant

Next Plaintiffs argue that the Court erred in finding the contracts between Plaintiffs and Defendants unambiguous. In so doing, Plaintiffs filed and submitted for the Court's review their entire deposition transcripts. As previously noted, Plaintiffs cannot make new arguments or introduce new evidence into the record on a motion to alter or amend. *Gartside*, *supra*. However, even if considered by the Court, Plaintiffs' deposition testimony does not create a genuine issue of material fact or establish any ambiguity in the Conditions of Admission forms.

Plaintiffs argue that it was their intent and understanding that "services to be rendered" by the hospital included the hospital ensuring that Dr. Brown complied with the Medial Staff Bylaws as well as the Subsidy Contract he had with the hospital. (Pl. Mem. p. 6) However, Mrs. McCord testified that she had never seen the Medical Staff Bylaws or had any knowledge of what they said. (McCord dep. p. 81:2-22.) She also stated that she didn't know anything about the Subsidy Contract between Dr. Brown and Laurens prior to the instant lawsuit. (McCord dep. p. 73:18-21.) Mrs. Sherfield also stated that she had no idea what was in the Bylaws or Subsidy Contract. (Sherfield dep. p. 70:11-22.)

Plaintiffs also contend that Mrs. Sherfield knew at the time she executed the Conditions of Admission form that Laurens required doctors privileged there to have insurance. (Pl. Mem. pp. 6-7.) That is a mischaracterization of what Mrs. Sherfield testified to. While she initially

stated that she knew about the insurance requirement, Mrs. Sherfield later confirmed that her belief there was a requirement was not based on any knowledge she had of the hospital Bylaws or the Subsidy Contract, but rather her erroneous belief, based upon what her aunt had told her, that there was a law in South Carolina that required physicians to maintain medical malpractice insurance. (Sherfield dep. pp. 71:10 – 72:13.) Mrs. Sherfield's erroneous belief based upon what her aunt told is insufficient to create a genuine issue of material fact. *See Yarborough and Co. v. Schoolfield Furniture Industries, Inc.*, 275 S.C. 151, 268 S.E.2d 42 (1980) (excluding affidavits based almost entirely on hearsay); James F. Flanagan, South Carolina Civil Procedure (second edition), at p. 450 ("dispute of fact must be established by evidence that would be admissible at trial")

Regardless, Plaintiffs' current subjective interpretation of the unambiguous language of the Conditions of Admission form does not matter. The law in South Carolina is well settled that one party's subjective interpretation of a contract is irrelevant when a court is constructing the contract's terms. M & M Group, Inc. v. Holmes, 379 S.C. 468, 476-77, 666 S.E.2d 262, 266 (Ct. App. 2008) (stating "[p]arties are governed by their outward expressions and the court is not free to consider their secret intentions"); Silver v. Abstract Pools & Spas, Inc., 376 S.C. 585, 593, 658 S.E.2d 539, 543 (Ct. App. 2008) (party to contract "is not permitted to reinterpret written contract terms midstream because he is unhappy with the contract he executed"); Ecclesiastes Prod. Ministries v. Outparcel Assocs., 374 S.C. 483, 498, 649 S.E.2d 494, 501 (Ct. App. 2007) ("Parties [to a contract] are governed by their outward expressions and the court is not at liberty to consider their secret intentions."); Bannon v. Knauss, 282 S.C. 589, 593, 320 S.E.2d 470, 472 (Ct. App. 1984) ("Interpretation of the contract is governed by the objective manifestation of the parties' assent at the time the contract was made. It does not depend on the subjective, after the

fact meaning one party assigns to it.") (internal citation omitted).

Plaintiffs have admitted they did not discuss the "services to be rendered" language with anyone at the hospital prior to their surgeries. (McCord Dep. p. 107:12-15, Sherfield Dep. p. 47:14-20.) They did not discuss whether Dr. Brown had medical malpractice insurance with anyone at the hospital. (McCord Dep. p. 58:15-25, Sherfield Dep. p. 58:9-17.) There is simply no evidence that, at the time the parties entered into the contract, either party outwardly expressed an intention that "services to be rendered" would include anything regarding Dr. Brown's insurance. To the contrary, the Conditions of Admission form expressed in clear and unambiguous language that the hospital was not responsible for any acts or admissions of Dr. Brown.

Apparently, in addition to the Conditions of Admission form, Plaintiffs also wish to impose their subjective beliefs on contracts they were not parties to and did not know anything about prior to this lawsuit. Plaintiffs argue that Dr. Brown was required by the Bylaws and the Subsidy Contract to "maintain" medical malpractice insurance. While Plaintiffs admit that Dr. Brown had insurance at all times while he was privileged at Laurens, they contend that he failed to "maintain" insurance when he failed to purchase tail coverage to cover their claims; however, there is nothing in the Bylaws or the Subsidy Contract that required Dr. Brown to purchase tail coverage or have coverage for every possible claim that could be made against him. And as Defendants have previously noted, there is nothing in the record which suggests that Laurens considered Dr. Brown to have been non-compliant with the insurance requirement in either the Bylaws or the Subsidy Contract. Plaintiffs' alleged subjective beliefs to the contrary are irrelevant.

3. Plaintiffs are not Third-Party Beneficiaries

Curiously, Plaintiffs conclude their breach of contract argument by disputing the Court's characterization of their claims as attempts to make third-party claims. (Pl. Mem. pp. 14-15.) Defendants fail to understand how Plaintiffs can argue on the one hand that Defendants owed them a duty to enforce the insurance requirements of the Bylaws and the Subsidy Contract, while on the other hand disputing the characterization of their claims as third-party claims. Nevertheless, Defendants are not going to argue with Plaintiffs. Since they now admit they were not third-party beneficiaries (Pl. Mem. p. 20), there is absolutely no basis for their argument that Defendants owed them a duty to enforce the insurance requirements of either the Bylaws or the Subsidy Contract.

4. "Special Relationship" did not Create Duty to Ensure Dr. Brown Purchased Tail Coverage

Finally, Plaintiffs argue the Court erred in not finding a duty arose due to the "special relationship" between the parties. It is difficult to follow Plaintiffs' argument, but it appears that Plaintiffs are contending that their status as a patient of the hospital created a duty on the part of Defendants to ensure that Dr. Brown had insurance for their claims. In so doing, Plaintiffs, as they have done previously, misstate the law in an attempt to create a question of fact. Plaintiffs contend there is a question of fact as to whether or not Defendants exercised due care in ensuring that Dr. Brown adhered to the insurance requirements of the Bylaws and the Subsidy Contract; however, Plaintiffs are skipping a step. Before questions about whether Defendants exercised due care fulfilling a particular duty can be asked, the Court must first decide whether that specific duty even existed.

Defendants would certainly admit that there are duties owed to patients outside of the contractual duties created by the Conditions of Admissions form. Medical malpractice actions

typically involve such duties. However, the question is not whether Defendants owed Plaintiffs any duty; the question is whether Defendants owed Plaintiffs a particular duty, and despite what Plaintiffs may contend, that is a legal question, not a factual question. While the court may consider several factors, including statutes, regulations, contractual relationships, status, property interests, or other special circumstances, it is for the court and the court alone to determine whether the law recognizes a particular duty. *Madison v. Babcock Ctr., Inc.*, 371 S.C. 123, 136, 638 S.E.2d 650, 656 (2007); *see also Doe ex rel. Doe v. Wal-Mart Stores, Inc.*, 393 S.C. 240, 246, 711 S.E.2d 908, 911 (2011). If there is no duty, then the defendant is entitled to summary judgment as a matter of law. *Id.* In this case, the Court has correctly found that the law does not recognize the particular duty Plaintiffs seek to impose upon Defendants, and thus summary judgment is appropriate.

In addition, Plaintiffs rely on several cases in support of their "special relationship" argument that are distinguishable from the instant case. In *South Carolina Ports Authority*, the Court held that a duty of care ran from a consultant to the commercial competitor the consultant was hired to critique when the consultant undertook to objectively analyze and compare the attributes of the commercial competitors for the purpose of giving one a market advantage over the other. 289 S.C. at 376-77. In *Tommy L. Griffin Plumbing & Heating Co.*, the Court held the economic loss rule and lack of privity did not prevent a contractor from maintaining a tort action against a design engineer. 320 S.C. 49. In both cases, the Court held the defendants owed a duty to the plaintiffs to perform their contractual duties owed to a third party with due care. That is not what Plaintiff is arguing should be done in this case. Rather, Plaintiffs are seeking to have Defendants held liable for Dr. Brown's failure to exercise due care in performing his contractual duty to maintain insurance.

Ultimately, it appears Plaintiffs are arguing that due to the "special relationship" Defendants had a duty to protect them from Dr. Brown's acts or omissions. Plaintiffs rely on *Doe ex. rel. Doe v. Wal-Mart Stores, Inc.*, but that case provides an exception for the general rule that one does not owe a duty to control the conduct of another or to warn a third person or potential victim of physical danger. Here, Plaintiffs are not contending that Defendants should have prevented Dr. Brown from physically harming them, but rather Defendants should have prevented Dr. Brown from causing them financial harm. Further, *Doe* held that a "defendant may have a common law duty to warn potential victims under the "special relationship" exception when the defendant has the ability to monitor, supervise, and control an individual's conduct and when the individual has made a specific threat of harm directed at a specific individual." 393 S.C. at 247 (internal citations omitted) (emphasis added). As an initial matter, as correctly noted in the Order, Defendants did not have the ability to force Dr. Brown to purchase tail coverage, so the required control element is missing. And in addition, there is not any evidence that Laurens knew of any specific threat on the part of Dr. Brown to harm Plaintiffs.

Finally, Plaintiffs' entire theory that Defendants owed them a duty to ensure that Dr. Brown had insurance coverage for their claims runs counter to both the terms and conditions of the Conditions of Admission form and the Tort Claims Act. From a contractual perspective, the undisputed evidence in the record shows Plaintiffs were put on notice that the hospital was not responsible for the acts or omissions of Dr. Brown. And from a tort perspective, the Tort Claims Act clearly holds that a governmental entity cannot be held liable for the acts or omissions of an independent contractor. Plaintiffs were allegedly injured both physically and financially by Dr. Brown's acts and omissions. To the extent they seek to recover for those injuries, they must look to Dr. Brown, and Dr. Brown alone.

Despite Plaintiffs' attempts to confuse the issues and create questions of fact, the sole legal question before the Court was fairly simple - did Defendants owe a legal duty to Plaintiffs to ensure that Dr. Brown had insurance coverage for their claims at the time those claims were made? For the reasons stated in the Order, as well as those reasons set forth in Defendants' memorandums in support of summary judgment that the Court considered but elected not to rule on, the Court properly decided that no such duty existed; therefore, the Court should deny Plaintiffs' instant motion and reaffirm its Order granting summary judgment on behalf of Defendants.

HAYNSWORTH SINKLER BOYD, P.A.

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Dated: 3/21/17
Greenville, SC

STATE OF SOUTH CAROLINA COUNTY OF LAURENS Chris Katina McCord, Christopher McCord, Janice Sherfield, and Jerry Sherfield, Plaintiffs, v. Laurens County Health Care System and Greenville Health System, Defendants.	IN THE COURT OF COMMON PLEAS C.A. No.: 2014-CP-30-250 ***Certificate of Service***

I HEREBY CERTIFY that a copy of **Defendants' Memorandum in Opposition to Plaintiffs' Motion to Alter or Amend** was served upon counsel of record, Joseph G. Wright, by email and by mailing a copy via the U.S. Postal Service on March 21, 2017.

HAYNSWORTH SINKLER BOYD, P.A.

Kenneth N. Shaw

Greenville, SC

EXHIBIT A

PROFESSIONAL LIABILITY POLICY

South Carolina Medical Malpractice Liability Insurance

Joint Underwriting Association

Policy Declarations

ASSESSABLE

CLAIMS MADE

Rewrite of: JBM00560 **Policy Number: JBC00041**

Item 1. Named Insured and Business Address:

Byron A Brown
700 Plaza Circle Suite N
Clinton, SC 29325

AGENCY
Joe H. Kirby
Attn: Broker
918 West Main Street
Laurens, SC 29360-2645

Item 2. Policy Period: (Mo. Day Yr.)

From 7/9/2008 To 7/9/2009
12:01 A.M., standard time at the address of the named insured as stated herein.

Item 3. The limit of the Association's liability shall be as stated herein, subject to all of the terms of this policy having reference hereto.

Coverage	Limits of Liability	Premium
PROFESSIONAL LIABILITY	$200,000 EACH CLAIM	$14,004.00
CLAIMS MADE	$600,000 ANNUAL AGGREGATE	
PRIOR ACTS DATE: 07/09/2008		
Employees as Additional Insureds:	**Included**	

Obstetrics - Gynecology

The following listed forms / endorsements are issued as part of this policy and are incorporated therein.

Forms / Endorsement Schedule:

SC JUA PL-200 (Ed. 10/06)
JUA PD-101A (Ed. 11/05)

COUNTERSIGNATURE DATE:	AUTHORIZED REPRESENTATIVE:	DATE ISSUED: 8/4/2008

SCJUA PD-200 (Ed. 10/06) JUA Copy

IV. LIMITS OF LIABILITY

The limit of liability stated in the **declarations** as applicable to each "**claim**" is the limit of the **Association's** liability for loss resulting from any **medical incident** causing injury or death, regardless of the number of:

1) Persons injured,
2) **Claims** made,
3) Claimants, or
4) Subsequent related or derivative **claims**.

The limit of liability stated in the **declarations** as "annual aggregate" is the total limit of the **Association's** liability during the policy period.

V. CONDITIONS

A. Insured's Duties

1. The **insured** has a duty to notify the **Association** in writing within 30 days if the **insured's** medical practice changes so that the **Association** can determine the **insured's** risk classification and what premium is owed to the **Association**. The **Association** will calculate the premium for **insured's** risk classification for this policy using the information available at the time. If the information is incomplete or incorrect, the **Association** will have the right to recalculate the **insured's** premium. The **Association** has the right to adjust premiums at any time based on rates and rating plans in effect at the time.

2. Upon the **insured** becoming aware of any **medical incident** or alleged injury, written notice containing the fullest information obtainable with respect to the circumstances, time and place thereof, and the names and addresses of the injured person and of available witnesses shall be given by or for the **insured** to the **Association** or any of its authorized agents as soon as practicable. The **insured** shall promptly take at their expense all reasonable steps to prevent other injury from arising out of the same or similar conditions, but such expense shall not be recoverable under this Policy.

3. If **claim** is made or suit is brought against the insured, the **insured** shall immediately forward to the **Association** every demand, notice, summons, complaint or other legal documents received by him or his representative.

4. The **insured** shall cooperate with the **Association** and, upon the **Association's** request, assist in making settlements, in the defense of suits and in enforcing any right of contribution or right of indemnity against any person or organization who may be liable to the **insured** because of bodily injury with respect to which insurance is afforded under this policy. The **insured** shall do nothing after loss to prejudice or impair such rights, and shall attend depositions, hearings, and trials and assist in securing and giving evidence and obtaining the attendance of witnesses.

5. The **insured** shall in no way alter any medical record after a **medical incident** has occurred. An addendum to the original record by the **insured** which is signed and dated shall not be considered an alteration.

1) fully and permanently retired from the practice of medicine; and
2) been continuously insured with the association for at least five years immediately preceding your retirement; and
3) attained the age of 55; and
4) met your premium payment(s) obligation;
5) for those meeting requirements (1), (3) and (4) above, but not (2), a 20% credit will be applied to the **extended reporting period** endorsement premium for each full year you have been continuously insured with us immediately preceding your retirement.

In order to this retirement benefit for the **extended reporting period** endorsement, acceptable proof of your retirement must be sent to the **association** in writing promptly following your retirement.

VII. DEFINITIONS

Unless otherwise stated in a respective coverage part or endorsement, where any of the following terms are found in **bold** print within this policy, they will have only the meaning shown below:

A. **Automobile** means a land vehicle, self-propelled or not, a trailer, or a semi-trailer. This includes any machinery or apparatus attached, whether or not subject to motor vehicles registration or designed for use principally on public roads.

B. **Bodily injury** means bodily harm, sickness, or disease, including death resulting therefrom.

C. **Claim(s)** means a demand for money damages. Administrative proceedings (including, but not limited to, disciplinary matters) and criminal proceedings are not claims.

D. **Declarations** means the Declarations Page issued by the **Association** to the **insured**, which lists the applicable coverages and coverage amounts.

E. **Medical Incident** means any act, error, or omission in your providing or failure to provide professional medical services.

Any such act, error or omission, together with all related or concurrent acts, errors or omissions in the furnishing of such services to any one person shall be considered one medical incident, regardless of the length of time or number of contacts such person may have with the insured.

F. **Personal or advertising injury** means injury arising out of one or more of the following offenses:

- false arrest, detention or imprisonment;
- malicious prosecution;
- the wrongful eviction from, wrongful entry into, or invasion of the right of private occupancy of a room, dwelling or premises that a person occupies, by or on behalf of its owner, landlord or lessor;
- oral or written publication of material that slanders or libels a person or organization or disparages a person's or organization's goods, products or services; or
- oral or written publication of material that violates a person's right of privacy.

STATE OF SOUTH CAROLINA COUNTY OF LAURENS Chris Katina McCord, Christopher McCord, Janice Sherfield, and Jerry Sherfield, Plaintiffs, v. Laurens County Health Care System and Greenville Health System, Defendants.	IN THE COURT OF COMMON PLEAS C.A. No.: 2014-CP-30-250 ***Defendants' Motion for Summary Judgment***

PLEASE TAKE NOTICE that pursuant to Rule 56 of the South Carolina Rules of Civil Procedure, Defendants Laurens County Health Care System ("Laurens") and Greenville Health System ("GHS") hereby move the Court for an order granting summary judgment in their favor. Defendants are entitled to summary judgment as a matter of law because under the laws of South Carolina and the facts of this case, Defendants owed no duty to Plaintiffs to ensure that Plaintiffs' physician, who had privileges to perform surgery at Defendants' hospital but was not employed by Defendants, had medical malpractice liability insurance coverage for their claims against him.

Background

While Plaintiffs' Complaint contains numerous allegations, the crux of their claim is they believe that Laurens and/or GHS[1] should be liable for the default judgments they obtained

[1] There are no allegations that GHS is independently liable to Plaintiffs. GHS is named as a defendant solely upon the basis that Plaintiffs allege that subsequent to the acts giving rise to the causes of action, Laurens entered into an agreement of consolidation or merger with GHS. Compl. ¶ 3. Though they don't directly allege it, presumably, Plaintiffs believe that as part of that agreement, GHS may have assumed responsibility for Laurens's pre-existing liabilities.

against Dr. Byron Brown and his OB/GYN practice.[2] Plaintiffs have been unable to collect on those judgments, because Dr. Brown no longer resides in the country and his medical malpractice carrier denied coverage on the basis that the claims were not timely made. While Plaintiffs' situation is unfortunate, they are unjustified in their attempts to recover from Laurens, because Laurens was, as a matter of law, not responsible for the acts or omissions of Dr. Brown and Laurens certainly was not Dr. Brown's insurer.

Facts

This case arises out of surgeries that were performed on Plaintiffs Chris Katina McCord and Janice Sherfield at Laurens County Hospital ("Hospital") from December 2008 to May 2009 by Dr. Byron Brown. It is undisputed that at the time of the surgeries, Dr. Brown had surgical privileges at the Hospital, but he was not employed by the Hospital.[3] Dr. Brown had his own practice with an office located offsite from the Hospital. It is undisputed that pursuant to the Hospital Medical Staff Bylaws ("Bylaws"), Dr. Brown had to maintain medical malpractice insurance in order to retain privileges at the Hospital (relevant portions of the Bylaws are attached hereto as Exhibit B). And, it is undisputed that at the time of the surgeries, he was in compliance with the Bylaws, as Dr. Brown had a claims-made medical malpractice liability insurance policy through Joint Underwriting Association ("JUA") with coverage limits of $200,000 per claim and $600,000 annual aggregate. In addition, Dr. Brown had excess coverage through Patients' Compensation Fund, which pushed his total coverage up to $1,000,000 per

[2] See C.A. No. 11-CP-30-1141 (McCord), and C.A. No. 12-CP-30-753 (Sherfield). Orders were entered for both cases on March 11, 2014. Neither Laurens nor GHS were parties to either case.

[3] There was a February 14, 2002 Agreement between Dr. Brown and Laurens whereby Laurens agreed to subsidize Dr. Brown's practice for three years (hereinafter "Subsidy Contract, attached hereto as Exhibit A), because the Hospital felt there were an insufficient number of OB/GYN physicians in the area. However, the Subsidy Contract made clear that Dr. Brown was an independent contractor who was free to admit patients at any hospital and maintain privileges to perform surgeries at any hospital.

claim and $3,000,000 annual aggregate.

A few months after the surgeries on Mrs. McCord and Mrs. Sherfield, in July, 2009, Dr. Brown decided to switch his medical malpractice insurance from JUA to MAG Mutual. He bought a claims-made policy from MAG Mutual, which covered claims arising on or after July 9, 2009. When he made the change he declined to purchase either "tail" or "prior bad acts" coverage, which meant there would be no coverage for previously unreported claims that occurred prior to July 9, 2009. As a result, since neither Mrs. McCord nor Mrs. Sherfield put Dr. Brown, or anyone else, on notice that they planned to file a claim against him until well after July 9, 2009, there was no insurance coverage for either of their claims.

Following their surgeries, both Mrs. McCord and Mrs. Sherfield continued to experience incontinence issues and both had to seek additional medical care in an attempt to resolve those issues. As a result, they both decided to pursue legal actions against Dr. Brown. They both retained Joseph G. Wright, III of McGowan, Hood & Felder, LLC as their counsel. Mrs. McCord had retained Mr. Wright by July, 2010, while Mrs. Sherfield retained him in May 2011. A Notice of Intent ("NOI") was filed on behalf of Mrs. McCord on July 29, 2011. The NOI mediation took place on December 1, 2011. It is admitted that as of that mediation, Mr. Wright was aware of the possibility that Dr. Brown did not have medical malpractice insurance coverage for the claims being brought by both the McCords and Sherfields.

Despite knowledge of the fact that Dr. Brown lacked insurance coverage for their claims, the McCords and Sherfields continued their legal actions against him. The McCords filed their Complaint against Dr. Brown and his practice on December 9, 2011. They did not name Laurens as a defendant in that action or assert any allegations against Laurens. The Sherfields filed their Complaint against Dr. Brown and his practice on September 25, 2012. Like the McCords, they

did not name Laurens or assert any allegations against Laurens.

While those actions were pending, Dr. Brown moved out of the country and refused to continue participating in the defense of the actions. As a result, both the McCords and Sherfields were ultimately able to obtain default judgments against Dr. Brown and his practice. (See C.A. No. 11-CP-30-1141, March 11, 2014 Judgment in the amount of $1,480,457 for Chris Katina McCord and $50,000 for Christopher McCord and C.A. No. 12-CP-30-753, March 11, 2014 Judgment in the amount of $1,468,580 for Janice Sherfield and $50,000 for Jerry Sherfield.) Shortly thereafter on March 26, 2014, Plaintiffs filed the instant action.

Summary Judgment Standard

Summary judgment is appropriate when it is clear that there is no genuine issue of material fact and the conclusions and inferences to be drawn from the facts are undisputed. Calvert v. House Beautiful Paint and Decorating Ctr., Inc., 313 S.C. 494, 443 S.E.2d 398 (1994). "The purpose of summary judgment is to expedite the disposition of cases which do not require the services of a fact finder." Dawkins v. Fields, 354 S.C. 58, 69, 580 S.E.2d 433, 438 (2003) (quoting George v. Fabri, 345 S.C. 440, 452, 548 S.E.2d 868, 874 (2001)). When a plaintiff cannot establish facts to meet all the elements of the cause of action, summary judgment is appropriate. Bessinger v. Bi-Lo, Inc., 329 S.C. 617, 496 S.E.2d 33 (Ct. App. 1997); Hunter v. Dixie Home Stores, 101 S.E.2d 262, 232 S.C. 139 (1957). A party may not rely upon an issue of fact that is not genuine or an inference which is not reasonable to rebut a motion for summary judgment. Main v. Corley, 281 S.C. 525, 316 S.E.2d 406 (1984).

In order to prevail on either of their causes of action, Plaintiffs must establish that Defendants breached a legal duty owed to them. "A legal duty is that which the law requires to be done or forborne with respect to a particular individual or the public at large." Byerly v.

Connor, 301 S.C. 441, 443 415 S.E.2d 796, 798 (1992). A legal duty may be created by statute, a contractual relationship, status, property interest, or some other special circumstance. Madison v. Babcock Ctr., Inc., 371 S.C. 123, 136, 638 S.E.2d 650, 656 (2007). The court must determine, as a matter of law, whether the law recognizes a particular duty. Id. If there is no duty, then the defendant is entitled to summary judgment as a matter of law. Id.

Legal Analysis

I. No Contractual Duty Owed

Plaintiffs' first cause of action is breach of contract; however they cannot point to a single document wherein Laurens directly promised them that it would ensure that Dr. Brown would have medical malpractice insurance coverage for their claims against him. In ruling on a motion for summary judgment, it is the court's duty to interpret and enforce the contract the parties actually made for themselves and the court cannot, under the guise of interpretation, create a better or different contract than the one the parties actually made. See Sphere Drake Ins. Co. v. Litchfield, 313 S.C. 471, 438 S.E.2d 275, 277 (Ct. App. 1993) (court "is limited to interpretation of the contract made by the parties" and "is without authority to alter a contract by construction or to make a new contract for the parties"); Chan v. Thompson, 302 S.C. 285, 395 S.E.2d 731, 734 (Ct. App. 1990) ("The rights of the parties must be measured by the contract which the parties themselves made, regardless of its wisdom, reasonableness, or failure of the parties to guard their rights carefully") (citations omitted). If the contract is unambiguous, it must be construed according to the terms the parties have used, and the terms are to be interpreted in their plain, ordinary, and popular sense. Litchfield, supra.

Here Plaintiffs are seeking to read into a contract terms and conditions that simply are not there. The document that Plaintiffs contend forms the basis of their breach of contract claim is the Conditions of Admission form which they executed prior to each of their surgeries (copies of

each of applicable Conditions of Admission forms are attached hereto as Exhibit C, hereinafter "the Contract"). Specifically, Plaintiffs point to the first sentence of the paragraph titled "Financial Agreement" which states,

> "The undersigned agrees he signs as agent or as patient that in consideration of the services to be rendered to that patient, he hereby individually obligates himself to pay the account of the hospital, in accordance with the regular rates and terms of the hospital."

Plaintiffs contend that sentence somehow created a duty on the part of the Hospital to ensure that Dr. Brown had medical malpractice insurance coverage for their claims against him; however, such an interpretation is completely unreasonable.

First, taking the terms in their plain, ordinary and popular sense, the purpose of the sentence is unambiguous. It simply obligates patients to pay the bills they receive for the services rendered to them by the Hospital. "Services to be rendered," in the context of that paragraph, simply refers to those services that the Hospital actually provides and bills for, such as room charges, medications, and meals. The Hospital has never billed a patient for ensuring that an independent physician had medical malpractice insurance coverage, and it didn't bill Plaintiffs for any such "service" in this case; therefore, that could not reasonably be considered a "service to be rendered."

Plaintiffs contend that the "services to be rendered" include: compliance with state and federal laws and regulations; compliance with the Bylaws, and; compliance with the contracts between the Hospital and privileged physicians. However, those things aren't actually services rendered by the Hospital. At most, they go toward the standard of care for how services should be rendered by the Hospital. In essence, Plaintiffs seem to be contending that the Contract implies that services will be rendered in a certain manner; however, South Carolina does not recognize a cause of action for breach of an implied contract in the context of medical treatment.

Banks v. Medical Univ., 314 S.C. 376, 444 S.E.2d 519 (1994).

Second, Plaintiffs' interpretation is unreasonable, because it requires one to ignore the plain and unambiguous language contained in other parts of the Contract. The paragraph entitled "Medical and Surgical Consent" states,

> The patient's care is under the direction of the attending physicians and the hospital is not responsible for any act or omission of the physicians.... The undersigned recognizes that most medical staff members furnishing services to the patient, including the radiologists, pathologist, anesthesiologists, and the like (are) independent contractors and not employees of the hospital.

That paragraph made it very clear to Plaintiffs that the Hospital was not responsible for any acts or omissions of Dr. Brown. To the extent that Dr. Brown's failure to purchase tail coverage could be construed as a violation of the Bylaws, it would be his violation of the Bylaws, not the Hospitals'. Plaintiffs cannot reasonably argue that the Hospital promised to ensure that Dr. Brown maintained medical malpractice insurance when the Hospital clearly stated that it was not responsible for anything Dr. Brown did or failed to do.

II. No Other Basis for a Duty Owed

Plaintiffs' second cause of action is negligence; however their claim appears to be based upon the same duty alleged in their breach of contract claim. *See* Compl. ¶¶ 66-67. To the extent Plaintiffs are alleging the duty arose under contract, their claims must be redressed under the terms of the contract, and a tort action will not lie. *See Tommy L. Griffin Plumbing & Heating Co. v. Jordan, Jones, & Goulding, Inc.*, 320 S.C. 49, 54-55, 463 S.E.2d 85, 88 (1995).

To the extent Plaintiffs are arguing negligence as an alternative to breach of contract on the realization that there actually was no contractual duty, the claim fails because there is no legal authority in South Carolina which suggests that a hospital owes a duty to its patients to ensure that a doctor maintain medical malpractice insurance. There is no such duty because it

would be completely unreasonable to impose such a duty, especially given the fact that there is no legal requirement in South Carolina that a doctor maintain medical malpractice insurance to begin with. *See Huggins v. Citibank*, 355 S.C. 329, 333, 585 S.E.2d 275, 277 (2003) ("The concept of duty in tort liability will not be extended beyond reasonable limits.") Further, even if there were such a duty, Plaintiffs still would not have a viable claim against Laurens, because Laurens's alleged breach of that duty did not proximately cause Plaintiff's injuries and their claims are barred by the statute of limitations.

a. Medical Staff Bylaws and Subsidy Contract Did Not Create a Duty Owed to Plaintiffs

Plaintiffs contend that Laurens owed them a duty to ensure that Dr. Brown complied with the requirements that he maintain medical malpractice insurance contained in the Bylaws and the Subsidy Contract. As an initial matter, there is no evidence that Dr. Brown failed to comply with the requirements of the Bylaws and/or the Subsidy Contract. It is undisputed that at the time of the surgeries on Plaintiffs, Dr. Brown had the required insurance. Plaintiffs contend that he fell out of compliance when he switched policies in July of 2009 and failed to purchase tail coverage; however, there is nothing in the Bylaws or the Subsidy Contract that specifically required Dr. Brown to purchase tail coverage, nor is there any evidence in the record that Laurens considered Dr. Brown to be in violation of the Bylaws or in breach of the Subsidy Contract by his failure to purchase tail coverage.

Nevertheless, even if the Bylaws and/or the Subsidy Contract could somehow be interpreted to have put a requirement on Dr. Brown to purchase tail coverage, that requirement would not inure to the benefit of Plaintiffs. Plaintiffs contend that they were intended beneficiaries of the requirement that Dr. Brown maintain insurance, but there is nothing in either the Bylaws or the Subsidy Contract that states that the insurance requirement is there for the

benefit of patients, and Plaintiffs' contention is inconsistent with South Carolina law. See Trancik v. USAA Ins. Co., 354 S.C. 549, 581 S.E.2d 858 (Ct. App. 2003) ("Third-party-liability-insurance contracts are generally indemnity contracts whereby the insurer, or the first party, agrees to pay the insured, or the second party, the amount of any damages the insured may become legally liable to pay a third party; thus, the third party, or the incidental beneficiary, does not have a contractual relationship with the insurer and cannot maintain an action against the insurer for breach of the insurance contract.") At best, Plaintiffs would be incidental beneficiaries of the Medical Staff Bylaws and Subsidy Contract, but that would not give them the right to sue to enforce those documents. Id.

Regardless, even if Plaintiffs could be considered intended beneficiaries, such status would only give them standing to sue Dr. Brown as the promisor, not Laurens as the promisee. Under the terms of both the Bylaws and the Subsidy Contract, the obligation to maintain insurance belonged to Dr. Brown. To the extent his failure to purchase tail coverage meant he had not fulfilled his obligations, Plaintiffs would, at best, have been able to sue Dr. Brown for breach of the Bylaws and Subsidy Contract, but that would not give them the right to sue Laurens. See Sullivan v. U.S., 625 F.3d 1378 (Fed. Cir. 2010) (holding plaintiffs could not maintain a breach of contract action against Postal Service for failing to enforce a contract with a transportation company, and noting that the contract provision requiring the contractor to purchase liability insurance for its vehicles was intended to protect the Postal Service from potential risk and plaintiffs were at best incidental beneficiaries); Hesse v. Long and Foster Real Estate, Inc., No. 1:11cv506, 2012 WL 1427793 (E.D.Va.2012) (noting that no jurisdiction recognizes a theory of liability whereby a third party to a contract can sue the non-breaching party for failure to enforce the contract).

And to the extent that Plaintiffs may be contending as much, the Bylaws and/or the Subsidy Contract did not create a duty owed to Plaintiffs as the result of a voluntary undertaking on the part of Laurens. First, a voluntary undertaking exists when one undertakes to render services to another which he should recognize as necessary for the protection of someone else. See *Restatement (Second) of Torts* § 323(a) (1965). In regards to the Bylaws and/or the Subsidy Contract, Laurens did not undertake to render any services. Again, pursuant to both those documents, it was Dr. Brown who undertook to render OB/GYN services and agreed to maintain medical malpractice insurance while rendering those services. Nowhere in either of those documents does Laurens state that it will ensure that Dr. Brown will maintain insurance.

But regardless, even if Laurens had undertaken the responsibility to ensure that Dr. Brown maintain insurance, it would not have created a duty owed to Plaintiffs, because the undertaking did not make Plaintiffs situation worse, nor did Plaintiffs rely on the undertaking to their detriment. See Staples v. Duell, 329 S.C. 503, 494 S.E.2d 639 (Ct. App. 1997) (holding defendant's failure to follow an internal policy which voluntarily undertook to conduct inspections of rural property was not actionable). It is admitted that Plaintiffs had never seen or read the Medical Staff Bylaws or the Subsidy Contract prior to their surgeries, and they had no knowledge of the terms and conditions of those documents. (See Plaintiffs' Responses to Defendants' Requests for Admissions, ¶¶ 6-8, attached hereto as Exhibit D.) They did not discuss those documents or the requirement that Dr. Brown have medical malpractice insurance with anyone at the Hospital prior to their surgeries. (Id.) They simply knew nothing about the medical malpractice insurance requirement, and thus, they could not have relied on that requirement to their detriment.

Finally, to hold that Laurens owes a duty to its patients to ensure that physicians comply

with the Bylaws would be contrary to public policy and the intentions of the Legislature in South Carolina. As previously mentioned, there is no law in South Carolina that requires doctors to maintain medical malpractice insurance. In addition, Laurens and GHS are both governmental entities subject to the South Carolina Tort Claims Act, S.C. Code Ann. § 15-78-10, et seq. (1976, as amended), and it and its agents and employees are, therefore, entitled to all rights, privileges, defenses, limitations, and immunities afforded by the Act and afforded by the doctrine of sovereign immunity, as is retained by the Act. See Murphy v. Richland Mem. Hosp., 317 S.C. 560, 455 S.E.2d 688 (1995) (citing Benton v Roger C Peace, 313 S.C. 520, 443 S.E.2d 537 (1994)). Pursuant to the Act, a governmental entity cannot be held liable for the acts or omissions of an independent contractor. S.C. Code § 15-78-60(20); see also Smith v. Reg'l Med. Ctr., 394 S.C. 110, 713 S.E.2d 656 (Ct. App. 2011) (holding governmental hospital could not be held liable for the negligent acts of an independent contractor physician). Therefore, it is the public policy of this State and the intent of the Legislature that Laurens cannot be held liable for Dr. Brown's failure to have insurance coverage for Plaintiffs' claims. Further, the Act retains immunity for governmental entities for failing to enforce written policies, S.C. Code § 15-78-60(4); therefore, even if Laurens owed Plaintiffs a duty to enforce the Bylaws, it would have immunity for any failure to do so.

b. Laurens's acts or omissions did not proximately cause Plaintiffs' injuries

Plaintiffs' inability to collect their judgments has not been the result of any act or omission on the part of Laurens. The current predicament can be blamed on several things, but none of those things are Laurens's fault. First, had Plaintiffs put Dr. Brown on notice of their claims at the time they first became aware of the injuries he allegedly caused them, there would have been coverage through Dr. Brown's JUA policy. It was not Laurens's fault that they each decided to wait so long to tell anyone that they felt they had been injured by Dr. Brown's

negligence. Second, it was not Laurens's fault that Dr. Brown switched insurance carriers and failed to purchase tail coverage. And finally, it was not Laurens's fault that Dr. Brown decided to move out of the country.

In their Complaint, Plaintiffs allege that Laurens had a duty to inform them that Dr. Brown had a claims-made policy in sufficient time for them to make a claim, Compl. ¶ 59; however, their own expert refuted that contention and stated that in his opinion, Laurens had no duty to do anything until it found out that Dr. Brown had switched policies and failed to purchase tail coverage or prior bad acts coverage. (See Depo of Charles Hyde, II, Ph.D., April 8, 2016, p. 123:18-23. Relevant excerpts are attached hereto as Exhibit E) But at that point, the damage had been done and there was nothing anyone, other than Dr. Brown, could do to rectify the situation. Plaintiffs allege that Laurens should have done something to force Dr. Brown to purchase tail coverage, but Laurens could not force Dr. Brown to do anything. Dr. Brown was not an employee of Laurens. Laurens had no direct control over him. The most Laurens could have done was terminate his privileges and require him to repay the amounts forwarded under the Subsidy Contract, but there is no evidence that doing either of those things would have prompted Dr. Brown to purchase tail coverage. In fact, Laurens ultimately did both those things and it did not have any impact on Dr. Brown's decision to not purchase tail coverage.

Plaintiffs' expert conceded that Laurens could not have forced Dr. Brown to purchase tail coverage, but argued that Laurens had a duty to purchase tail coverage on Dr. Brown's behalf since he refused. However, Plaintiff's own insurance expert conceded that in order for a company to be able to purchase liability insurance coverage for a person, it must have an insurable interest in that person. (See Dep. Of James M. Carson, Ph.D., July 7, 2016, pp. 35:17 – 36:8. Relevant excerpts are attached hereto as Exhibit F) Therefore, for Laurens to have had an

insurable interest in Dr. Brown, there had to be a possibility that Laurens could be held vicariously liable for Dr. Brown's actions, but as noted above, that was not a possibility under the Tort Claims Act. See Smith, supra. Accordingly, under the law, Laurens could not have purchased tail coverage on Dr. Brown's behalf even if it wanted to.

The fact is that once Dr. Brown made the decision to switch carriers and decline to purchase tail coverage or prior bad acts coverage, there was nothing anyone, other than Dr. Brown, could do to ensure that Plaintiffs would be compensated for the injuries he allegedly caused them. It was solely Dr. Brown's fault that Plaintiffs were injured and it was Dr. Brown's fault (not withstanding Plaintiffs' failure to timely file their claims) that Plaintiffs have been unable to collect any money for their alleged injuries.

c. Plaintiffs' claims are barred by the statute of limitations

Under the Tort Claims Act, the applicable statute of limitations is two years. S.C. Code Ann. § 15-78-110. South Carolina applies the discovery rule to claims for negligence. Republic Contr. Corp. v. South Carolina Dep't of Highways & Pub. Transp., 332 S.C. 197, 503 S.E.2d 761 (S.C. Ct. App. 1998). Under the discovery rule, the statutory period begins to run when a person knew or by the exercise of reasonable diligence should have known that he had a cause of action. S.C. Code Ann. § 15-3-535 (2008); Smith v. Smith, 291 S.C 420, 426, 354 S.E.2d 36, 40 (S.C. 1987). The test is objective based upon when a person could or should have known that a cause of action might exist in his or her favor, rather than when a person obtains actual knowledge of either the potential claim or of the facts giving rise thereto. Burgess, supra; see also Austin v. Conway Hosp., Inc., 292 S.C. 334, 339, 356 S.E.2d 153, 156 (S.C. Ct. App. 1987) (quoting Rogers v. Efird's Exterminating Co., Inc., 284 S.C. 377, 379, 325 S.E.2d 541, 542 (1985)). Further, the Supreme Court of South Carolina held in Wiggins v. Edwards, 314 S.C. 126, 128, 442 S.E.2d 169, 170 (S.C. 1994):

> The focus is upon the date of discovery of the injury, not the date of discovery of the wrongdoer. The important date under the discovery rule is the date that a plaintiff discovers the injury, not the date of the discovery of the identity of another alleged wrongdoer. If, on the date of injury, a plaintiff knows or should know that she had some claim against someone else, the statute of limitations begins to run for all claims based on that injury. (emphasis added).

Applying the law to the facts of this case, it is clear that Plaintiff's claims are barred as matter of law. Plaintiffs are trying to recover damages sustained when they were allegedly injured by Dr. Brown; therefore, the statute of limitations for all claims based on those injuries began to run when those injuries occurred. Mrs. McCord felt she had been injured by Dr. Brown following her second surgery on February 19, 2009; therefore, all of her claims began to accrue on February 19, 2009. Mrs. Sherfield was told immediately following her surgery on May 29, 2009 that there had been complications; therefore, all of her claims began to accrue on May 29, 2009. Plaintiffs did not file this action until March of 2014, nearly three years beyond the statute of limitations.

Plaintiffs will likely argue that their claims against the hospital did not begin to accrue until they discovered that Dr. Brown did not have medical malpractice insurance coverage for their claims against him, but that position would be inconsistent with the damages Plaintiffs are seeking to recover. Plaintiffs have alleged that they are entitled to recover the full amount of the judgments they received against Dr. Brown. Those judgments were compensation for the injuries allegedly caused by Dr. Brown during the aforementioned surgeries. Therefore, in this case, Plaintiffs are again seeking to be compensated for the injuries they sustained during those surgeries, and as previously stated, all claims to recover for those injuries began to accrue at the time of the injuries in 2009. Wiggins, supra.

Nevertheless, even assuming that Plaintiffs claims did not accrue until they knew about

the problem with Dr. Brown's insurance, their claims against Defendants would still be barred by the applicable statute of limitations. It is admitted that as of December 1, 2011 Plaintiffs, through their attorney, were aware of the possibility that Dr. Brown did not have medical malpractice insurance coverage for their claims against him. (See Plaintiffs' Response to Defendants' Requests for Admission, ¶ 5.) Therefore, even assuming the lack of insurance caused a distinct and separate injury, which again would be inconsistent with Plaintiffs' claimed damages in this case, Plaintiffs were aware of that injury as of December 1, 2011, which means they were still several months beyond the applicable statute of limitations when they filed this action on March 26, 2014.

WHEREFORE, for the reasons stated herein, Laurens and GHS respectfully requests this Court enter an order granting them summary judgment on all claims and for such other and further relief as this Court may deem just and proper.

HAYNSWORTH SINKLER BOYD, P.A.

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Attorneys for Defendants

Dated: 7/27/16
Greenville, SC

STATE OF SOUTH CAROLINA COUNTY OF LAURENS Chris Katina McCord, Christopher McCord, Janice Sherfield, and Jerry Sherfield, Plaintiffs, v. Laurens County Health Care System and Greenville Health System, Defendants.	IN THE COURT OF COMMON PLEAS C.A. No.: 2014-CP-30-250 ***Certificate of Service***

I HEREBY CERTIFY that a copy of **Defendants' Motion for Summary Judgment** was served upon counsel of record by depositing true and accurate copies thereof in the United States Mail, proper postage affixed thereto, on the 27th day of July, 2016, addressed to:

Joseph G. Wright
McGowan, Hood & Felder, LLC
PO Drawer 1778
Anderson, SC 29622-1778

HAYNSWORTH SINKLER BOYD, P.A.

Julee Lyons
Paralegal to Kenneth N. Shaw

7/27/16
Greenville, SC

EXHIBIT A

AGREEMENT

THIS AGREEMENT IS SUBJECT TO ARBITRATION

AGREEMENT made this 14th day of February, 2002 by and between Byron Brown, M. D. (hereinafter referred to as "Physician") and Laurens County Health Care System hereinafter referred to as "Hospital").

WITNESSETH

WHEREAS, Physician is an OB/GYN having his medical degree in the State of South Carolina; and

WHEREAS, Hospital is a political subdivision of the State of South Carolina charged with the responsibility of providing quality health care to the citizens of Laurens County; and,

WHEREAS, Hospital has performed an assessment of the existing needs of the Laurens County community, and the assessment indicates there exists within the community a demand for physicians trained in the specialty of OB/GYN to efficiently and conveniently satisfy patient care needs;

WHEREAS, Physician is licensed to practice medicine in South Carolina; and

WHEREAS, Physician desires to establish an OB/GYN practice in Laurens County, State of South Carolina and Hospital agrees to assist Physician in establishing the practice in Laurens County, South Carolina:

NOW, THEREFORE, in consideration of the terms, conditions, covenants, agreements and obligations herein stated it is now mutually agreed by and between the parties hereto as follows:

ARTICLE I: OBLIGATIONS OF THE HOSPITAL

A. Contingent upon the Physician's fulfillment of his obligations and this Agreement and subject to the limitations herein set forth, the Hospital agrees to subsidize the net practice collections of Physician for a 36-month period beginning on July 1 2002, 2002, contingent upon approval of credentialling at the hospital and opening of an office in Laurens County, unless otherwise agreed in writing, not to exceed $27,000 per month in any month under this Agreement.

B. The net practice income for the purposes of this Agreement equals all collections by Physician for professional fees and office or hospital practice and any other income from the

practice of medicine, less reasonable, professional expenses attributable directly to Physician necessary to conduct the practice of medicine during the 36-month period. Professional expenses shall include all expenses normally and reasonably associated with the operation of the medical practice directly attributable to Physician and which are deductible for federal income tax purposes, with the exception of the following: contributions to retirement or deferred compensation plans; federal, state, and local income taxes; professional liability insurance.

B. A sample monthly calculation may be as follows:

Net practice collections	$10,000
Subsidy amount	$27,000
Hospital payment	$17,000

In the event net practice income for any month exceeds $27,000, one-half (1/2) of the excess shall be paid by Physician to Hospital to be applied against subsidy amounts already advanced, or the following month's subsidy shall be reduced by a like amount.

ARTICLE II: PHYSICIAN OBLIGATION

A. Establishment of Practice and Time Commitment:

1. On or before January 1, 2002, the Physician shall establish his practice in Laurens County, South Carolina. Physician shall, in good faith and with due diligence, pursue the practice on a full-time basis for at least 40 hours per weeks for 48 weeks per year to include office and hospital practice and shall, in good faith, use his best efforts to develop a successful practice. Physician shall maintain reasonable hours so that the practice can be developed. He will maintain his license to practice medicine in South Carolina, and his provisional/active status on the medical staff in good standing throughout the term of this Agreement and repayment period and shall comply with all provisions of the medical staff By-laws of the Hospital as well as any other policies, procedures, rules, and regulations issued by the Hospital which govern its medical staff.

2. Physician hereby covenants and agrees to furnish and to make available to Hospital a reporting by the 10th day following the prior month ended, or as soon as practical after month-end. The report will consist of gross billings, gross collections, professional expenses, net practice income or net practice loss, records of deposits to the account of Physician and his banking institution, office visits and hospital visits. Any subsidy payment due to Physician shall be paid on or before the 15th day of the month for the preceding month, provided the first

payment shall be due Aug. 15, 2002.

3. Physician hereby authorizes the Hospital to conduct an audit of Physician's books and records upon reasonable notice during normal business hours.

4. Physician agrees to provide his best efforts to bill within a reasonable time period after services are rendered and will make attempts to collect receivables as expediently as possible.

5. The Physician must treat Medicaid and Medicare patients, and do so in a nondiscriminatory manner.

6. Physician agrees to provide services based on an on-call rotation to all patients he is requested by other Physicians in Laurens County to see at the Laurens County Hospital for purposes of consultation, emergency services, or otherwise, regardless of type of insurance or patient's ability to pay.

7. No benefit or payment hereunder shall, in any way, be based upon referral of patients or be volume sensitive.

8. The Physician shall exercise diligence to assist the Hospital in controlling the costs of the Hospital related to medical services including completing medical records on a timely basis and participating in the Hospital's quality assurance, utilization review, and peer review programs.

9. The Physician shall cooperate with the Hospital and shall properly notify the Hospital regarding legal claims, investigations, or lawsuits involving this Agreement or any medical services provided by the Physician.

10. The Physician agrees that, during the term of this Agreement, he will provide professional services to the community and to the Hospital patients including providing periodic medical care within his specialty to medically indigent; reasonable on-call rotation in the emergency room; and presentations to community groups and organizations as appropriate.

ARTICLE III: MOVING EXPENSES

Moving expenses incurred by the Physician's family will be reimbursed by the Hospital in conformance with the provisions of this Agreement. Unless otherwise provided herein reimbursable expenses are limited to expenses associated with moving Physician's household goods and travel, meals and lodging expenses incurred during the move to Physician's new residence. Upon proper documentation, Hospital will reimburse Physician or moving company

based on prior arrangements. Payment for moving expenses will not exceed ten thousand dollars ($10,000.00).

ARTICLE IV: REPAYMENT

The physician shall repay any subsidy made pursuant to this agreement. Hospital has determined that there is a benefit and value to the Hospital and community if physician maintains a private medical practice and office in Laurens County. Therefore, for each month the physician maintains his hospital practice, medical practice, and office in Laurens County after the 3 year term of this Agreement, the Hospital will forgive repayment of 1/120 of the unrepaid subsidy. Any unrepaid subsidy not forgiven shall become immediately due and payable at such time as physician leaves Laurens County or ceases to maintain a private medical practice and office in the county or maintain privileges at Laurens County Hospital. The unpaid subsidy shall bear interest at the rate of Wall Street Journal Prime plus 2% determined as of the 24th month of this Agreement.

ARTICLE V: TERMINATION

Notwithstanding any other provisions contained herein, the Hospital may elect to terminate its obligations set forth in this Agreement, upon the happening of any of the following events:

(1) Physician fails to maintain a South Carolina medical license through the suspension or revocation by the State of South Carolina or Physician is placed on probation.

(2) Physician's medical staff privileges at Hospital are terminated or suspended in accordance with the Hospital's Medical Staff By-laws.

(3) Physician's professional liability insurance is canceled.

(4) Physician's application for appointment to Medical Staff at Hospital is denied for whatever reason.

(5) Disability of Physician for more than sixty (60) days.

(6) Written mutual consent of both Hospital and Physician.

(7) Conviction of a felony or a crime of moral turpitude or serious misdemeanor.

(8) Material breach of this Agreement by Physician provided Physician is given written notice of this breach and given thirty (30) days after notice to cure same.

Should agreement be terminated because of any of the above reasons except for material breach by Hospital or death or long-term disability of Physician, Physician will be required to

repay all subsidy advances immediately. However, the Hospital may allow payments over a period of time at its option. Physician may elect to terminate his obligation contained herein upon the failure of the Hospital to meet any of its obligations as set forth in previous articles of this Agreement. Election to terminate this Agreement by either party must be made in writing and delivered to the respective addresses of the Physician and Hospital.

The Hospital may purchase a life insurance policy in the Physician's name and will serve as beneficiary during the time of the income guarantee and subsequent repayment. After that period, the Physician will be given the option to assume ownership, change the beneficiary and assume payment of the policy.

ARTICLE VI: PROFESSIONAL LIABILITY INSURANCE

The Physician shall furnish to the Hospital proof of insurance. Said policy shall cover professional liability in a minimum amount of $1,000,000 per claim/$3,000,000 aggregate or JUA/PCF coverage. Physician shall furnish to the Hospital evidence that the premium on said policy is prepaid and that said policy is in full force and effect. Further, Physician shall notify his insurance company that if said policy is canceled for any reason, notice of cancellation shall be provided by insurance company to the C.E.O. of the Hospital.

ARTICLE VII. INDEPENDENT CONTRACTOR

It is expressly understood and agreed that Physician is an independent contractor expected and entitled to freely and independently exercise his judgment in accordance with good medical practice in the care and treatment of his patients. Physician shall exercise his skill, learning, intelligence, and experience in evaluation, diagnoses, medication, treatment, and hospitalization of his patients according to his informed judgment and shall not be constrained in the exercise of his independent judgment by the terms or conditions of this Agreement. Physician is free to admit patients to any Hospital of Physician's choice and to maintain staff privileges at other hospitals. Physician is under no obligation to admit patients to Laurens County Hospital. The sole purpose of this Agreement is to induce the Physician to establish his practice in the area of the Hospital because of the Hospital's belief that there are not a sufficient number of OB/GYN Physicians in the area.

ARTICLE VIII: REGULATORY REQUIREMENTS

The Hospital and the Physician will operate at all times in compliance with federal, state and local law, rules, and regulations, the policies, rules and regulations of the Hospital, the

applicable standards of the Joint Commission on Accreditation of Healthcare Organizations and all currently accepted and approved methods and practice of medicine. In the event that there shall be a change in federal or state law (including case law, statute, or regulation) or the interpretation thereof, or in the event facts material to this Agreement, known to one party are not disclosed to the other, or material facts known to either party are later developed, any of which when applied to either of the parties to this Agreement make compliance with Agreement illegal or onerous, then in such event, Physician and Hospital agree, upon written notice from the other, to renegotiate this Agreement, within thirty (30) days of said notice, to bring the Agreement into compliance with federal or state laws or to relieve the onerous aspects hereof. Upon renegotiation of this Agreement under the above, neither party shall have any further obligations to the other except to the extent such further obligations may be set out in a renegotiated agreement.

ARTICLE IX: LAW

The interpretation and enforcement of this agreement shall be governed by the laws of the State of South Carolina.

ARTICLE X: ASSIGNABILITY

The right and obligations of the Hospital hereunder shall enure to the benefit of and be binding upon the successors and assigns of the Hospital. Physician may not assign his rights or obligations under this Agreement without written approval of Hospital, except that the Physician shall be required to assign this Agreement to any corporate entity succeeding to his practice and shall promptly give the hospital notice of such assignment.

ARTICLE XI: AMENDMENTS

Any amendments to this Agreement shall be effective only if in writing and signed by the Hospital and the Physician.

ARTICLE XII: ENTIRE AGREEMENT

This Agreement constitutes the entire Agreement of the parties with respect to the subject matter.

ARTICLE XIII: NO WAIVER

No waiver of a breach of any provision of this Agreement shall be construed to be a waiver of any breach of any other provision. No delay in acting with regard to any breach of any provision of this Agreement shall be construed to be a waiver of such breach.

ARTICLE XIV: AUTHORIZATION FOR AGREEMENT

The execution and performance of this Agreement by Physician and Hospital have been duly authorized by all necessary laws, resolutions or corporate action, and this Agreement constitutes the valid and enforceable obligations of Physician and Hospital in accordance with its terms.

The Hospital has caused its name to be hereunto subscribed by duly authorized officer thereunto and Physician has hereunto subscribed his name as of the day and year first-above written.

ARTICLE XV: ARBITRATION

Any dispute, controversy or disagreement arising from this contract shall be submitted to arbitration pursuant to the Uniform Arbitration Act of South Carolina, § 15-48-10 et. Seq.

ARTICLE XVI: ACCESS TO BOOKS AND RECORDS

Upon the written request of the Secretary of Health and Human Services, or the Comptroller General, or any of their duly authorized representatives, the Physician will make available those contracts, books, documents, and records necessary to verify the nature and extent of the costs of providing services under this Agreement. Such inspection shall be available up to four (4) years after the rendering of such services. If the Physician carries out any of the duties of this Agreement through a subcontract with a value of $10,000 or more over a twelve (12) month period with a related individual or organization, the Physician agrees to include this requirement in any such subcontract. This section is included pursuant to and is governed by the requirements of Public Law 96-499, Sec. 952 (Sec. 1861 (b) (1) of the Social Security Act) and the regulations promulgated thereunder. No attorney-client, accountant-client or other legal privileges will be deemed to have been waived by the Hospital or the Physician by virtue of this Agreement.

PHYSICIAN:

Byron Brown, M.D.

Witness:

LAURENS COUNTY HEALTH CARE SYSTEM

By: Michael Kozar
Its: CEO

Witness:

EXHIBIT B

LAURENS COUNTY HEALTH CARE SYSTEM

MEDICAL STAFF
BYLAWS

AS APPROVED BY THE MEDICAL STAFF

LAURENS COUNTY HEALTH CARE SYSTEM

AUGUST 24, 2009

AS APPROVED BY THE BOARD OF TRUSTEES

AUGUST 24, 2009

applicant's fitness for appointment to the Medical Staff. At least four (4) of the six (6) professional references shall be provided by physicians who practice in the same medical specialty and who exercise substantially similar Clinical Privileges for which the LIP is applying. Professional references for physicians practicing for the first time after completing his or her residency program should typically be provided by the applicant's academic supervising physicians. Special circumstances regarding the ability of the LIP to provide such professional references shall be considered on a case by case basis by the appropriate Department Chairman.

Professional references refer, as appropriate, to the applicant's relevant training and/or experience, current competence, fulfillment of obligations as a member of a Medical Staff, and any effects of health status on performance and/or Privileges to be recommended.

7.2.9 Information on Liability Insurance Coverage:

Information as to whether the applicant currently has professional liability insurance coverage in the amount determined from time to time by the Board. New applicants must provide proof of malpractice insurance for the last ten (10) years.

7.2.10 Information of Affiliations with Other Hospitals or Facilities

The names and locations of all hospitals and other health care facilities where applicant currently has clinical privileges to provide patient care.

7.2.11 A criminal background check shall be conducted on each new applicant.

7.2.12 The application shall require the applicant to provide accurate answers concerning the following items. The applicant shall agree to immediately notify the Medical Staff Office in writing should any of the information regarding these items change during the period of their Medical Staff membership or Privileges. If the applicant provides information identifying a problem with any of the following items, the applicant will be required to submit a written explanation of the circumstances involved.

(a) Have any disciplinary actions been initiated or are any pending against you by any state licensure board?

(b) Has your license to practice in any state ever been relinquished, denied, limited, suspended, or revoked, whether voluntarily or involuntarily?

(c) Have you ever been asked to surrender your license?

(d) Have you ever been suspended, sanctioned, or otherwise restricted from participating in any private, federal, or state health insurance program (for example, Medicare, TRICARE, or Medicaid)?

EXHIBIT C



CONDITIONS OF ADMISSION

GENERAL DUTY NURSING: The hospital provides only general duty nursing care. Under this system nurses are called to the bedside of the patient by a signal system. If the patient is in such condition as to need continuous or special duty nursing care, such must be arranged by the patient or legal representative. The hospital is not responsible for failure to provide the same and is hereby released from any and all liability arising from the fact that said patient is not provided with such additional care.

IMAGERY: I understand that photographs, videotapes, digital, or other images may be recorded to document my care, and I consent to this. I understand that Laurens County Health Care System will retain the ownership rights to these photographs, videotapes, digital, or other images, but that I will be allowed access to view them or obtain copies. I understand that these images will be stored in a secure manner that will protect my privacy and that they will be kept for the time period required by law or outlined in Laurens County Health Care System's policy. Images that identify me will be released and/or used outside the institution only upon written authorization from me or my legal representative.

MEDICAL AND SURGICAL CONSENT: The patient's care is under the direction of the attending physicians and the hospital is not responsible for any act or omission of the physicians. The undersigned consents to any x-ray examination, laboratory procedure, anesthesia, debridement, biopsy, medical or surgical treatment or hospital services rendered the patient under the general and special instructions of the physician. The undersigned recognizes that most medical staff members furnishing services to the patient, including the radiologists, pathologist, anesthesiologists, and the like (are) independent contractors and not employees of the hospital.

ASSIGNMENT OF INSURANCE BENEFITS AND THIRD PARTY CLAIMS: I/we hereby guarantee payment of all charges incurred for the account of the patient and hereby assign any hospital benefits, major medical benefits, PIP benefits, sick benefits, or injury benefits due because of any insurance policy and the proceeds of all claims resulting from the liability of the third party payable by any person, employer or insurance company to or for the patient unless we pay account in full upon discharge. If eligible for Medicare, I request Medicare services and benefits. I understand I am responsible for any charges not covered by insurance, Medicare, Medicaid, or other benefits.

ASSIGNMENT OF PHYSICIAN BENEFITS: In the event that I, the patient in addition to hospital benefits, am entitled to physician or physicians benefits of any type whatsoever, arising out of a policy of insurance insuring me or any other party's liability to me, I hereby assign said benefits to my physician rendering care or treatment during this stay or outpatient visits, to be applied to my bill.

FINANCIAL AGREEMENT: The undersigned agrees he signs as agent or as patient that in consideration of the services to be rendered to that patient, he hereby individually obligates himself to pay the account of the hospital, in accordance with the regular rates and terms of the hospital. Should the account be referred to an attorney for collection, the undersigned shall pay reasonable attorney's fees and collection expense. All delinquent accounts may bear interest at the legal rate. I do hereby appoint the Hospital as my true lawful attorney to act in my behalf to collect the above mentioned claims and to give full and final receipt for me for all amounts so collected, and to endorse for me any checks made payable to me for benefits or claims collected under the above agreements. In the event insurance benefits exceed the actual amount of hospitalization, I hereby authorize and direct the Hospital to apply any overpayment that I may otherwise be entitled to, to any account that may exist at the Hospital for myself, my spouse, or my children or any other account for which I am responsible.

RELEASE OF MEDICAL INFORMATION: I hereby authorize the Hospital and the Physician to furnish necessary information from the medical record requested by my insurance company, its designated agency, or sponsoring third parties (to include Medicare and Medicaid) whose benefits have been assigned for purposes of benefit payment. This information may be transmitted in writing or verbally for the sole purpose to receive benefit payment for services rendered. During my hospitalization at the Hospital, I authorize my treating physicians to direct copies of my medical records to other physicians as they deem necessary for continuity of care while an inpatient.

PERSONAL VALUABLES: The hospital is not responsible for personal property retained in the patient's room and will not be responsible for any personal property of the patient unless it is accepted for safekeeping by the hospital and receipts are issued therefore.

TESTING TO PROTECT HOSPITAL EMPLOYEES AND OTHERS: I consent to appropriate tests for the presence of infection, such as, but not limited to, the Hepatitis B virus or HIV, if deemed necessary for the protection of others. I authorize the withdrawal of blood or other body fluids for this purpose.

[redacted]

Check the following statements that pertain to you:

_____ I HAVE executed an Advance Directive
_____ A Living Will
_____ Designation of a Health Care Surrogate
_____ Durable Power of Attorney for Health Care
__X__ I HAVE NOT executed an Advance Directive (A Living Will, Durable Power of Attorney for Health Care Designation of a Health Care Surrogate).
_____ I WOULD like additional information concerning Advance Directives.

To be completed by Admitting

_____ Patient is unable to complete at time of admission.
_____ Copy of Advance Directive not available at the time of admission. Requested that a copy be provided.
_____ Patient requests more information.
_____ Copy of Advance Directive is included on the chart for admission.

__X__ I have received a copy of "Patient Rights in Health Care Decisions". Medical Care is not conditioned, NOR will discrimination in care occur based on whether Advance Directives have been executed.

_____ I acknowledge that the LAURENS COUNTY HEALTH CARE SYSTEM cannot be responsible for PRE-CERTIFICATION. It is the responsibility of the patient and/or the patient's physician.

__X__ I acknowledge that I have received the Louis Stedman Patient Safety Information Sheet of the LAURENS COUNTY HEALTH CARE SYSTEM, which sets forth the ways in which I may contact my attending physician, addresses the practice of clinical trainees, and provides a list of abbreviations utilized on LCHCS name badges.

__X__ I acknowledge that I have read (or have had read to me) the conditions of admission. I understand and consent to the conditions.

_____ Have you fallen in past 3 months? _____ Do you feel dizzy? _____ Do you need a wheelchair to complete your testing today?

_____ At Risk for Falls- Green wrist band applied

Patient: [redacted] DOB: 12/04/1972

Account Number: 7[redacted] Medical Record Number: 22[redacted]

2/12/2020 DATE — TERESSA A FRANCH WITNESS — PCA AUTHORIZED BY — RELATIONSHIP TO PT

DATE — WITNESS — PCA AUTHORIZED BY — RELATIONSHIP TO PT

Wednesday, February 12, 2020 11:11 AM EST

nty HealthCare System

CONDITIONS OF ADMISSION

...TY NURSING: The hospital provides only general duty nursing care. Under this system nurses are called to the bedside of the patient by a signal ... patient is in such condition as to need continuous or special family duty nursing care, such must be arranged by the patient or legal ... The hospital is not responsible for failure to provide the nurse and is hereby released from any and all liability arising from the fact that said ... was not provided with such additional care.

...ORY: I understand that photographs, videotapes, digital, or other images may be recorded to document my care, and I consent to this. I understand that Laurens ... Health Care System will retain the ownership rights to these photographs, videotapes, digital, or other images, but that I will be allowed access to view them or ... copies. I understand that these images will be stored in a secure manner that will protect my privacy and that they will be kept for the time period required by law or ... outlined in Laurens County Health Care System's policy. Images that identify me will be released and/or used outside the institution only upon written authorization from me or my legal representative.

MEDICAL AND SURGICAL CONSENT: The patient's care is under the direction of the attending physicians and the hospital is not responsible for any act or omission of the physicians. The undersigned consents to any x-ray examination, laboratory procedure, anesthesia, debridement, biopsy, medical or surgical treatment or hospital services rendered the patient under the general and special instructions of the physicians. The undersigned recognizes that many medical staff members furnishing services to the patient, including the radiologists, pathologist, anesthesiologists, and the like (are) independent contractors and not employees of the hospital.

ASSIGNMENT OF INSURANCE BENEFITS AND THIRD PARTY CLAIMS: I/we hereby guarantee payment of all charges incurred for the account of the patient and hereby assign any hospital benefits, major medical benefits, PIP benefits, sick benefits, or injury benefits due because of any insurance policy and the proceeds of all claims resulting from the liability of the third party payable by any person, employer or insurance company to or for the patient unless we pay account in full upon discharge. If eligible for Medicare, I request Medicare services and benefits. I understand I am responsible for any charges not covered by insurance, Medicare, Medicaid, or other benefits.

ASSIGNMENT OF PHYSICIAN BENEFITS: In the event that I, the patient in addition to hospital benefits, am entitled to physician or physicians benefits of any type whatsoever, arising out of a policy of insurance insuring me or any other party's liability to me, I hereby assign said benefits to my physician rendering care or treatment during this my or outpatient visits, to be applied to my bill.

FINANCIAL AGREEMENT: The undersigned agrees to sign as agent or as patient that in consideration of the services to be rendered to that patient, he hereby individually obligates himself to pay the account of the hospital, in accordance with the regular rates and terms of the hospital. Should the account be referred to an attorney for collection, the undersigned shall pay reasonable attorney's fees and collection expense. All delinquent accounts may bear interest at the legal rate. I do hereby appoint the Hospital as my true lawful attorney to act in my behalf to collect the above mentioned claims and to give full and final receipt for me for all amounts so collected, and to endorse for me any checks made payable to me for benefits or claims collected under the above agreements. In the event insurance benefits exceed the actual amount of hospitalization. I hereby authorize and direct the Hospital to apply any overpayment that I may otherwise be entitled to, to my account that may exist at the Hospital for myself, my spouse, or my children or any other account for which I am responsible.

RELEASE OF MEDICAL INFORMATION: I hereby authorize the Hospital and the Physician to furnish necessary information from the medical record requested by my insurance company, its designated agency, or sponsoring third parties (to include Medicare and Medicaid) whose benefits have been assigned for purposes of benefit payment. This information may be transmitted in writing or verbally for the sole purpose to receive benefit payment for services rendered. During my hospitalization at the Hospital, I authorize my treating physicians to direct copies of my medical records to other physicians as they deem necessary for continuity of care while an inpatient.

PERSONAL VALUABLES: The hospital is not responsible for personal property retained in the patients room and will not be responsible for any personal property of the patient unless it is accepted for safekeeping by the hospital and receipts are issued therefore.

TESTING TO PROTECT HOSPITAL EMPLOYEES AND OTHERS: I consent to appropriate tests for the presence of infection, such as, but not limited to, the Hepatitis B virus or HIV, if deemed necessary for the protection of others. I authorize the withdrawal of blood or other body fluids for this purpose.

Check the following statements that pertain to you:

_____ I HAVE executed an Advance Directive
_____ A Living Will
_____ Designation of a Health Care Surrogate
_____ Durable Power of Attorney for Health Care
X I HAVE NOT executed an Advance Directive (A Living Will, Durable Power of Attorney For Health Care Designation of a Health Care Surrogate).
_____ I WOULD like additional information concerning Advance Directives.

To be completed by Admitting:

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_____ Requested that a copy be provided.
_____ Patient requests more information.
_____ Copy of Advance Directive is included on the chart for admission.

X I have received a copy of "Patient's Rights in Health Care Decisions". Medical Care is not conditional, NOR will discrimination in care occur based on whether Advance Directives have been executed.

X I acknowledge that the LAURENS COUNTY HEALTH CARE SYSTEM cannot be responsible for PRE-CERTIFICATION. It is the responsibility of the patient and/or the patient's physician.

X I acknowledge that I have received the Laurens Electronic Patient Safety Information Sheet of the LAURENS COUNTY HEALTH CARE SYSTEM, which sets forth the ways in which I may consent my attending physician, addresses the practice of clinical trainees, and provides a list of abbreviations utilized on LCHCS name badges.

X I acknowledge that I have read (or have had read to me) the conditions of admission. I understand and consent to the conditions.

Patient: [redacted] DOB: [redacted]

Account Number: [redacted] Medical Record Number: [redacted]

4/16/2019 [redacted] [redacted]
DATE WITNESS PTCR AUTHORIZED REP RELATIONSHIP TO PT

DATE WITNESS PTCR AUTHORIZED REP RELATIONSHIP TO PT

...Care System

CONDITIONS OF ADMISSION

...MENT: The hospital provides only general duty nursing care. Under this system nurses are called to the bedside of the patient by a signal ... is in such condition as to need continuous or special duty nursing care, such must be arranged by the patient or legal ... and hospital is not responsible for failure to provide the same and is hereby released from any and all liability arising from the fact that said ... provided with such additional care.

...I understand that photographs, videotapes, digital, or other images may be recorded to document my care, and I consent to this. I understand that Laurens ... Care System will retain the ownership rights to these photographs, videotapes, digital, or other images, but that I will be allowed access to view them or ... I understand that these images will be stored in a secure manner that will protect my privacy and that they will be kept for the time period required by law or ... Laurens County Health Care System's policy. Images that identify me will be released and/or used outside the institution only upon written authorization from ... legal representative.

...AL AND SURGICAL CONSENT: The patient's care is under the direction of the attending physicians and the hospital is not responsible for any act or ... of the physicians. The undersigned consents to any x-ray examination, laboratory procedures, anesthesia, administered, biopsy, medical or surgical ... and/or hospital services rendered the patient under the general and special instructions of the physician. The undersigned recognizes that most medical staff ... perform ...ithdrawing services to the patient, including the radiologists, pathologist, anesthesiologists, and the like (not) independent contractors and not employees of ... this hospital.

...SIGNMENT OF INSURANCE BENEFITS AND THIRD PARTY CLAIMS: I/we hereby guarantee payment of all charges incurred for the account of the ... and hereby assign my hospital benefits, major medical benefits, PIP benefits, sick benefits, or injury benefits due because of any insurance policy and the ... proceeds of all claims resulting from the liability of the third party payable by any person, employer or insurance company to or for the patient unless we pay ... amount in full upon discharge. If eligible for Medicare, I request Medicare services and benefits. I understand I am responsible for any charges not covered by ... insurance, Medicare, Medicaid, or other benefits.

ASSIGNMENT OF PHYSICIAN BENEFITS: In the event that I, the patient in addition to hospital benefits, am entitled to physician or physicians benefits of any type whatsoever, arising out of a policy of insurance insuring me or any other party's liability to me, I hereby assign said benefits to my physician rendering care or treatment during this stay or outpatient visits, to be applied to my bill.

FINANCIAL AGREEMENT: The undersigned agrees to sign as agent or as patient that in consideration of the services to be rendered to that patient, he hereby ... individually obligates himself to pay the account of the hospital, in accordance with the regular rates and terms of the hospital. Should the account be referred to ... an attorney for collection, the undersigned shall pay reasonable attorney's fees and collection expenses. All delinquent accounts may bear interest at the legal ... rate. I do hereby appoint the Hospital as my true lawful attorney to act in my behalf to collect the above mentioned claims and to give full and final receipt for ... me for all accounts so collected, and to endorse for me any checks made payable to me for benefits or claims collected under the above agreements. In the ... event insurance benefits exceed the actual amount of hospitalization. I hereby authorize and direct the Hospital to apply any overpayment that I may otherwise be ... entitled to, to any account that may exist at the Hospital for myself, my spouse, or my children or any other account for which I am responsible.

RELEASE OF MEDICAL INFORMATION: I hereby authorize the Hospital and the Physician to furnish necessary information from the medical record requested ... by my insurance company, its designated agency, or sponsoring third parties (to include Medicare and Medicaid) where benefits have been assigned for purposes ... of benefit payment. This information may be transmitted in writing or verbally for the sole purpose to receive benefit payment for services rendered. During my ... hospitalization at the Hospital, I authorize my treating physicians to direct copies of my medical records to other physicians as they deem necessary for continuity ... of care while an inpatient.

PERSONAL VALUABLES: The hospital is not responsible for personal property retained in the patient's room and will not be responsible for any personal ... property of the patient unless it is accepted for safekeeping by the hospital and receipts are issued therefore.

TESTING TO PROTECT HOSPITAL EMPLOYEES AND OTHERS: I consent to appropriate tests for the presence of infection, such as, but not limited to, the Hepatitis B virus ... or HIV, if deemed necessary for the protection of others. I authorize the withdrawal of blood or other body fluids for this purpose.

[redacted]

Check the following statements that pertain to you:

_____ I HAVE executed an Advance Directive
_____ A Living Will
_____ Designation of a Health Care Surrogate
_____ Durable Power of Attorney for Health Care
__X__ I HAVE Not executed an Advance Directive (A Living Will, Durable Power of Attorney For Health Care Designation of a Health Care Surrogate).
_____ I WOULD like additional information concerning Advance Directives.

To be completed by Admitting:

_____ Patient is unable to complete at time of admission.
_____ Copy of Advance Directive not available at the time of admission.
_____ Requested that a copy be provided.
_____ Patient requests more information.
_____ Copy of Advance Directive is included on the chart for admission.

...

__X__ I have received a copy of "Patients Rights to Health Care Decisions". Medical Care is not conditional, NOR will discrimination be done ... whether Advance Directives have been executed.

__X__ I acknowledge that the LAURENS COUNTY HEALTH CARE SYSTEM cannot be responsible for PRE-CERTIFICATION. It is the responsibility of the patient and/or the patient's physician.

__X__ I acknowledge that I have received the Lewis Blackman Patient Safety Information Sheet of the LAURENS COUNTY HEALTH CARE SYSTEM, which sets forth the ways in which I may contact my attending physician, reference the practice of clinical trials, and provides a list of abbreviations utilized on LCHCS nurse badges.

__X__ I acknowledge that I have read (or have had read to me) the conditions of admission. I understand and consent to the conditions.

...

Patient [redacted] DOB: [redacted]

Account Number: [redacted] Medical Record Number: [redacted]

Opinder Dhaliwal

_____ _____ _____ _____
DATE WITNESS WITNESS AUTHORIZED BY RELATIONSHIP TO PT

EXHIBIT D

STATE OF SOUTH CAROLINA	IN THE COURT OF COMMON PLEAS
COUNTY OF LAURENS	C.A. FILE NO. 14-CP-30-250
Chris Katina McCord, Christopher McCord, Janice Sherfield, and Jerry Sherfield, Plaintiffs, vs. Laurens County Health Care System and Greenville Healthcare System, Defendants.	RESPONSES TO DEFENDANTS' FIRST REQUESTS FOR ADMISSIONS TO PLAINTIFFS

Plaintiffs respond to Defendants' First Requests for Admissions to Plaintiffs as follows:

1. Admit that on December 1, 2011 Plaintiffs' attorney, Joseph G. Wright, was present at a mediation involving several of his clients' claims against Dr. Byron A. Brown, including the claims asserted by Chris Katina McCord and Christopher McCord.

RESPONSE:

Admitted.

2. Admit that as of December 1, 2011, Mr. Wright was aware of the fact that MAG Mutual Insurance Company was denying medical malpractice insurance coverage for Dr. Brown on claims that arose prior to July 9, 2009.

RESPONSE:

Admit in part that as of December 1, 2011, Mr. Wright was aware that MAG Mutual Insurance Company denied coverage on claims asserted by Chris Katina McCord and Christopher McCord.

3. Admit that as of December 1, 2011, Mr. Wright was aware of the fact that Joint Underwriting Association ("JUA") was denying medical malpractice insurance coverage for Dr. Brown on any claims that had not been reported to JUA prior to July 9, 2009.

RESPONSE:

Admit in part that knowledge of JUA denying coverage on claims asserted by Chris Katina McCord/Chris McCord and Janice Sherfield/Jerry Sherfield was acquired in February-March 2012.

4. Admit that as of December 1, 2011, Mr. Wright was aware of the possibility that Dr. Brown did not have medical malpractice insurance coverage for the claims brought by Mr. and Mrs. McCord.

RESPONSE:

Admit.

5. Admit that as of December 1, 2011, Mr. Wright was aware of the possibility that Dr. Brown did not have any medical malpractice insurance coverage for the claims brought by Mr. and Mrs. Sherfield.

RESPONSE:

Admit.

6. Admit that Plaintiffs did not read the Laurens County Hospital's Medical Staff Bylaws prior to their surgeries with Dr. Brown.

RESPONSE:

Admit.

7. Admit that no employee or agent of Defendants discussed the Medical Staff Bylaws with Plaintiffs prior to their surgeries with Dr. Brown.

RESPONSE:

Admit.

8. Admit that Plaintiffs had no knowledge of Dr. Brown's "Subsidy Contract" (as defined in paragraph 15 of the Amended Complaint) prior to their surgeries with Dr. Brown.

RESPONSE:

Admit.

9. Admit that no employee or agent of Defendants discussed medical malpractice insurance with Plaintiffs prior to their surgeries with Dr. Brown.

RESPONSE:

Admit.

McGowan, Hood & Felder, LLC

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ATTORNEYS FOR THE PLAINTIFFS

May 13, 2016

Anderson, South Carolina

EXHIBIT E

STATE OF SOUTH CAROLINA IN THE COURT OF COMMON PLEAS

COUNTY OF LAURENS C.A. NO.: 2014-CP-30-0250

CHRIS KATINA McCORD, CHRISTOPHER McCORD, JANICE SHERFIELD, AND JERRY SHERFIELD,

PLAINTIFFS,

V.

LAURENS COUNTY HEALTH CARE SYSTEM AND GREENVILLE HEALTH SYSTEM,

DEFENDANTS.

DEPOSITION OF JOHN CHARLES HYDE, II, Ph.D.

Taken at the instance of the Defendants on Tuesday, April 5, 2016, in the offices of Edwards Reporting, Inc., 435 Katherine Drive, Suite A, Flowood, Mississippi, beginning at 12:54 p.m.

APPEARANCES:

JOSEPH G. WRIGHT, ESQ.
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Anderson, South Carolina 29621
COUNSEL FOR PLAINTIFFS

KENNETH N. SHAW, ESQ.
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COUNSEL FOR DEFENDANTS

REPORTED BY: MIRANDA M. SCHOGGEN, RPR, CSR
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800-705-DEPO (3376)

"file suit," I'm thinking more of officially. But, yes, I know that they can -- basically, it's intention to sue.

Q. Okay. The same thing with Ms. McCord. Her last surgery, I believe, was -- let me make sure I have the date right. It looks like April -- maybe April 18th of 2009, somewhere around that -- April 16th or April 18th. I'm not sure which date it is.

A. 2009 or '10?

Q. 2009.

A. Okay.

Q. All right. I will represent to you that all -- there were four surgeries combined for these two patients. All of them took place prior to July of 2009.

A. Okay.

Q. Consequently, why there's no coverage.

A. Okay.

Q. Her surgery is sometime in mid-April of 2009. At the time of her surgery, was there anything that would have prompted the hospital to reach out to Ms. McCord and tell Ms. McCord about Dr. Brown's insurance?

A. No. Because they weren't put on notice that there may be a change in his carrier -- insurance carrier.

Q. All right. So the -- your number G here, "To inform the patients directly," that obligation arose

EXHIBIT F

STATE OF SOUTH CAROLINA — IN THE COURT OF COMMON PLEAS

COUNTY OF LAURENS — CASE NO. 2014-CP-30-0250

Chris Katina McCord,
Christopher McCord,
Janice Sherfield and
Jerry Sherfield,

Plaintiffs,

vs.

Laurens County Health Care System and Greenville Health System,

Defendants.

DEPOSITION OF JAMES M. CARSON, Ph.D.

DATE TAKEN: July 7, 2016

TIME BEGAN: 11:00 A.M.

TIME ENDED: 1:16 P.M.

LOCATION: McGowan Hood & Felder, LLC
1501 North Fant Street
Anderson, South Carolina

REPORTED BY: Sheila B. Smith, CVR-CM-M
Certified Verbatim Reporter
Certificate of Merit

CAROLINA COURT REPORTING, LLC
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right this moment, it is anticipated that there will be very shortly?

A. Right.

Q. What I'm asking, though, is that if I wanted to buy a life insurance policy for you, who I have no insurable interest, no relationship to, I would not be allowed to do that, would I?

A. Right, in general. In recent years, there's ways to do that in secondary markets, but I think that's a side point that we're not probably really focused on. So in general, that's correct. But just a footnote that there are -- markets have developed that actually allow people to purchase life insurance policies, usually blind, on lives that they have no insurable interest in, more as an investment.

Q. Let's make it more specific. If I wanted to buy an umbrella liability policy for you, I would not be allowed to do that, would I?

A. Probably not.

Q. Again, because I have no insurable interest in you? I could not be responsible for your liability, and therefore an insurance company is not going to allow me to buy a liability policy for you; is that right?

A. Correct.
Q. So in regards to liability policies, the only way that a third party is going to be allowed to buy a liability policy for someone else is that they could somehow or another be held responsible for that person's liability; is that generally correct?
A. Generally, yes.
Q. So in this case, do you have any opinion as to whether or not in July or August of 2009, when Laurens County became aware of -- or I think the allegation is should have been aware of the fact that Dr. Brown had switched insurance policies and had not purchased tail coverage or extended-period coverage, do you have any opinion as to whether or not Laurens Hospital could have purchased that coverage for him?
A. They certainly weren't the named insured. And so any insurance that it could have or would have purchased would have been a different policy. They would have been the named insured. They might have sought coverage under that, but it'd be a different contract.
Q. But how could Laurens, who has -- again, under the laws of South Carolina -- and I don't know if

STATE OF SOUTH CAROLINA COUNTY OF LAURENS	IN THE COURT OF COMMON PLEAS C.A. FILE NO. 14-CP-30-250
Chris Katina McCord, Christopher McCord, Janice Sherfield, and Jerry Sherfield, Plaintiffs, vs. Laurens County Health Care System and Greenville Healthcare System, Defendants.	MEMORANDUM IN OPPOSTION TO MOTION FOR SUMMARY JUDGMENT

LYNN W. LANCASTER
2016 AUG 15 P 12:01
LAURENS COUNTY
CLERK OF COURT

This case is an action against Laurens County Health Care System ("Laurens County Hospital") and Greenville Healthcare System ("GHS") for breach of contract and breach of the duty to exercise due care in the special relationship between Laurens County Hospital and patients who underwent surgery at Laurens County Hospital. The patients are Chris Katina McCord and Janice Sherfield (sometimes collectively referred to as "Patients") and their spouses are Christopher McCord and Jerry Sherfield, respectively. The Patients allege in the First Cause of Action that they entered into several contracts with Laurens County Hospital and Laurens County Hospital breached the contracts by failing to fully perform the services it provided. (See paragraphs 70, 71, 72, and 73 of the Second Amended Complaint)[1]. Also, the Patients allege in the Second Cause of Action that there was a special relationship between Laurens County Hospital and its patients undergoing surgery and that Laurens County Hospital was

[1] The Motion to Amend Complaint and the Second Amended Complaint were filed March 31, 2016; however, the motion has not as yet been heard. Plaintiffs expect that the motion will be granted since the amendment is in accordance with facts obtained in discovery, will conform the pleadings to the evidence, and will not cause undue prejudice to Defendants.

negligent in exercising due care which resulted in damages to the Patients. (See paragraphs 81, 82, and 83 of Second Amended Complaint).

The defendants admit to entering into a separate contract with the Patients for each of the four surgeries performed by Byron A. Brown, MD ("Dr. Brown") at Laurens County Hospital. (Attachment 1 – Defendant's Supplemental Response to Request for Admission #5). One of the written documents states "services to be rendered" by Laurens County Hospital. The parties dispute what "services" are included in the contracts that are to rendered by Laurens County Hospital. For example, Laurens County Hospital was paid for providing "OR Services", "Anesthesia", and "Recovery Room" services; however, there is no description of the services. (Attachment 2 – Exhibit 1 and Exhibit 2). Patients submit that the services include, but are not limited to, Laurens County Hospital complying with state law and DHEC regulations relating to the operation of the hospital, complying with its own Medical Staff Bylaws promulgated in accordance with state law and DHEC regulations, and complying with contracts that Laurens County Hospital entered into with physicians, specifically, Dr. Brown, that affect the health, safety, and legal rights of the Patients.

There is, however, no disagreement that Laurens County Hospital and the Patients entered into four separate contracts regarding surgeries by Dr. Brown; that valuable consideration was paid to Laurens County Hospital by, or on behalf of, Patients; and that the scope and extent of the "services to be performed" were not described in the contracts.

The plaintiffs allege that Laurens County Hospital breached the contracts by not enforcing the Medical Staff Bylaws which required physicians privileged by Laurens

County Hospital to have and maintain professional liability insurance; by not enforcing the terms of its contract with Dr. Brown which also required Dr. Brown to maintain professional liability insurance; and by not complying with the prevailing standard of hospitals which requires physicians to maintain professional liability insurance. Further, Patients allege that Laurens County Hospital had a special relationship with the Patients and failed to exercise due care in the special relationship it had with its patients undergoing surgery in the hospital. As a result of Laurens County Hospital breaching and negligently failing to exercise due care, there was no insurance coverage to pay the judgments rendered against Dr. Brown. Since Dr. Brown was judgment proof and had permanently left the United States to reside in New Zealand, the plaintiffs have suffered the following damages:

*	Chris Katina McCord	$1,740,392.75, plus interest;
*	Christopher McCord	$ 58,789.40, plus interest;
*	Janice Sherfield	$1,468,580.00, plus interest;
*	Jerry Sherfield	$ 50,000.00, plus interest.

(See paragraphs 73, 74, 75, 81, and 83 of the Second Amended Complaint)

After the breach of contract with the Patients, Laurens County Hospital entered into an agreement with Greenville Healthcare System ("GHS"). The agreement between Laurens County Hospital and GHS was effective July 1, 2013 whereby GHS agreed to assume, perform, and discharge any and all obligations of Laurens County Hospital related to the hospital which existed as of July 1, 2013. The liabilities and obligations of Laurens County Hospital to Plaintiffs for breach of contract and negligence related to the operations of the hospital that existed as of July 1, 2013 and were thus assumed by GHS. (Attachment 3 – portion of Greenville Health System and

Laurens County Health Care System agreement effective July 1, 2013, **Section 2.3 Assumption of Liabilities**).

A. STANDARD OF REVIEW

In a motion for summary judgment, the evidence and inferences which can be drawn therefrom are to be viewed in a light most favorable to the nonmoving party. Summary Judgment is a drastic remedy, it should be cautiously invoked so that no person will be improperly deprived of a trial of the disputed facts. *Baird v. Charleston County*, 571 S.E. 2d 69 (1999).

Summary judgment is improper where the motion presents a question as to the construction of a written contract, and the contract is ambiguous because the intent of the parties cannot be gathered from the four corners of the contract. Where a contract is unclear, or is ambiguous, and capable of more than one construction, the parties' intentions are matters of fact to be submitted to the jury. If a contract is ambiguous, parol evidence is admissible to ascertain the true meaning and intent of the parties. *H.K. New Plan Exchange Property Owner 1, LLC v. Cohen*, 649 S.E.2d 181, 184 (S.C. App. 2007), citing *Bishop v. Benson*, 374 S.E.2d 517, 518-519; *Wheeler v. Globe Rutgers Fire Ins. Co. of City of N.Y.*, 118 S.E. 609, 610 (1923); *Penton v. J.F. Cleckly Co.*, 486 S.E.2d 742, 745 (1997).

B. TERMS OF THE CONTRACT

The plaintiff Chris Katina McCord ("Mrs. McCord") underwent three surgeries at Laurens County Hospital on December 18, 2008, February 19, 2009, and April 17,

2009. The plaintiff Janice Sherfield ("Mrs. Sherfield") underwent surgery at Laurens County Hospital on May 29, 2009.

The surgeries on Mrs. McCord and Mrs. Sherfield were performed by Dr. Brown who was an obstetrician/gynecologist granted privileges to perform the surgeries by Laurens County Hospital. It has been judicially determined that Dr. Brown committed medical malpractice during each surgery and the following are verdicts and judgments rendered against Dr. Brown:

*	Chris Katina McCord	$1,740,392.75;
*	Christopher McCord (loss of consortium)	$ 58,789.40;
*	Janice Sherfield	$1,468,580.00;
*	Jerry Sherfield (loss of consortium)	$ 50,000.00.

(Attachment 4 – Exhibit 5 and Exhibit 6)[2]

It is admitted that the Patients and Laurens County Hospital entered into a contract – actually four separate contracts. The defendants allege that the contract is a unilateral contract and plaintiffs allege that the contract is a bilateral contract. However, the result is the same whether the contract is unilateral or bilateral because Laurens County Hospital undertook to perform services for the Patients under the contract. The issue is did Laurens County Hospital fully perform the services it undertook to perform?

The contract is set forth, in part, by the document entitled "Conditions of Admission" which was executed prior to each of the surgeries performed on Mrs.

[2] A jury verdict was returned for $2,960,000 in favor or Pamela and Carroll Neighbors against Dr. Brown on July 25, 2014 which was reduced for noneconomic damages caps and prejudgment interest added for a net judgment of $1,125,464.35, which was later settled for an undisclosed amount; a jury verdict was returned for $2,000,000 in favor of Lisa and Jeffrey Dennie against Dr. Brown on August 29, 2014 which was reduced because of noneconomic damages caps and prejudgment interest added for a net judgment of $1,609,445.44, which was later settled for an undisclosed amount. The cases of Dixie Mitchell and Betty and Donald Ward against Dr. Brown were settled for undisclosed amounts.

McCord and prior to the surgery performed on Mrs. Sherfield. (Attachment 5 - Exhibit 8 and Exhibit 9)[3]. The operative language is as follows:

> The undersigned (patient) agrees .... that in consideration of the **services to be rendered to that patient**, he hereby individually obligates himself to pay the account of the hospital, in accordance with the regular rates and terms of the hospital. (emphasis supplied).

Laurens County Hospital billed Mrs. McCord $56,962 and billed Mrs. Sherfield $51,269 for services rendered and was paid an agreed upon price for these services. (Attachment 2).

There is a dispute between the parties as to what should have been included in the services rendered by Laurens County Hospital for which it was paid. Plaintiffs submit that the following are included in the requirements of Laurens County Hospital in performing services relating to the hospitalizations of the Patients:

* compliance with state law and regulations;
* compliance with federal law and regulations;
* compliance with the Medical Staff Bylaws by Laurens County Hospital and the privileged physicians, specifically the portions that affect the health, safety, and legal rights of the patients; and
* compliance with the contracts between Laurens County Hospital and privileged physicians, specifically the portions that affect the health, safety, and legal rights of the patients.

Since the scope of the services language in the contract, i.e., "services to be rendered", cannot be determined within the four corners of the contract, then the term "services" is ambiguous. *Carolina Ceramics, Inc. v. Carolina Pipeline Co.*, 161 S.E.2d 179, 181 (S.C. 1968) (holding that a contract is ambiguous if it is capable of being understood in more senses than one, if the agreement is obscure in meaning, or has indefiniteness of expression, or has a double meaning.)

[3] The Conditions of Admission for the McCord December 18, 2006 surgery cannot be located; however, Sandra Thompson, the Manager of Quality Resources which includes Risk Management, testified that the document was probably executed, but can't be located. (Attachment 6 – Thompson deposition, 49:17-25).

The ambiguous language in a contract should be construed liberally and most strongly in favor of the party who did not write or prepare the contract and is not responsible for the ambiguity. Any ambiguity in a contract, doubt, or uncertainty as to its meaning should be resolved against the party who prepared the contract or is responsible for its verbiage. *Ecclesiastes Production Ministries v. Outparcel Associates, LLC*, 649 S.E.2d 494, 499 (S.C. App. 2007) citing *Myrtle Beach Lumber Co., Inc. v. Willoughby*, S.E.2d 423, 426 (1987) (quoting 17A C.J.S. Contracts §324).

The construction of an ambiguous contract is a question of fact to be determined by the jury. *Café Associates, Ltd. V. Gerangross*, 406 S.E.2d 162 (1991); *Peoples v. South Carolina Power Co*, 164 S.E. 605 (1932).

The *Rule 30(b)(6), SCRCP* designee for Laurens County Hospital, Sandra Thompson, testified that the Conditions of Admission forms were prepared by Laurens County Hospital, that the document in this form had been used by Laurens County Hospital for at least 15 years prior to the surgeries, and was used in all the McCord and Sherfield surgeries. (Attachment 6 – Thompson deposition, 48:19-50:17). Additionally, it is apparent that Laurens County Hospital is the sophisticated party in this transaction and prepared this standard contract. Thus, the terms of the contract are to be liberally construed in favor of plaintiffs and any reasonable interpretation of "services" favorable to patients would be mandated. *Contracts §206, Restatement 2d of Contracts*.

The plaintiffs submit that a reasonable construction of the contract term "services" is that Laurens County Hospital would comply with state law and regulations, comply with federal law and regulations, comply with its Medical Staff Bylaws, and

comply with its contracts with privileged physicians, specifically the portions that affect the health, safety, and legal rights of the patient.

C. HOSPITAL LEGAL REQUIREMENTS

Laurens County Hospital is mandated by South Carolina statute and South Carolina Department of Health and Environmental Control ("DHEC") to comply with certain requirements for licensing and operating a hospital. *§44-7-260 S.C. Code of Laws; Regulation 61-16 Minimum Standards for Licensing Hospitals and Institutional Infirmaries.* Additionally, Laurens County Hospital is subject to requirements of its accreditation agency, the Joint Commission on Accreditation of Hospitals ("Joint Commission"). The accreditation by Joint Commission of Laurens County Hospital is vital to the operation of the hospital. For example, Laurens County Hospital would not be able to submit bills for Medicare and Medicaid patients if the accreditation was lost – this would, in effect, force the hospital to close its doors. (Attachment 6 – Thompson deposition, 46:20-47:8).

The requirements imposed by South Carolina law and the Joint Commission are for the protection and safety of patients. (Attachment 7 – Hyde deposition, 212:17-213:1). Thus, plaintiffs submit that when a patient enters into a contract with Laurens County Hospital for an intended surgical procedure, then it is reasonable to expect Laurens County Hospital to comply with South Carolina statutes and regulations and comply with requirements of its accreditation agency, especially as such relate to the protection, safety, and benefits of the patients.

A hospital cannot provide any services to patients until after it has been licensed (*§44-7-260 (A) S. C. Code of Laws*) and deemed in compliance with the regulations which set forth the **minimum standards** for operation of hospitals in South Carolina. *(DHEC Regulation 61-16).*

Section 202. Control states, in part, that the governing board "shall be the supreme authority in the hospital responsible for the management control of the hospital and appointment of the medical staff." Further, that the "medical staff shall be responsible to the governing authority for the clinical work of the hospital."

Section 301. Appointment states, in part, that each "hospital must have a single organized medical staff that has overall responsibility for the quality of medical care provided to patients." Further, this "organized group, shall, with the approval of the hospital governing body, adopt bylaws, rules, and regulations to govern its operation."

In compliance with DHEC regulations, Laurens County Hospital adopted Medical Staff Bylaws. (Attachment 8 – Exhibit 4A, portion of Medical Staff Bylaws). **Section 3.2.1(e) Basic Qualifications** sets forth the following requirement for "initial and **continuing** (emphasis added) appointment" to the Medical Staff:

> (e) "LIPs (i.e., Licensed Individual Practitioners) shall **maintain** (emphasis added) valid professional liability insurance coverage in the amounts deemed necessary by the Board from time to time and shall provide a current certificate of insurance as recommended;"

Thus, the medical staff at Laurens County Hospital is designated by the governing body of the hospital to require LIP's, such as Dr. Brown, to "maintain valid professional liability insurance in the amounts deemed necessary by the Board."

Plaintiffs also submit that it is reasonable to expect, as part of the services rendered during their hospitalization, for the Medical Staff to comply with and

require the LIP's to comply with the Medical Staff Bylaws. This would include the requirement of the doctors performing surgery, in this case Dr. Brown, to have and "maintain professional liability insurance coverage" which would compensate patients for injuries and damages suffered from physician malpractice.

Laurens County Hospital also entered into contracts with LIP's that would affect rights and benefits of the patients. On February 14, 2002, Laurens County Hospital and Dr. Brown entered into an agreement in which Laurens County Hospital agreed to subsidize and guarantee his net practice collection of $27,000 per month for 36 months and then to be repaid prorata over the next ten years. (Attachment 9 – Exhibit 7, Subsidy Contract). The total amount disbursed to Dr. Brown in subsidy payments was $644,447. The payments were to be repaid by being forgiven on a prorated basis over ten years at $5370 per month beginning July 2005 until June 2015, as long as Dr. Brown complied with all provisions of the Medical Staff Bylaws and the Subsidy Contract which included maintaining professional liability insurance with minimum limits of $1,000,000/$3,000,000 aggregate. (Attachment 10 – Exhibit 29, Subsidy Contract Repayment/Forgiveness Schedule; Attachment 9 – Exhibit 7, Article II, IV, V, VI Subsidy Contract).

Thus, a legal requirement of Laurens County Hospital was for the Medical Staff to adopt Bylaws to govern the operation of the hospital. These Bylaws required the Medical Staff to ensure that the Licensed Independent Practitioners, i.e., the physicians privileged to practice in Laurens County Hospital, "shall maintain valid professional liability insurance coverage". Further, the Subsidy Contract between Laurens County Hospital and Dr. Brown required Dr. Brown to maintain

professional liability insurance "in a minimum amount of $1,000,000 per claim/$3,000,000 aggregate of JUA/PCF coverage". (Attachment 9 – Exhibit. 29, Article VI Subsidy Contract).

The plaintiffs submit that a reasonable interpretation of the contract is for Laurens County Hospital to comply with the legal requirement of South Carolina law which is for the medical staff to enforce its Bylaws that govern the operation of the hospital and to enforce contractual requirements on the physicians, especially when the requirements affect the health, safety, and legal rights of the patients.

D. PREVAILING PRACTICE – HOSPITALS REQUIRE PROFESSIONAL LIABILITY INSURANCE

The Institute of Medicine, which acts under the responsibility of the National Academy of Sciences that was established by Congress in 1863 as an advisor to identify issues of medical care in the United States, published a report in 1999 entitled "To Err is Human". This was a sentinel report on health care in U.S. hospitals that noted "at least 44,000 people, and perhaps as many as 98,000 people, die in hospitals each year as a result of medical errors that **could have been prevented**" (emphasis supplied). This death total exceeds the deaths from motor-vehicle wrecks and breast cancer. (Attachment 11 – Exhibit 13, excerpts). The death total does not include patients who are harmed by preventable errors and suffer substantial medical bills together with physical and psychological discomfort. (Attachment 7 – Hyde deposition, 195:23-196:8). The Institute of Medicine termed the situation in our nation's hospitals as an "epidemic of medical errors".

In 2010, the Office of Inspector General of the United States Department of Health and Human Services published a report entitled "*Adverse Events in*

Hospitals: National Incidences Among Medicare Beneficiaries". The report noted as follows:

* an estimated 13.5 percent of hospitalized Medicare beneficiaries experienced adverse events during their hospital stay;[4]
* an estimated 15,000 Medicare patients die each month (which is 180,000 patients per year) from adverse events that contribute to their death; and
* 44 percent of adverse and temporary harm events were clearly or likely preventable.

(Attachment 12 – Exhibit 14, excerpts from DHHS study).

In 2013, a report published in the Journal of Patient Safety from a literature review reported that a more accurate number of premature deaths associated with preventable harm to patients in hospitals was estimated at more than 400,000 per year. Further, that the number of patients suffering serious harm, short of lethal harm, in hospitals was between 4,000,000 to 8,000,000 per year. (Attachment 13 – Exhibit 15).

A witness for the plaintiffs who is a professor at the University of Mississippi Medical Center in the Department of Health Services and Family Medicine and has considerable experience teaching and working for private institutions in hospital management issued the following opinions in his deposition that:

* there is and has been an epidemic of medical negligence causing serious injuries and deaths to patients in hospitals in the United States;
* because of this epidemic of medical negligence, it is both the common practice and a prevailing requirement for hospitals to require its physicians to carry and maintain professional liability insurance;
* the purpose of the hospitals requiring surgeons that operate in the hospitals to carry and maintain professional liability insurance is so patients injured due to the negligent conduct of surgeons have a means to recover damages for injuries wrongly inflicted; and

[4] Adverse event is defined as harm to a patient as a result of medical care.

* the professional liability insurance is for the benefit of the injured patient in addition to the benefit of the hospitals.

(Attachment 7 – Hyde deposition, 197:16-198:18).

Accordingly, a reasonable interpretation of the contracts between the patients and Laurens County Hospital is that the doctors who are privileged and allowed by Laurens County Hospital to practice medicine in the hospital are to have and maintain professional liability insurance which is the prevailing practice in the United States.

E. BREACH OF CONTRACT BY LAURENS COUNTY HOSPITAL

In 2002, Dr. Brown was given initial privileges by Laurens County Hospital, and he obtained a professional liability insurance policy in compliance with the Medical Staff Bylaws and Subsidy Contract. The policy was an Occurrence Policy issued by JUA/PCF which had a limit of $1,000,000 Per Claim/$3,000,000 Annual Aggregate. (Attachment 14 – Exhibit 30, Occurrence Policy).

Dr. Brown maintained professional liability insurance occurrence coverage from JUA/PCF until July 9, 2008. If malpractice occurred during the term of the policy period, then there was insurance coverage for the malpractice. For the term beginning July 9, 2008, the JUA/PCF policy was changed from an Occurrence to a Claims-Made policy. The primary difference in coverage between the two is that both require the malpractice to occur during the term of the policy period, but Claims-Made also requires that the claim be reported during the policy period. If the claim is not made during the policy period, then the malpractice event is not covered since the insurance coverage is not

maintained after the policy period. (Attachment 15 – Exhibit 34, Claims-Made Policy; Attachment 16 – Exhibit 31, Claims-Made vs. Occurrence).

During the term from July 8, 2008 to July 9, 2009, Dr. Brown committed malpractice during the surgeries on McCord (December 8, 2008; February 19, 2009; and April 17, 2009) and on Sherfield (May 29, 2009). Dr. Brown changed insurance companies from JUA/PCF to MAG Mutual Insurance Company ("MAG Mutual") for the term July 9, 2009 to July 9, 2010. In order to maintain coverage for non-reported claims prior to July 9, 2009, Dr. Brown needed to purchase Extended Reporting Endorsement ("Tail") from JUA/PCF or purchase Prior Acts Coverage from MAG Mutual.

Dr. Brown had the ability to obtain Tail insurance from JUA/PCF by paying the premium of $28,023 prior to January 14, 2010. The Tail insurance would extend into perpetuity and essentially convert the policy to an occurrence form. (Attachment 17 – Exhibit 37, JUA letter; Attachment 18 – Davison deposition 32:11-25). JUA/PCF also had available premium financing which Dr. Brown had used to finance the 2008 premium. (Attachment 19 – Exhibit 35, Brown financing 2008 premium). Dr. Brown also had the ability to purchase Prior Acts Coverage from MAG Mutual by paying the premium of $11,861; but declined the purchase. (Attachment 20 – Exhibit 43, paragraph 4 Affidavit of Reece).

If either Tail coverage or Prior Acts Coverage is not obtained under a Claims-Made policy when non-renewed, then this would be a failure to maintain insurance coverage. (Attachment 7 – Hyde deposition, 202:18-25).

During the six month period of time from July 9, 2009 to January 14, 2010, Laurens County Hospital allowed Dr. Brown to continue performing surgery on patients[5] and continued to forgive his debt at the rate of $5,730 per month since Laurens County Hospital allowed the hospital privileges of Dr. Brown to continue. It is alleged by Patients that Laurens County Hospital had the ability to require Dr. Brown to comply with the Medical Staff Bylaws and Subsidy Contract to maintain professional liability insurance coverage on the plaintiffs and other injured patients. For example, the privileges of Dr. Brown could have been revoked for failure to comply with the Medical Staff Bylaws or the Subsidy Contract – both of which required Dr. Brown to maintain professional liability insurance. The revoking of privileges would have resulted in Dr. Brown not being able to earn a living performing surgery in the hospital. Also, Dr. Brown would not have received a monthly forgiveness of debt of $5,730. Also, Laurens County Hospital could have demanded that Dr. Brown immediately pay the balance due of over $300,000 that was advanced to Dr. Brown under the Subsidy Contract if he remained in default for not maintaining professional liability insurance. (Attachment 9 – Exhibit 7, Subsidy Contract).

The fact that Laurens County Hospital allowed Dr. Brown to violate and continue in violation of the Medical Staff Bylaws and the Subsidy Contract constituted a breach of contract with the plaintiffs as well as failure to properly train its employees, failure to inform the employee responsible for ensuring that Dr. Brown maintained professional liability insurance that Dr. Brown was under investigation for committing malpractice on

[5] The privileges of Dr. Brown continued until around December 15, 2009 when Dr. Brown relinquished his privileges to perform certain gynecological surgeries. (Attachment 21 – Exhibit 27, Brown relinquish privileges).

numerous patients of Laurens County Hospital, and failure to inform patients that claims needed to be filed by July 9, 2009. (See paragraph 81 of Second Amended Complaint).

F. NEGLIGENCE - BREACH OF DUTY IN SPECIAL RELATIONSHIP

The South Carolina Supreme Court in *Meddin v. Southern Ry-Carolina Division, et al.*, 62 S.E.2d 109 (SC 1950), quoted with approval the United States Supreme Court, *Atlantic & Pacific R. Co. v. Laird*, 164 US 393 (1896) as follows:

> if the relation of the plaintiff and defendants be such that a duty arises from that relationship, irrespective of contract, to take due care, and the defendants are negligent, then the action is one of tort.
> *Id.* 62 S.E. at 112

Further, the court held that "the negligent and willful failure to perform certain legal duties, not arising out of the particular contract between the plaintiffs and this defendant, but arising out of the relationship created by the contract.... *Id.* 62 S.E.2d at 113.

The South Carolina Supreme Court, in a case presenting a certified question from the Fourth Circuit Court of Appeals, held that a consulting firm owed a duty to the South Carolina State Ports Authority to exercise due care to accurately report objective factual data concerning the Charleston Port if it knew or should have known that the report was to also be used by a competitor. The duty of the tort-fearsor arises from the relationship to the injured party. *South Carolina Ports Authority v. Borg-Allen & Hamilton, Inc.*, 346 S.E.2d 324, 325-326.

The court further held that a cause of action is met if the following are proved:

1) the existence of a duty on the part of the defendant to **protect** the plaintiff (because of the special relationship);

2) the failure of defendant to discharge that duty; and
3) injury to the plaintiff resulting from the defendant's failure to perform.

Id. 436 S.E.2d at 325

The South Carolina Supreme Court issued an opinion in *Tommy L. Griffin Plumbing and Heating Co. v. Jordan, Jones and Goulding, Inc.* 463 S.E.2d 85 (1995) to a novel question in South Carolina – whether design professionals incur tort liability to a contractor for purely economic loss. At the time, a tort action for economic loss was not recognized. However, the South Carolina Supreme Court noted:

> In the last few years, a growing number of states have refused to apply the "economic loss" rule to actions against design professionals when there is a "special relationship" between the design professional and the contractor.
> (*Id*, 463 S.E.2d 87)

Also, the Supreme Court noted:

> applying these concepts (i.e., a special relationship creating a duty of care outside the terms of the contract) to professional liability, we have long held lawyers and accountants liable in tort for malpractice (citations omitted). These professionals owe a duty to the client ... which arises separate and distinct from the contract for services. (citations omitted). We see no logical reason to insulate design professionals from liability when the relationship between design professionals and the plaintiff is such that the design professional owes a professional duty to the plaintiff arising separate and distinct from any contractual duties between the parties or with third parties. (citations omitted). Whether such duty exists will depend on the facts and circumstances of each case.
> (*Id.* 463 S.E.2d 89

Subsequently, the South Carolina Supreme Court cited *Tommy L. Griffin* favorably by reversing a lower court order of summary judgment and stating "Further, we noted that whether the design professional owes a duty depends on the facts and circumstances of each case and holding "We find it is a factual issue whether these circumstances give rise to a special relationship between Architect and Cullum." *Cullum*

Mechanical Construction, Inc. v. South Carolina Baptist Hospital, 544 S.E.2d 838, 842 (2001).

The plaintiffs allege that the providing of services by Laurens County Hospital to the Patients created a special relationship. The Patients elected to undergo surgery that could have serious consequences to their health and life expectancy. The hospital provides certain services such as independently determining the scope of practice and types of surgeries each physician can perform in the hospital and protecting the patients by operating the hospital in accordance with state law and regulations. (See paragraphs 13, 41, and 80 of Second Amended Complaint). The patient is virtually putting his life in the hands of the hospital employees. It is difficult to imagine anyone arguing that the relationship between a hospital and a patient is not a special relationship.

The plaintiffs allege that Laurens County Hospital breached the duty of care with the plaintiffs in one or more of the following particulars:

a) failure to require Dr. Brown to comply with the Medical Staff Bylaws which require the physicians privileged to perform surgery to maintain current, valid professional liability insurance coverage in an amount satisfactory to Laurens County Hospital;
b) failure to require Dr. Brown to comply with the Subsidy Contract requirement of maintaining professional liability insurance in the minimum amount of $1,000,000 per occurrence and $3,000,000 aggregate;
c) failure to require Dr. Brown, as a condition of having continuing privileges to perform surgery at Laurens County Hospital, to purchase Extended Reporting Endorsement Coverage (Tail) from JUA under a claims-made policy upon change to another insurance company;
d) failure to require Dr. Brown, as a condition of having continuing privileges to perform surgery at Laurens County Hospital, to purchase Prior Acts Endorsement Coverage from MAG Mutual under a claims-made policy upon change to another insurance company;
e) failure to train, instruct, or employ employees who were knowledgeable about the differences between Occurrence and Claims-Made policies, and who were knowledgeable about Extended Reporting Endorsement Coverage (Tail) and who were knowledgeable about Prior Acts Endorsement Coverage;

f) failure to inform the employee who was responsible for ensuring that Dr. Brown maintained professional liability coverage in accordance with the Medical Staff Bylaws and Subsidy Contract that Dr. Brown was under investigation by Laurens County Hospital for injuries to surgical patients potentially caused from inappropriate surgical/ medical treatment and malpractice; and

g) failure to inform surgical patients of Dr. Brown who received unexpected complications during surgeries performed at Laurens County Hospital that to preserve insurance coverage for their claim, that the claim need to be filed before June 9, 2009 when Laurens County Hospital knew, or should have known, that the patients most probably did not have this information; and Laurens County Hospital had the ability to identify and notify the patients.

The person Laurens County Hospital assigned to monitor the physicians to ensure compliance with the requirement to maintain professional liability insurance was Lynn Reaves who was manager of medical staff services. Ms. Reaves was the person solely responsible on behalf of the hospital, in addition to the Board of Directors, for requiring that the physicians maintain the proper insurance according to the Medical Staff Bylaws. (Attachment 22 – Reaves deposition, 17:6-12). Unfortunately, the Manager of Medical Staff Services had not been properly trained or educated concerning professional liability insurance policies, as partially evidenced by the following:

* did not know the insurance coverage differences between a claims made policy and an occurrence policy because no one from Laurens County Hospital ever explained or informed her of the difference;
* did not know the necessity of Extended Coverage Reporting (Tail Coverage) nor the necessity of Prior Acts Coverage when insurance companies were changed under a claims made policy;
* did not know when Extended Coverage Reporting (Tail Coverage) or Prior Acts Coverage needed to be purchased or the amount of the cost to purchase;
* did not know the effect of change in insurance companies on existing potential claims of patients injured at Laurens County Hospital by the malpractice of Dr. Brown;

* never asked insurance companies to explain coverage even though the insurance policies advised interested persons to contact the company for further information;
* did not know what the retroactive date meant in the MAG Mutual insurance certificate nor the steps to determine its meaning; and
* did not inquire about restrictive endorsements contained in the insurance policy although the insurance certificate stated to contact insurance company for further information.

(Attachment 22 – Reaves deposition, 41:7-10; 25:20-26:2; 37:6-10; 23:19-25; 24:8-12; 24:13-18).

In addition, Ms. Reaves did not know that patients injured by the malpractice of Dr. Brown needed to file a claim with JUA by July 8, 2009. Even though such information was available to a person knowledgeable in professional liability insurance and even though Ms. Reaves knew, or should have known, that the patients injured by Dr. Brown did not have this information, Ms. Reaves did not know to notify the patients that a claim needed to be filed by July 8, 2009. Even worse, Ms. Reaves testified that even if she had known of patients who were injured by Dr. Brown, that she would not have monitored the insurance policy of Dr. Brown more closely nor taken steps to inform appropriate personnel at the hospital that the injured patients needed to be informed of their rights because "that would not have been part of my duties for the hospital." (Attachment 22 – Reaves deposition, 39:12-40:6).

Additionally it was known by the hospital staff during the period of July 9, 2009 to January 14, 2010, (i.e., the period during which Dr. Brown had the right *and opportunity* to purchase Tail insurance) that Dr. Brown was potentially committing malpractice on numerous occasions.

The Affidavit of Sandra Thompson, who was Risk Manager, confirms that:

* concerns arose regarding the October 27, 2009 surgery by Dr. Brown on Dixie Mitchell as being malpractice;

* concerns were raised by Rufus Watkins, MD and Dr. Brown himself about Dr. Brown properly performing the surgeries;
* in early December 2009, eleven charts of patients of Dr. Brown were sent for review by Dr. Madis who submitted his report to the hospital;
* Dr. Stribling, the Chief of Surgery of Laurens County Hospital, raised concerns about a surgical complication caused by Dr. Brown that occurred on December 11, 2009;
* Dr. Stribling raised concerns to Dr. Brian Weaver, Chief of Staff, on December 14, 2009 that resulted in Dr. Brown voluntarily relinquishing certain privileges on a temporary basis on December 15, 2009.

(Attachment 23 – Affidavit of Thompson)

The memo dated January 22, 2010 by Dr. R.W. Watkins sets forth that it was common knowledge among all eleven Scrub Techs that Dr. Brown injured numerous patients during surgeries. The memo stated, in part, that:

> There was a general concern that there were an inordinate number of inadvertent injuries to the bladder, bowel, and ureters, especially with the sling procedure. There was (sic) concerns that when performed by this MD the procedure was dangerous and it was stated there were injuries in "almost every case" and that the procedures "caused more harm than good."

(Attachment 24 – Exhibit 25, Report of R.W. Watkins)

The December 2009 letter from the Chief of Surgery, Dr. Stribling, to the Chief of Staff, Dr. Weaver, sets forth the gravity of concern the medical staff had about the surgical performance of Dr. Brown. Dr. Stribling states "a situation that is of great concern to me. I worry greatly about what appears to be a continuing pattern of surgical misadventures by Dr. Byron Brown. ..... Because of what appears to me to me (sic) a worrisome pattern of complications, I will, as Chief of Surgery, respectfully ask Dr. Brown to temporarily relinquish his privileges to do all pelvic surgery..." (Attachment 25 – Exhibit 26, Letter from Dr. Stribling).

The next day, Dr. Brown relinquished his privileges at Laurens County Hospital to perform hysterectomies, anterior and posterior repairs, and urethral slings until the beginning of 2010. (Attachment 21 – Exhibit 27, letter from Dr. Brown resigning certain privileges). Two months later, Dr. Brown voluntarily entered into an agreement with Laurens County Hospital to significantly reduce the gynecological surgeries he was allowed to perform and agreed to take a leave of absence from the hospital staff positions he held. (Attachment 26 – Exhibit 28, Agreement between Laurens County Hospital and Dr. Brown).

The September 15, 2011 Memorandum of MAG Mutual documents that Dr. Brown self-reported ten separate claims (two for Mitchell for separate surgeries) against his insurance policy. (Attachment 27 – Exhibit 12, Memo of MAG Mutual).

The foregoing is substantial evidence that officials at Laurens County Hospital knew that Dr. Brown was causing serious injuries to patients during surgeries at Laurens County Hospital. The injuries were occurring during the time period from July 9, 2009 to January 14, 2010. Dr. Brown had the right to obtain Tail coverage from JUA during this time which would reinstate the insurance coverage on the McCord and Sherfield claims. Since the Tail coverage was not obtained by Dr. Brown from JUA nor Extended Coverage from MAG Mutual, the professional liability coverage was not maintained in compliance with the Medical Staff Bylaws and Subsidy Contract.

The plaintiffs submit that a factual issue presents as to whether Laurens County Hospital, which was in a special relationship with McCord and Sherfield and with its patients undergoing surgery, negligently breached the duty of care by failing to inform McCord and Sherfield of the claim deadline before July 9, 2010; by failing to require Dr.

Brown to maintain the professional liability insurance while Laurens County Hospital had financial leverage over Dr. Brown; by failing to train, instruct, or employ employees knowledgeable in insurance matters; by failing to monitor physicians committing malpractice to maintain professional liability insurance; and by failing to communicate with other employees regarding malpractice committed by physicians.

G. CASE FILED WITHIN STATUTE OF LIMITATIONS

1. Breach of Contract

An action for breach of contract must be brought within three years of the date the action accrues. *S.C. Code §15-3-530(1)*. The discovery rule determines the date of accrual for a breach of contract cause of action. Pursuant to the discovery rule, a breach of contract accrues not on the date of the breach, but rather on the date the aggrieved party either discovered the breach or could or should have discovered the breach. *Maher v. Tietex Corp*, 500 S.E.2d 204 (S.C. App. 1998).

The Notice of Intent to File Suit in McCord was filed July 29, 2011. The pre-suit mediation was held December 1, 2011 and it was disclosed that MAG Mutual Insurance Company was not providing insurance coverage for the claim. McCord then subpoenaed JUA for the insurance records of Dr. Brown. The insurance records were subpoenaed in January 2012 and responses were probably received in the February-March 2012 time frame. Sometime thereafter, it was learned that JUA did not issue Tail insurance coverage to Dr. Brown. Further, it was months later before McCord received documents from Laurens County Hospital in discovery which included the Medical Staff Bylaws and Subsidy Contract. Sherfield did not contact the law firm until May 5, 2012.

The Notice of Intent to File Suit in Sherfield was filed May 25, 2012. On March 11, 2014, Judge Addy entered judgment in favor of McCord and Sherfield. (Attachment 4 – Exhibit 5 and Exhibit 6)

It would have been some months after December 2011 when documents were produced in the McCord lawsuit that would allow McCord to discover the breach of contract by Laurens County Hospital. It would have been even later for Sherfield because she did not contact the law firm until May 2012. However, even using the earliest date of December 2011as the date of discovery or "accrual" of the breach of contract cause of action, the commencement of action against Laurens County Hospital on March 11, 2014 was well within the three year statute of limitations, Thus, the statute of limitations does not apply to the breach of contract cause of action.

2. Negligent Breach of Duty of Care

An action for negligence under the South Carolina Tort Claims Act must be "commenced within two years after the date the loss was or should have been discovered." *S.C. Code §15-78-10.* It is clear that a cause of action for negligence cannot accrue until there is an injury. An injury must first occur before a party can maintain an action to enforce it since injury is an element of a cause of action in tort. *McAlhany v. Carter*, 781 S.E.2d 105 (S.C. App. 2015).

The plaintiffs did not suffer a loss by the actions of Laurens County Hospital nor have a right to sue Laurens County Hospital until judgment was rendered against Dr. Brown. At that point, the negligent acts of Laurens County Hospital employees resulted in a loss, i.e., judgments would have been covered by professional liability insurance but

was not available. The judgments in favor of McCord and Sherfield were rendered March 11, 2014. (Attachment 4 – Exhibits 5 and Exhibit 6). The action against Laurens County Hospital was filed 15 days later on March 26, 2014, well within the two year time period.

The complaint against Laurens County Hospital and Greenville Health System was filed within the three year time period for breach of contract actions and was filed within the two year time period for negligent breach of duty of care.

H. EXCEPTION TO WAIVER OF IMMUNITY IN TORT CLAIMS ACT DOES NOT APPLY IN THIS CASE

Laurens County Hospital contends that paragraph 4 of *S.C. Code §15-78-60* provides immunity to Laurens County Hospital; however, the immunity provisions do not apply to the breach of contract cause of action.

The title of this Act is "South Carolina Tort Claims Act". *S.C. Code §15-78-20.* The purpose of the Act, in part, is stated as "Public Policy Regarding Tort Liability" ... "Contract Liability Unaffected". *S.C. Code §15-78-20.* Specifically, "d) Nothing in this chapter affects liability based on a contract nor does it affect the powers of the State or its political subdivisions to contract." *S.C. Code §15-78-20 (d).*

Thus, it is clear that the South Carolina Tort Claims Act does not apply to breach of contract which is the first cause of action.

The second cause of action is a negligence cause of action for failure to exercise due care by Laurens County Hospital in providing services related to surgeries performed by Dr. Brown at Laurens County Hospital that had serious affect on the quality of life and life expectancy of McCord and Sherfield. A special relationship required Laurens County Hospital to exercise due care in providing services which

plaintiffs allege Laurens County Hospital failed to do. (See paragraphs 5, 6, 7, 8, 9, 10, 11, 12, 13, 14, 15, 16, 80, 81 and 82 of Second Amended Complaint).

The South Carolina Tort Claims Act does not provide immunity for Laurens County Hospital failing to exercise due care in providing services to its patients with whom it has a special relationship. This is a general negligence action. (See: *Dawkins v. Union Hospital District*, 658 S.E.2d 501 (S.C. 2014) holding action against hospital for injuries to patient from fall when patient attempted to use bathroom was a negligence claim, not a malpractice claim.)

There is also a legal question that has not been established which is "Are Laurens County Hospital and Greenville Health System political subdivisions of the State of South Carolina or some other corporate form such as a public service district?" The distinction is relevant because the South Carolina Tort Claims Act appears to cover just "the State, political subdivisions, and employees, while acting within the scope of official duty." *S.C. Code §15-78-20(b)*.

Recently, various newspapers have reported that the Greenville Health System governing board has denied the State of South Carolina from conducting an audit because Greenville Health System took the position that it is not a political subdivision of the State; but, rather, a public service district. Also, the Greenville Health System filed and threatened to file legal actions to determine its legal status so that it may enter into contracts with out-of-state corporations. Suffice it to say that there has been no evidence that Laurens County Hospital or Greenville Health System are political subdivisions of the State of South Carolina. If Greenville Health System or Laurens

County Hospital make this claim, the plaintiffs request the opportunity to conduct discovery, including depositions and document production, on this issue.

The plaintiffs submit that the immunity of the South Carolina Tort Claims Act does not cover breach of contract which is the First Cause of Action. Also, the South Carolina Tort Claims Act does not cover negligent breach of the duty of care in a special relationship which is the Second Cause of Action. Further, there is no evidence that either Laurens County Hospital or Greenville Health System is a political subdivision of the State and entitled to the protection of the South Carolina Tort Claims Act.

CONCLUSION

The plaintiffs request that the Motion for Summary Judgment be denied for the reasons set forth above.

Respectfully submitted,

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ATTORNEYS FOR THE PLAINTIFFS

August 11, 2015
Anderson, South Carolina

STATE OF SOUTH CAROLINA	)	IN THE COURT OF COMMON PLEAS
	)	
COUNTY OF LAURENS	)	C.A. FILE NO. 14-CP-30-250
Chris Katina McCord, Christopher McCord, Janice Sherfield, and Jerry Sherfield,	)	
Plaintiffs,	)	CERTIFICATE OF SERVICE
vs.	)	
Laurens County Health Care System and Greenville Healthcare System,	)	
Defendants.	)	

I, Terry D. Allen, am an employee with the law firm of McGowan, Hood & Felder, LLC, attorneys for the Plaintiffs. I do hereby certify that I have served all counsel in this action with a copy of the documents herein specified by mailing a copy of the same by U.S. Mail at Anderson, South Carolina, with first class postage paid as follows:

PLEADINGS: Plaintiffs' Memorandum in Opposition to Motion for Summary Judgment

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DATE OF MAILING: August 11, 2016

McGowan, Hood & Felder, LLC

Terry D. Allen,
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August 11, 2016

STATE OF SOUTH CAROLINA COUNTY OF LAURENS Chris Katina McCord, Christopher McCord, Janice Sherfield, and Jerry Sherfield, Plaintiffs, v. Laurens County Health Care System and Greenville Health System, Defendants.	IN THE COURT OF COMMON PLEAS C.A. No.: 2014-CP-30-250 ***Defendants' Reply Memorandum in Support of Summary Judgment***

In response to Defendants' Motion for Summary Judgment, Plaintiffs have filed a "Memorandum in Opposition to Motion for Summary Judgment" dated August 11, 2016 (hereinafter "Plaintiffs' Memo") and a "Supplement to Memorandum in Opposition to Motion for Summary Judgment" dated December 8, 2016 (hereinafter "Plaintiffs' Supplement"). While many of Plaintiffs' arguments were anticipated and addressed in Defendants' initial motion and memorandum, Defendants feel compelled to file this reply memorandum to address a few issues raised by Plaintiffs' memorandums. Defendants will address each issue in the order in which they were raised by Plaintiffs:

1. On page 5 of Plaintiffs' Memo, Plaintiffs state that it "has been judicially determined that Dr. Brown committed medical malpractice..." Technically, that is not correct. Plaintiffs obtained default judgments against Dr. Brown. A factfinder never determined that Dr. Brown committed malpractice. That is important because Plaintiffs now contend that Defendants should be responsible for damages that neither Defendant, nor anyone else, contested in court.

2. On pages 6 and 7 of Plaintiffs' Memo, Plaintiffs argue that the term "services" is ambiguous and should include things like complying with state laws and regulations. While Defendants anticipated this argument and addressed it in their initial memorandum, Plaintiffs' own use of the term "services" further demonstrates how disingenuous the argument is. In the first sentence on page 9, Plaintiffs contend that "a hospital cannot provide any services to patients until after it has been licensed..." How can "services" include complying with laws and regulations if, by Plaintiffs' own admission, hospitals have to be in compliance with the laws and regulations before they can provide any "services."

3. On page 9, Plaintiffs quote Section 3.2.1(e) of the Medical Staff Bylaws. As noted there, the section states LIPs "shall maintain valid professional liability insurance coverage in the amounts deemed necessary by the Board from time to time and shall provide a current certificate of insurance as recommended." Plaintiffs and their expert, Dr. Hyde, have tried to insert the words "at all times" after "maintain" to support their argument that Dr. Brown was required under the Bylaws to purchase "tail coverage." However, those words simply are not there. In fact, other than briefly referencing the amount of coverage required, The Bylaws are silent as to any specifics about the professional liability coverage that is required. They do not specify whether the policy should be claims made or occurrence based. They do not specify what endorsements or exclusions may or may not be in the policy. There is simply nothing in The Bylaws, or any other evidence in the record, indicating that Laurens required Dr. Brown to maintain professional liability insurance that would cover all claims made against him.

4. On page 15, Plaintiffs contend that Laurens had several options in which it could have forced Dr. Brown to purchase tail coverage, but all of Plaintiffs' contentions are purely speculative.

There is no evidence that Dr. Brown would have agreed to purchase tail coverage if Laurens threatened to suspend his privileges or threatened to demand immediate repayment of the amount owed under the Subsidy Contract. In fact, it is undisputed that Laurens did each of those things and it had no impact on Dr. Brown's decision to forego tail coverage.

5. Beginning on page 16, Plaintiffs argue that they should be allowed to maintain a negligence action against Defendants, because there were duties breached that did not arise out of the contract between the parties; however, it is unclear what duties Plaintiffs are referring to. The duties identified on pages 18 and 19 that they allege arose from the "special relationship" are the exact same duties they spent the first 15 pages of their memo arguing were contractual duties. The law does not allow Plaintiffs to argue a breach of the same duty under both a contract and tort theory. *See Tommy L. Griffin Plumbing & Heating Co. v. Jordan, Jones, & Goulding, Inc.*, 320 S.C. 49, 54-55, 463 S.E.2d 85, 88 (1995).

6. Beginning on page 23, Plaintiffs argue that the case was filed within the statute of limitations. As an initial matter, at this time, Defendants are only alleging the defense bars Plaintiffs' tort cause of action, not their contract cause of action. Plaintiffs do not dispute that the McCords were aware of the possibility that there was no insurance coverage by December 1, 2011. Plaintiffs contend in the last line on page 23 that "Sherfield did not contact the law firm until May 5, 2012." Defendants believe this to be a typo as the records produced during discovery show that Sherfield filled out a client questionnaire on May 5, 2011 and had entered into a retainer agreement with counsel by December 2011. Further, Plaintiffs already admitted that their counsel was aware as of December 1, 2011 of the possibility that Dr. Brown did not have any medical malpractice insurance coverage for the claims brought by Mr. and Mrs.

Sherfield. (*see* Plaintiffs' Resp. to Def. First Req. for Admissions, ¶ 5, attached as Exhibit D to Defendants' motion)

7. On page 24, Plaintiffs argue that they did not suffer a loss by the actions of Laurens or have a right to file suit against Laurens until a judgment was rendered against Dr. Brown. This point highlights many of the fallacies of this case. First it proves that Plaintiffs are essentially contending that Laurens should indemnify Dr. Brown when there is no evidence that Laurens ever agreed to do so. Second, contrary to their contentions, had Dr. Brown purchased tail coverage or extended bad acts coverage, they would not have automatically recovered the entirety of their judgments. Dr. Brown had a $1M/$3M policy, so at most they would have received $1M each, and it is certainly a possibility that given the fact that several other claims were made against Dr. Brown in 2009, he may have already exceeded his $3M annual aggregate, which would have precluded Plaintiffs from receiving any insurance proceeds. In addition, the testimony from Plaintiffs' insurance expert confirmed that Dr. Brown's move out of the country and subsequent refusal to participate in the defense of the case could have provided grounds for his carrier to deny coverage for the claims. (See Dep. Of James M. Carson, Ph.D., July 7, 2016, pp. 18-19, attached hereto as Exhibit A). Finally, Plaintiffs knew as of December 1, 2011 that there may not be coverage for their claims against Dr. Brown, but in an attempt to get around the statute of limitations, Plaintiffs now argue that they were not actually injured until they were unable to collect the judgments against Dr. Brown in March of 2014. However, if their claims are dependent upon their inability to collect the judgments, then their claims still have not ripened as they have another six years in which they could enforce the judgments against Dr. Brown. *See* S.C. Code § 15-35-810.

8. In the last part of Plaintiffs' Memo, Plaintiffs argue that there is a legal question as to whether Defendants are subject to the Tort Claims Act. As noted in Defendants initial memorandum, there are no allegations that GHS is independently liable to Plaintiffs, so GHS's status is irrelevant, though Defendants would point out that the South Carolina Supreme Court has held the Tort Claims Act applicable to GHS. *See Benton v Roger C Peace*, 313 S.C. 520, 443 S.E.2d 537 (1994). All negligent acts or omissions are asserted against Laurens prior to its agreement with GHS, so the only question is whether Laurens was subject to the Tort Claims Act at the time of the alleged negligent acts or omissions. Plaintiffs do not and cannot dispute that it was as Plaintiffs' counsel has acknowledged the applicability of the Tort Claims Act to Laurens in numerous prior cases in front of this court.
9. In Plaintiffs' Supplement, they argue that because South Carolina statutes specify that hospitals are to operate for the benefit of the inhabitants of the area, they are intended beneficiaries of the hospital's operations, including its bylaws. While hospitals without question provide a benefit to the citizens of the community, not everything the hospital does is for the benefit of individual citizens. It is a business, and it has to do many things to ensure that it stays in business, which includes things that may not benefit individual citizens. For example, the hospital's services generally are not provided for free. At times those services can come at a great cost to individual citizens. The same is true with the bylaws. While some bylaws certainly provide a benefit to patients, others are enacted solely for the benefit of the hospital to ensure that its business interests are protected.
10. On page 2 of Plaintiffs' Supplement, they misquote Defendants' expert. Mr. Weiss specifically denied that the professional liability insurance requirement in the Bylaws was there for the benefit of the patients. (Weiss dep., p. 58:9-14). Plaintiffs take the quoted

portion from page 67:2-20 of Weiss's deposition out of context and change the pronoun "they" at the beginning to "the patients," but when the sentence is read in its full context, it is clear that when Mr. Weiss said "they" he was referring to the hospital.

11. On page 3, they cite p. 71:12-21 of Weiss's deposition for the proposition that the failure of the medical staff to enforce the Bylaws would be a violation of their duties. Again, when read in its full context, it is clear that Weiss only agreed that if the medical staff failed to enforce some of the Bylaws (he was specifically asked about a hypothetical situation in which a doctor would be allowed to perform a surgery he was not credentialed to perform), it could be a violation of their duties. He did not agree that the medical staff owed a duty to patients to enforce all of the Bylaws.

12. On page 3, Plaintiffs again argue that Laurens had access to information about Dr. Brown committing malpractice that Plaintiffs did not have any way of discovering, and that had Laurens shared that information with Plaintiffs, they would have filed a lawsuit before the policy expired. Defendants will point out again that there is no evidence that Laurens had any knowledge of Dr. Brown potentially committing malpractice until several months after he switched insurance carriers and declined to purchase tail or prior bad acts coverage. And once Laurens found out, they immediately began an investigation which ultimately led to Dr. Brown's privileges being revoked.

In conclusion, Plaintiffs have submitted "voluminous" amounts of information and set forth a litany of "facts" in an attempt to confuse the issue and create a question of fact, but this case is not nearly as complicated as Plaintiffs would have this Court believe. They each filed suit against Dr. Brown alleging medical malpractice, and they each obtained default judgments against him. They have been unable to collect those judgments, so they now want to have

Defendants held responsible for the judgments despite the fact that Defendants were not a party to those actions and had no opportunity to defend those actions, which would be a fairly obvious violation of the Due Process Clause.

At the end of the day, the question for this Court is fairly simple - did Laurens owe a legal duty to Plaintiffs to ensure that Dr. Brown had insurance coverage for their claims at the time those claims were made? That is a question that must be answered by this Court and one that cannot be left for a jury to decide. *Madison v. Babcock Ctr., Inc.*, 371 S.C. 123, 136, 638 S.E.2d 650, 656 (2007). If this Court determines that there was no such duty, then Defendants are entitled to summary judgment as a matter of law. Id.

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Dated: 1/5/17
Greenville, SC

STATE OF SOUTH CAROLINA COUNTY OF LAURENS Chris Katina McCord, Christopher McCord, Janice Sherfield, and Jerry Sherfield. Plaintiffs, v. Laurens County Health Care System and Greenville Health System, Defendants.	IN THE COURT OF COMMON PLEAS C.A. No.: 2014-CP-30-250 ***Certificate of Service***

I HEREBY CERTIFY that a copy of **Defendants' Reply Memorandum in Support of Summary Judgment** was served upon counsel of record, Joseph G. Wright, by email dated January 5, 2017 and an additional copy will be served by hand delivery at the motion hearing scheduled for January 6, 2017.

HAYNSWORTH SINKLER BOYD, P.A.

Kenneth N. Shaw

Greenville, SC

EXHIBIT A

Q. And what are some other reasons that coverage may not have applied?

A. Well, every -- wouldn't be an insurance contract without exclusions. And so, like other policies, there's a host of exclusions and a section of exclusions of course. And so anything from fraud to violating statutes and a whole host of other reasons.

Q. If the doctor failed to cooperate in the defense of the claim, would that be a reason for denying coverage?

A. One of the duties is to cooperate with the insurer. And so it's usually not in the exclusions section, but it's more part of the duties that you follow for coverage. And so I wouldn't say it necessarily gave rise to denial of coverage, but it certainly can be problematic in how the insurer is able to handle the claim or the coverage.

Q. In your experience, has an insurance company ever denied coverage because the insured refused to cooperate in the claim?

A. I've never been involved in a case where that was the question. And I don't have particular knowledge that that has been a cause for denial of

coverage. So I'm not sure if that's been a reason that's been used.

Q. But certainly there's language in most insurance policies, liability insurance policies, that request or require that the insured cooperate in any defense of a claim on the policy; is that correct?

A. Yes.

Q. And if the insured did not do that, the insured would then be in breach of the contract between the insured and the insurance carrier, correct?

A. I'm not sure if I'd use the word breach, but certainly they -- if they weren't cooperating, as you say, then that would be against the policy terms.

Q. In an insurance contract, the insurance company -- so if we say in this case JUA. JUA's obligations under the insurance policy would be to the insured, to Dr. Brown, correct?

A. Dr. Brown was the named insured, so yes.

Q. And the insurance company owes their obligations and their duties to the insured. Am I correct in that?

A. The insured would be the primary person in this case that the insurer owes allegiance to.

STATE OF SOUTH CAROLINA	)	IN THE COURT OF COMMON PLEAS
	)	
COUNTY OF LAURENS	)	C.A. FILE NO. 14-CP-30-250
Chris Katina McCord, Christopher McCord, Janice Sherfield, and Jerry Sherfield,	)	
Plaintiffs,	)	SECOND AMENDED COMPLAINT AND DEMAND FOR JURY TRIAL
vs.	)	
Laurens County Health Care System and Greenville Health System,	)	
Defendants.	)	

LAURENS COUNTY
CLERK OF COURT
2017 JAN 11 11:09
LYNN W. LANCASTER

Plaintiffs, complaining of Defendants herein, would respectfully show unto the Court and allege that:

1. Plaintiffs, Chris Katina McCord ("Mrs. McCord") and Christopher McCord ("Mr. McCord"), are residents of the County of Laurens, State of South Carolina and are presently and were husband and wife at all relevant times herein.

2. Plaintiffs, Janice Sherfield ("Mrs. Sherfield") and Jerry Sherfield ("Mr. Sherfield"), are residents of the County of Laurens, State of South Carolina and are presently and were husband and wife at all relevant times herein.

3. Defendant, Laurens County Healthcare System, d/b/a Laurens County Hospital ("Laurens County Hospital"), was, at all relevant times herein, upon information and belief, a private non-profit corporation organized and existing under the laws of the State of South Carolina with its principal place of business in Laurens County, South Carolina. Subsequent to the acts giving rise to the causes of action herein, upon

information and belief, Laurens County Hospital entered into an agreement of consolidation or merger with Greenville Health System dated July 1, 2013.

4. Defendant, Greenville Health System ("GHS"), is a political subdivision of the State of South Carolina with its principal place of business in Greenville County, South Carolina. Subsequent to the acts giving rise to the causes of action herein, upon information and belief, GHS entered into an agreement with Laurens County Hospital entitled Lease and Contribution Agreement Between Laurens County Health Care System and Greenville Health System ("Agreement"). Under Section 2.3 Assumption of Liabilities, GHS agreed, among other things, to assume, perform and discharge any and all liabilities and obligations of Laurens County Hospital related to the hospital which existed as of July 1, 2013. The liability and obligation of Laurens County Hospital to McCord and Sherfield was related to the hospital and existed as of July 1, 2013. Accordingly, the McCord and Sherfield liability and obligation was assumed by GHS and GHS agreed to perform and discharge the liability and obligation to McCord and Sherfield.

5. In 1999, the Institute of Medicine published a report entitled "To Err Is Human" which estimated that as many as 98,000 people a year die in U.S. hospitals because of medical errors. On an annual basis, in the United States, there are more deaths in hospitals due to medical errors than deaths from motor vehicle accidents. This is in addition to patients who do not die but suffer serious injuries from medical errors as experienced by Mrs. McCord and Mrs. Sherfield.

6. In 2010, the Office of the Inspector General for the Department of Health and Human Services estimated that medical negligence contributed to the deaths of 180,000 Medicare patients a year.

7. In 2013, the Journal of Patient Safety estimated that between 210,000 and 440,000 patients suffer some type of preventable harm in U.S. hospitals that contributed to their death.

8. United States hospitals were aware in 2008 and 2009 of the medical malpractice epidemic that caused the high incidence of deaths and serious injuries to patients in hospitals; consequently, it was common practice for hospital administrations to require physicians that are allowed to treat patients and perform surgery in hospitals to carry and maintain medical malpractice insurance.

9. The purpose of hospitals requiring physicians that it allows to perform surgery to carry and maintain medical malpractice insurance is, in part, to benefit and protect innocent patients who are injured while in the hospital due to negligent conduct of the surgeon to have a means to recover damages for the injuries wrongfully inflicted upon them.

10. The public policy of South Carolina in 2008 and 2009 required hospitals to monitor patient care through oversight, to ensure that the patient received quality medical care, to have as a high priority the safety of the patients, and to protect the patients while in the hospital.

11. The State of South Carolina in 2008 and 2009 had in force policies, procedures, programs, statutes, and funding to support the public policy to monitor patient care through oversight, to ensure that the patients received quality medical care,

to have as a high priority the safety of the patients, and to protect the patients while in the hospital, such as:

* funding of Medicaid to pay hospitals for patient care;
* funding for the Medical University of South Carolina and the University of South Carolina Medical School for physician training to deliver healthcare in the hospitals of South Carolina; and
* tax reductions and financial grants to hospitals in South Carolina.

12. Laurens County Hospital, like other hospitals in South Carolina, adopted Medical Staff Bylaws to monitor patient care through oversight, to ensure that the patients received quality medical care, to have as a high priority the safety of the patients, and to protect the patients while in the hospital by requiring the following:

a) To ensure that all patients admitted to or treated in any of the facilities, departments, or services of the Hospital shall receive the quality of patient care that is achievable commensurate with community resources available;

b) To be accountable to the Board for ensuring an optimal level of professional performance of all LIPs ("physicians") authorized to practice in the Hospital through the appropriate delineation of Clinical Privileges and through an ongoing review and evaluation of each physician's performance in the Hospital;

c) To provide oversight of care, treatment and services provided by members of the Medical Staff, assure uniform quality of patient care treatment and services and be accountable to the Board for same;

d) To initiate and maintain rules and regulations for the proper functioning of the Staff;

e) To account and report to the Board concerning organizational performance improvement activities in the Hospital;

f) To assure the qualifications and competence of physicians through a credentialing procedure, including mechanisms for appointment and reappointment and the delineation of Clinical Privileges;

g) To evaluate and monitor the quality of patient care;

h) To develop and monitor compliance with these Bylaws, the Rules and Regulations of the Staff, and other Hospital policies, all as may be in effect and as may be from time to time amended;

i) To assure that the same level of care will be provided for all patients receiving a similar service, regardless of the location in which the service is provided.

13. Laurens County Hospital independently determines the scope of practice and types of surgeries each physician can perform in the hospital. The scope of practice and types of surgeries the hospital approves for each physician is referred to as privileges granted by Laurens County Hospital.

14. One of the requirements for being privileged initially and continuing at Laurens County Hospital was for the physician to possess current, valid professional liability insurance in an amount satisfactory to the hospital. This requirement is to make certain that the physician has medical malpractice insurance to compensate any patients that the physician injured by malpractice.

15. On February 14, 2002, Byron A. Brown, MD ("Dr. Brown") and Laurens County Hospital entered into an agreement in which Laurens County Hospital agree, among other things, to assist Dr. Brown in establishing his practice in Laurens County, South Carolina, by agreeing to subsidize and guarantee his net practice collection of $27,000 per month for 36 months ("Subsidy Contract") and then to be repaid prorata over the next ten years. Dr. Brown agreed to pursue the medical practice on a full-time basis, to comply with all provisions of the Medical Staff Bylaws of Laurens County Hospital, to provide services in his specialty on an on-call rotation basis to all patients he is requested by other physicians to see at Laurens County Hospital, and to provide professional services to the community and to patients at Laurens County Hospital.

16. An important condition of the Subsidy Contract, as well as compliance with the Medical Staff Bylaws, was the requirement that Dr. Brown maintain professional liability insurance and failure to maintain the professional liability insurance made the Subsidy Contract subject to termination. Further, that the professional liability limits be a minimum of $1,000,000 per claim / $3,000,000 aggregate; that proof that the premiums on said policy have been prepaid be furnished; and that the policy remain in full force and effect. Additionally, Dr. Brown was required to notify his insurance company that if said policy was cancelled for any reason, that notice of cancellation was to be provided by the insurance company to the Chief Executive Officer of Laurens County Hospital.

17. Dr. Brown obtained a Professional Liability Policy, i.e., medical malpractice insurance policy, issued by South Carolina Medical Malpractice Insurance Joint Underwriting Association ("JUA") Policy Number JBM00560 in the amount of $200,000 each claim and $600,000 annual aggregate for the policy period July 9, 2002 to July 9, 2003 ("JUA Policy") and additional unlimited coverage from the South Carolina Patients' Compensation Fund ("PCF").

18. Dr. Brown maintained professional liability insurance coverage from JUA/PCF until July 9, 2009.

19. Dr. Brown received the sum of $644,447 in subsidy payments from Laurens County Hospital from 2002 until June 2005. The Subsidy Contract provided the subsidy payments would be forgiven on a prorated portion over ten years which was $5,370 per month beginning July 2005 and continuing until June 2015.

20. Laurens County Hospital had the authority to terminate its obligations to Dr. Brown under the Subsidy Contract if the professional liability insurance was canceled and require Dr. Brown to repay all subsidy advances immediately.

21. On December 18, 2008, Mrs. McCord presented to Laurens County Hospital for elective surgery to be performed by Dr. Brown. Before admission to the hospital, Mrs. McCord and the agents, servants, and employees of Laurens County Hospital entered into a contract and executed certain documents, one of which is entitled "Conditions of Admission". The express and implied terms of the contract included, among other things, a promise by Mrs. McCord to pay, or cause to be paid, the account of the hospital in accordance with the regular rates and terms of the hospital and the hospital agreed to render services to Mrs. McCord.

22. The "Conditions of Admission" document did not specify the services to be rendered to the patient by Laurens County Hospital, however, the services would include, at a minimum, the requirements of Laurens County Hospital to provide the following essential services:

* compliance with state law and regulations;
* compliance with federal law and regulations;
* compliance with the Medical Staff Bylaws by Laurens County Hospital and the privileged physicians, specifically the portions that affect the health, safety, and legal rights of the patients; and
* compliance with the contracts between Laurens County Hospital and privileged physicians, specifically the portions that affect the health, safety, and legal rights of the patients.

23. The Conditions of Admission document was prepared by agents, servants, or employees of Laurens County Hospital and has been used by Laurens County Hospital since, at least, 1993.

24. On December 18, 2008, Dr. Brown performed surgery on Mrs. McCord by implanting mesh and a sling during surgery without assessing Mrs. McCord for signs or symptoms of incontinence. The surgery was unnecessary and Mrs. McCord was severely injured by the malpractice of Dr. Brown.

25. On February 19, 2009, Mrs. McCord again presented to the Laurens County Hospital for corrective surgery to be performed by Dr. Brown. Before admission to the hospital, Mrs. McCord and the agents, servants, and employees of Laurens County Hospital entered into a contract and executed certain documents, one of which is entitled "Conditions of Admission". Dr. Brown performed additional surgery on Mrs. McCord. Again, Mrs. McCord was severely injured during this surgery by the malpractice of Dr. Brown.

26. On April 17, 2009, Mrs. McCord again presented to the Laurens County Hospital for corrective surgery to be performed by Dr. Brown. Before admission to the hospital, Mrs. McCord and the agents, servants, and employees of Laurens County Hospital again entered into a contract and executed certain documents, one of which is entitled "Conditions of Admission". Dr. Brown performed additional surgery on Mrs. McCord. Again, Mrs. McCord was severely injured during this surgery by the malpractice of Dr. Brown.

27. Dr. Brown committed numerous acts of medical malpractice on Mrs. McCord that caused significant injuries resulting in 33 corrective surgeries to date with additional future medical treatment which will be needed for treating the injuries caused by Dr. Brown's negligence.

28. Laurens County Hospital submitted medical bills to Mr. and Mrs. McCord in the amount of $56,962.00 for the three surgeries which occurred at Laurens County Hospital and, in accordance with the terms and conditions of the contract, Mr. and Mrs. McCord paid, or caused to be paid, an agreed upon amount to Laurens County Hospital.

29. The malpractice claims of Mrs. McCord against Dr. Brown for the surgeries he performed on December 18, 2008, February 19, 2009, and April 17, 2009 were covered under the JUA Policy at the time of the surgeries.

30. It has been judicially determined that Dr. Brown was negligent and inflicted damages on Mrs. McCord as a result of his malpractice in the amount of $1,740,392.75, plus interest, and to Mr. McCord in the amount of $58,789.40,plus interest.

31. On May 29, 2009, Mrs. Sherfield presented to Laurens County Hospital for elective surgery to be performed by Dr. Brown. Before admission to the hospital, Mrs. Sherfield and the agents, servants, and employees of Laurens County Hospital entered into a contract and executed certain documents, one of which is entitled "Conditions of Admission". The express and implied terms of the contract, among other things, included a promise by Mrs. Sherfield to pay, or cause to be paid the account of the hospital in accordance with the regular rates and terms of the hospital and the hospital agreed to render services to Mrs. Sherfield.

32. On May 29, 2009, Dr. Brown performed surgery on Mrs. Sherfield by implanting mesh without assessing Mrs. Sherfield for signs or symptoms of incontinence. The surgery was unnecessary and Mrs. Sherfield was severely injured during this surgery by the malpractice of Dr. Brown.

33. Dr. Brown committed acts of medical malpractice on Mrs. Sherfield that caused significant injuries resulting in 11 corrective surgeries to date with additional future medical treatment which will be needed for treating the injuries caused by Dr. Brown's negligence.

34. Laurens County Hospital submitted medical bills to Mr. and Mrs. Sherfield in the amount of $51,269.00 for the surgery which occurred at Laurens County Hospital and, in accordance with the terms and conditions of the contract, Mr. and Mrs. Sherfield paid, or caused to be paid, an agreed upon amount to Laurens County Hospital.

35. The malpractice claims of Mrs. Sherfield against Dr. Brown for the surgery he performed on May 29, 2009 were covered under the JUA Policy at the time of the surgery.

36. It has been judicially determined that Dr. Brown was negligent and inflicted damages on Mrs. Sherfield as a result of his malpractice in the amount of $1,468,580, plus interest, and to Mr. Sherfield in the amount of $50,000, plus interest.

37. The JUA Policy was issued July 9, 2002 for a one year period and renewed each year thereafter until July 9, 2008. The JUA Policy was an Occurrence Policy which meant that if malpractice occurred during the term of the policy, then insurance coverage would be in effect.

38. For the term beginning July 9, 2008, the JUA Policy was changed from an Occurrence to a Claims-Made policy and the Policy Number was changed to JBC00041. The primary difference in coverage between the two is that both require the bad acts to occur during the policy period, but Claims-Made also requires that the claim be reported during the policy period.

39. Laurens County Hospital required insurance companies to provide certificates of medical malpractice insurance for the purpose of monitoring physician compliance with the Medical Staff Bylaws and, in Dr. Brown's case, the Subsidy Contract to benefit and protect patients by ensuring that funds are available to compensate patients who are injured due to physician malpractice during surgery at Laurens County Hospital.

40. The importance of physicians maintaining malpractice insurance is partially reflected by the requirement Laurens County Hospital set forth in the Medical Staff Bylaws and the provisions of the Subsidy Contract that physicians must maintain malpractice insurance coverage to continue being allowed to practice medicine in the hospital.

41. The providing of services by Laurens County Hospital to Mr. and Mrs. McCord and the providing of services by Laurens County Hospital to Mr. and Mrs. Sherfield created a special relationship. This is the same relationship that exists between patients and hospitals throughout the United States. The patients elect to undergo surgery that could have serious consequences to their health and life expectancy. The patients elect to use the hospital and pay the hospital fees. The hospital agrees to provide the services to operate the hospital according to state and federal laws and regulations and to protect the patient, in part, by requiring the physicians to comply with the hospital policies and procedures, medical staff by-laws, and any contracts between the hospital and physicians.

42. Laurens County Hospital had the means to be informed about the medical malpractice coverage of Dr. Brown which neither Mr. and Mrs. McCord nor Mr. and Mrs. Sherfield had. Thus, Laurens County Hospital is the sophisticated party in the special relationship between Laurens County Hospital and its patients.

43. During the policy period of 7/9/2008 to 7/9/2009, the negligence of Dr. Brown caused injury to Chris Katina McCord and Janice Sherfield so that the claims arose while the JUA Claims Made Policy was in effect. Additionally, the spousal claims of Christopher McCord and Jerry Sherfield also arose while the JUA Claims Made Policy was in effect.

44. For the policy period of 7/9/2009 to 7/9/2010, Dr. Brown changed insurance companies from JUA to MAG Mutual Insurance Company ("MAG Mutual"). In order to maintain coverage for non-reported claims prior to 7/9/2009, Dr. Brown needed to purchase Extended Reporting Endorsement ("Tail") from JUA or purchase Prior Acts Coverage from MAG Mutual.

45. If Laurens County Hospital had properly monitored the professional liability insurance coverage of Dr. Brown, Laurens County Hospital would have known that the change in the insurance policy providing professional liability insurance coverage for Dr. Brown would require, for insurance coverage to be maintained on existing potential claims of patients, either:

a) the purchase of Extended Reporting Coverage ("Tail") from JUA;
b) the purchase of Prior Acts Coverage from MAG Mutual; or
c) filing a claim with JUA prior to July 9, 2009.

46. Laurens County Hospital had the means to require Dr. Brown to maintain the professional liability insurance because the Medical Staff Bylaws required

professional liability insurance coverage to be maintained as did the Subsidy Contract and failure to comply would subject Dr. Brown to a loss of privileges and cancellation of the obligations of Laurens County Hospital under the Subsidy Contract to continue forgiveness of the subsidy outstanding at the rate of $5,370 per month.

47. The person solely responsible for collecting insurance certificates documenting compliance by the physicians privileged to practice at Laurens County Hospital with the malpractice insurance requirements set forth in the Medical Staff Bylaws and the Subsidy Contract was the Manager of Medical Staff Services and ultimately the Board of Directors of Laurens County Hospital was responsible for making sure the physicians complied with the Medical Staff Bylaws and the Subsidy Contract.

48. Unfortunately, the Manager of Medical Staff Services had not been properly trained or educated concerning medical malpractice insurance policies, as partially evidenced by the following:

* did not know the insurance coverage differences between a claims made policy and an occurrence policy because no one from Laurens County Hospital ever explained or informed her of the difference;
* did not know the necessity of Extended Coverage Reporting (Tail Coverage) nor the necessity of Prior Acts Coverage when insurance companies were changed under a claims made policy;
* did not know when Extended Coverage Reporting (Tail Coverage) or Prior Acts Coverage needed to be purchased or the amount of the cost to purchase;
* did not know the effect of change in insurance companies on existing potential claims of patients injured at Laurens County Hospital by the malpractice of Dr. Brown;
* never asked insurance companies to explain coverage even though the insurance policies advised interested persons to contact the company for further information;
* did not know what the retroactive date meant in the MAG Mutual insurance certificate nor the steps to determine its meaning; and

* did not inquire about restrictive endorsements contained in the insurance policy although the insurance certificate stated to contact insurance company for further information.

49. During 2009, Dr. Brown severely injured a number of patients while performing surgery at Laurens County Hospital.

50. Concerns about the frequency and severity of injuries to patients undergoing surgery at Laurens County Hospital that were caused by Dr. Brown were raised by other surgeons on, or before, October 2009.

51. As a result of these concerns, the Risk Manager of Laurens County Hospital selected patient charts to be reviewed by outside gynecological surgeons because of concerns about the surgical competence of Dr. Brown. Nine charts were initially sent to Mark Madis, MD ("Dr. Madis") for his review.

52. In December 2009, while this review was underway, the Chief of Surgery reported to the Chief of Staff a serious injury caused to another patient by Dr. Brown that prompted a letter demand for Dr. Brown to temporarily relinquish surgical privileges because the situation with Dr. Brown was of "great concern" and "appears to be a continuing pattern of surgical misadventures" that has developed into a "worrisome pattern of complications."

53. Dr. Brown complied with the request of the Chief of Staff and temporarily relinquished his surgical privileges in December 2009.

54. On December 30, 2009 the report of Dr. Madis documented numerous occurrences outside the standard of care by Dr. Brown and recommended additional training and supervision of Dr. Brown.

55. Additional charts were selected by the Risk Manager for review by Dr. Madis and John Monroe, MD ("Dr. Monroe"), another gynecologist.

56. The Risk Manager did not inform the Manager of Medical Staff Services of the serious occurrences of potential malpractice of Dr. Brown under investigation nor inquire as to the status of Dr. Brown's insurance coverage for the injured patients.

57. At this time, Laurens County Hospital was forgiving a portion of the $644,000 subsidy provided under the Subsidy Contract at the rate of $5,370 per month because the privilege to perform surgery at Laurens County Hospital had not been withdrawn.

58. The failure, however, of Dr. Brown to maintain malpractice insurance coverage was a violation of the Subsidy Contract and a violation of the Medical Staff Bylaws for which Laurens County Hospital had the authority to terminate the privileges of Dr. Brown and demand payment of the balance due of the subsidy payments which would have been approximately $300,000 in January 2010.

59. Laurens County Hospital had the means to require Dr. Brown to comply with the Medical Staff Bylaws and the Subsidy Contract by purchasing either Extended Coverage from JUA or Prior Acts coverage from MAG Mutual.

60. The claims of Mrs. McCord and Mrs. Sherfield for injuries received from the malpractice of Dr. Brown vested subject only to notification to JUA of the claims during the policy term.

61. Laurens County Hospital should have known that Dr. Brown had changed from an Occurrence Policy to a Claims-Made policy for the term beginning June 9, 2008, and that claims for injuries that occurred from medical malpractice during this time

were subject to be non-covered if JUA was not timely put on notice prior to termination of the policy; or Extended Reporting Endorsement coverage was not purchased from JUA; or Prior Acts Coverage Endorsement was not purchased from MAG Mutual.

62. Laurens County Hospital also should have known that if a letter in the format set forth on Exhibit 1 was submitted prior to termination of the JUA Policy that the notice condition of the JUA Policy would be satisfied for the claims of Mr. and Mrs. McCord.

63. Laurens County Hospital also should have known that if a letter in the format set forth on Exhibit 2 was submitted prior to termination of the JUA Policy that the notice condition of the JUA Policy would be satisfied for the claims of Mr. and Mrs. Sherfield.

64. Laurens County Hospital also had the ability to inform the patients who suffered complications from surgery performed by Dr. Brown since 7/9/2008 that notification needed to be made in writing to JUA under the Claims-Made policy before the policy terminated in order for the injured patients to perfect their claims for payment under the JUA Policy.

65. Laurens County Hospital should have known that the innocent victims had no way of discovering the information known to Laurens County Hospital that notice of a claim for malpractice committed by Dr. Brown during surgeries at Laurens County Hospital needed to be given to JUA under the Claims-Made policy by a certain date to perfect a claim for payment under the JUA Policy.

66. Laurens County Hospital would have known, if proper inquiry had been made, that Dr. Brown intended to change insurance companies for his professional

liability insurance, that the JUA Claims-Made policy required Extended Reporting Coverage be made available to Dr. Brown, and that the offer to purchase Extended Reporting Coverage was available until January 14, 2010.

67. Laurens County Hospital did not inform directly or by public notice any of the patients who received complications or injuries during surgeries performed at Laurens County Hospital by Dr. Brown that notice of a claim must be made to JUA prior to expiration of the insurance policy to perfect the claims of patients for injuries due to medical malpractice of Dr. Brown.

68. Consequently, neither Mrs. McCord, Mr. McCord, Mrs. Sherfield, nor Mr. Sherfield provided notice to JUA prior to 7/9/2009 of their respective claims for damages resulting from injuries suffered due to the medical malpractice of Dr. Brown; nor did Laurens County Hospital require Dr. Brown to maintain insurance coverage in accordance with its contract with Mrs. McCord and Mrs. Sherfield by requiring Dr. Brown to carry Extended Reporting Endorsement Coverage from JUA or Prior Acts Coverage Endorsement from MAG Mutual.

FOR A FIRST CAUSE OF ACTION

69. The relevant and consistent allegations of paragraphs 1-68 are incorporated herein by this reference.

70. Laurens County Hospital and Mr. and Mrs. McCord had a meeting of the minds as to the essential and material terms of the contract, to wit: Mr. and Mrs. McCord would pay, or cause to be paid, the agreed upon price for the services and facilities provided by Laurens County Hospital and Laurens County Hospital would provide services that, in part, would require compliance by Dr. Brown with the Medical

Staff Bylaws, would require compliance with its Subsidy Contract with Dr. Brown to maintain professional liability insurance coverage in the minimum amount of $1M/$3M; and would appropriately monitor the quality of patient care rendered by physicians performing surgery at Laurens County Hospital.

71. Laurens County Hospital and Mr. and Mrs. Sherfield had a meeting of the minds as to the essential and material terms of the contract, to wit: Mr. and Mrs. Sherfield would pay, or cause to be paid, the agreed upon price for the services and facilities provided by Laurens County Hospital and Laurens County Hospital would provide services that, in part, would require compliance by Dr. Brown with the Medical Staff Bylaws, would require compliance with its Subsidy Contract with Dr. Brown to maintain professional liability insurance coverage in the minimum amount of $1M/$3M; and would appropriately monitor the quality of patient care rendered by physicians performing surgery at Laurens County Hospital.

72. Laurens County Hospital received valuable consideration from Mr. and Mrs. McCord and from Mr. and Mrs. Sherfield pursuant to the terms of the contract.

73. Laurens County Hospital breached the contract with Mr. and Mrs. McCord and Mr. and Mrs. Sherfield in one or more of the following particulars:

a) failure to require Dr. Brown to comply with the Medical Staff Bylaws which require the physicians privileged to perform surgery to maintain current, valid professional liability insurance coverage in an amount satisfactory to Laurens County Hospital;
b) failure to require Dr. Brown to comply with the Subsidy Contract requirement of maintaining professional liability insurance in the minimum amount of $1,000,000 per occurrence and $3,000,000 aggregate;
c) failure to require Dr. Brown, as a condition of having continuing privileges to perform surgery at Laurens County Hospital, to purchase Extended Reporting Endorsement Coverage (Tail) from

JUA under a claims-made policy upon change to another insurance company;

d) failure to require Dr. Brown, as a condition of having continuing privileges to perform surgery at Laurens County Hospital, to purchase Prior Acts Endorsement Coverage from MAG Mutual under a claims-made policy upon change to another insurance company;

e) failure to train, instruct, or employ employees who were knowledgeable about the differences between Occurrence and Claims-Made policies, and who were knowledgeable about Extended Reporting Endorsement Coverage (Tail) and who were knowledgeable about Prior Acts Endorsement Coverage;

f) failure to inform the employee who was responsible for ensuring that Dr. Brown maintained professional liability coverage in accordance with the Medical Staff Bylaws and Subsidy Contract that Dr. Brown was under investigation by Laurens County Hospital for injuries to surgical patients potentially caused from inappropriate surgical/ medical treatment and malpractice;

g) failure to inform surgical patients of Dr. Brown who received unexpected complications during surgeries performed at Laurens County Hospital that to preserve insurance coverage for their claim, that the claim need to be filed before June 9, 2009 when Laurens County Hospital knew, or should have known, that the patients most probably did not have this information; and Laurens County Hospital had the ability to identify and notify the patients;

h) in such other manners as will be shown from the evidence at trial.

74. The damages suffered by Mrs. McCord from the breach of contract by Laurens County Hospital total $1,740,392.75, plus interest from March 11, 2014, and the damages suffered by Mr. McCord from the breach of contract by Laurens County Hospital total $58,789.40, plus interest from March 11, 2014.

75. The damages suffered by Mrs. Sherfield from the breach of contract by Laurens County Hospital total $1,468,580, plus interest from March 11, 2014 and the damages suffered by Mr. Sherfield from the breach of contract by Laurens County Hospital total $50,000, plus interest from March 11, 2014.

76. Dr. Brown is judgment proof and outside the jurisdiction of the United States.

77. Consequently, Mrs. McCord is informed and believes that she is entitled to judgment against Laurens County Hospital in the amount of $1,740,392.75, plus interest from March 11, 2014, and Mr. McCord is informed and believes that he is entitled to judgment against Laurens County Hospital in the amount of $58,789.40, plus interest from March 11, 2014.

78. Consequently, Mrs. Sherfield is informed and believes that she is entitled to judgment against Laurens County Hospital in the amount of $1,468,580, plus interest from March 11, 2014, and Mr. Sherfield is informed and believes that he is entitled to judgment against Laurens County Hospital in the amount of $50,000, plus interest from March 11, 2014.

FOR A SECOND CAUSE OF ACTION

79. The relevant and consistent allegations of paragraphs 1-78 are incorporated herein by this reference.

80. The providing of services by Laurens County Hospital related to the surgeries performed by Dr. Brown at Laurens County Hospital had a serious affect on the quality of life and life expectancy of Mrs. McCord and Mrs. Sherfield and created a special relationship between Laurens County Hospital and its patients undergoing surgery.

81. Laurens County Hospital failed to exercise due care in this special relationship in the following particulars:

a) failure to require Dr. Brown to comply with the Medical Staff Bylaws which require the physicians privileged to perform surgery to maintain current, valid professional liability insurance coverage in an amount satisfactory to Laurens County Hospital;
b) failure to require Dr. Brown to comply with the Subsidy Contract requirement of maintaining professional liability insurance in the

minimum amount of $1,000,000 per occurrence and $3,000,000 aggregate;

c) failure to require Dr. Brown, as a condition of having continuing privileges to perform surgery at Laurens County Hospital, to purchase Extended Reporting Endorsement Coverage (Tail) from JUA under a claims-made policy upon change to another insurance company;

d) failure to require Dr. Brown, as a condition of having continuing privileges to perform surgery at Laurens County Hospital, to purchase Prior Acts Endorsement Coverage from MAG Mutual under a claims-made policy upon change to another insurance company;

e) failure to train, instruct, or employ employees who were knowledgeable about the differences between Occurrence and Claims-Made policies, and who were knowledgeable about Extended Reporting Endorsement Coverage (Tail) and who were knowledgeable about Prior Acts Endorsement Coverage;

f) failure to inform the employee who was responsible for ensuring that Dr. Brown maintained professional liability coverage in accordance with the Medical Staff Bylaws and Subsidy Contract; that Dr. Brown was under investigation by Laurens County Hospital for injuries to surgical patients potentially caused from inappropriate surgical/ medical treatment and malpractice;

g) failure to inform surgical patients of Dr. Brown who received unexpected complications during surgeries performed at Laurens County Hospital that to preserve insurance coverage for the claim that the claim need to be filed before June 9, 2009 when Laurens County Hospital knew, or should have known, that the patients most probably did not have this information and Laurens County Hospital had the ability to identify and notify the patients; and

h) in such other manners as will be shown from the evidence at trial.

82. As a result of the negligence of Laurens County Hospital, the insurance coverage on the claims of Mr. and Mrs. McCord and Mr. and Mrs. Sherfield was extinguished without their knowledge and through no fault of their own. Also, the insurance coverage was not extended because Laurens County Hospital did not require Extended Reporting Coverage or Prior Acts Coverage.

83. The aforementioned acts and derelicts of Laurens County Hospital were negligent and careless and caused the following damages:

* Chris Katina McCord in the amount of $1,740,392.75 , plus interest from March 11, 2014;
* Christopher McCord in the amount of $58,789.40, plus interest from March 11, 2014;
* Janice Sherfield in the amount of $1,468,580, plus interest from March 11, 2014; and
* Jerry Sherfield in the amount of $50,000, plus interest from March 11, 2014.

84. Consequently, Mrs. McCord is informed and believes that she is entitled to judgment against Laurens County Hospital in the amount of $1,740,392.75, plus interest from March 11, 2014, and Mr. McCord is informed and believes that he is entitled to judgment against Laurens County Hospital in the amount of $58,789.40, plus interest from March 11, 2014.

85. Consequently, Mrs. Sherfield is informed and believes that she is entitled to judgment against Laurens County Hospital in the amount of $1,468,580, plus interest from March 11, 2014, and Mr. Sherfield is informed and believes that he is entitled to judgment against Laurens County Hospital in the amount of $50,000, plus interest from March 11, 2014.

WHEREFORE, Plaintiffs Chris Tina McCord, Christopher McCord, Janice Sherfield, and Jerry Sherfield request that the Court enter judgment as follows:

a) for a trial by jury;

b) under the First Cause of Action:

i) judgment in favor of Chris Katina McCord and against Laurens County Hospital and Greenville Health System in the amount of $1,740,392.75 , plus interest since judgment from March 11, 2014;
ii) judgment in favor of Christopher McCord and against Laurens County Hospital and Greenville Health System in the amount of $58,789.40, plus interest from March 11, 2014;
iii) judgment in favor of Janice Sherfield and against Laurens County Hospital and Greenville Health System in the amount of $1,468,580, plus interest from March 11, 2014; and

iv) judgment in favor of Jerry Sherfield and against Laurens County Hospital and Greenville Health System in the amount of $50,000, plus interest from March 11, 2014.

c) under the Second Cause of Action:

i) judgment in favor of Chris Katina McCord and against Laurens County Hospital and Greenville Health System in the amount of $1,740,392.75 , plus interest from March 11, 2014;

ii) judgment in favor of Christopher McCord and against Laurens County Hospital and Greenville Health System in the amount of $58,789.40, plus interest from March 11, 2014;

iii) judgment in favor of Janice Sherfield and against Laurens County Hospital and Greenville Health System in the amount of $1,468,580, plus interest from March 11, 2014; and

iv) judgment in favor of Jerry Sherfield and against Laurens County Hospital and Greenville Health System in the amount of $50,000, plus interest from March 11, 2014.

d) for the costs of this action; and

e) for such other and further relief as the Court deems just and proper.

Respectfully submitted,

McGowan, Hood & Felder, LLC

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ATTORNEYS FOR THE PLAINTIFFS

January 9, 2017

Anderson, South Carolina

DATE

South Carolina Medical Malpractice Insurance
Joint Underwriting Association
South Carolina Patients' Compensation Fund
Claims Department
550 South Main Street, Suite 600
Greenville, SC 29601

RE: NOTIFICATION OF CLAIM

Dear Sir:

This letter is to notify you of a claim under the medical malpractice insurance policy your company issued to Byron A. Brown, MD. I am submitting a claim for malpractice committed by Dr. Brown on me during surgeries on December 18, 2008, February 19, 2009, and April 17, 2009 at Laurens County Hospital.

Very truly yours,

Chris Katina McCord

EXHIBIT 1

DATE

South Carolina Medical Malpractice Insurance
Joint Underwriting Association
Patients' Compensation Fund
Claims Department
550 South Main Street, Suite 600
Greenville, SC 29601

RE: NOTIFICATION OF CLAIM

Dear Sir:

This letter is to notify you of a claim under the medical malpractice insurance policy your company issued to Byron A. Brown, MD, I am submitting a claim for malpractice committed by Dr. Brown on me during the surgery on May 29, 2009 at Laurens County Hospital.

Very truly yours,

Janice Sherfield

EXHIBIT 2

STATE OF SOUTH CAROLINA COUNTY OF LAURENS	IN THE COURT OF COMMON PLEAS
Chris Katina McCord, Christopher McCord, Janice Sherfield, and Jerry Sherfield, Plaintiffs, vs. Laurens County Health Care System and Greenville Health System, Defendant.	C.A. No.: 2014-CP-30-250 **ANSWER TO SECOND AMENDED COMPLAINT**

Defendants Laurens County Healthcare System ("Laurens") and Greenville Health System ("GHS") (collectively hereinafter referred to as "these Defendants"), answering Plaintiffs' Second Amended Complaint, would hereby show the Court:

These Defendants contend that a response to Plaintiffs' Second Amended Complaint is not necessary in light of the Court's decision to grant these Defendants' motion for summary judgment. In ruling on the motion for summary judgment, the Court took under consideration Plaintiffs' allegations in the Second Amended Complaint, thus rendering the necessity of responding to the allegations moot. These Defendants are responding to Plaintiffs' Second Amended Complaint solely out of an abundance of caution, and in no way intend to acknowledge that this case has not been dismissed or waive any grounds for dismissal. Defendants incorporate herein by reference all defenses and arguments set forth in Defendants' motion for summary judgment and all memorandums filed in support thereof, and deny any allegations in Plaintiffs' Second Amended Complaint that are inconsistent therewith.

FOR A FIRST DEFENSE

1. Defendants admit the allegations in Paragraph 1 of Plaintiffs' Complaint upon

information and belief.

2. Defendants admit the allegations in Paragraph 2 of Plaintiffs' Complaint upon information and belief.

3. In response to Paragraph 3, Laurens states that at all times relevant to this action it was a governmental entity and healthcare facility pursuant to the South Carolina Tort Claims Act § 15-78-10 et seq. located in Laurens County, South Carolina, and it denies any allegations inconsistent therewith. As to the remaining allegation of Paragraph 3, Defendants would admit only that effective July 1, 2013, Laurens and GHS entered into a lease and contribution agreement, which is incorporated herein by reference.

4. In response to Paragraph 4, GHS states that it is a governmental entity pursuant to the South Carolina Tort Claims Act § 15-78-10 et seq. with its principal place of business in Greenville County, South Carolina, and it denies any allegations inconsistent therewith. As to the remaining allegations of Paragraph 4, Defendants would admit only that effective July 1, 2013, Laurens and GHS entered into a written lease and contribution agreement. The agreement speaks for itself, and Defendants deny any allegations in Paragraph 4 which are inconsistent therewith.

5. Defendants are without sufficient information to admit or deny the allegations of Paragraph 5; therefore, those allegations are denied.

6. Defendants are without sufficient information to admit or deny the allegations of Paragraph 6; therefore, those allegations are denied.

7. Defendants are without sufficient information to admit or deny the allegations of Paragraph 7; therefore, those allegations are denied.

8. Defendants are without sufficient information to admit or deny the allegations of Paragraph 8; therefore, those allegations are denied.

9. Defendants deny the allegations in Paragraph 9.

10. The allegations of Paragraph 10 of Plaintiffs' Complaint are legal conclusions to which no response is necessary. To the extent a response is necessary, Defendants would deny the allegations as stated.

11. The allegations of Paragraph 11 of Plaintiffs' Complaint are legal conclusions to which no response is necessary. To the extent a response is necessary, Defendants would deny the allegations as stated.

12. In response to Paragraph 12 of Plaintiffs' Complaint, Laurens admits only that it adopted Medical Staff Bylaws, the terms and conditions of which are incorporated herein by reference. Laurens denies any allegations in Paragraph 12 that are inconsistent therewith.

13. Laurens generally admits the allegations of Paragraph 13.

14. In response to Paragraph 14, Laurens admits only that pursuant to its Medical Staff Bylaws, it requires new Licensed Independent Practitioner (LIP) applicants to provide proof of malpractice insurance in an amount determined by the hospital. These Defendants deny the remaining allegation of Paragraph 14.

15. In response to Paragraph 15, Laurens admits only that it entered into a contract with Dr. Byron Brown, M.D. on or about February 14, 2002, the terms and conditions of which are incorporated herein by reference. Laurens denies any allegations in Paragraph 15 that are inconsistent therewith.

16. In response to Paragraph 16, Laurens would admit only that the Subsidy Contract and the Medical Staff Bylaws contained provisions regarding the requirement that Dr. Brown maintain medical malpractice insurance coverage. The full terms of those provisions are incorporated herein by reference, and Laurens denies any allegations in Paragraph 16 that are inconsistent therewith.

17. Defendants admit the allegations of Paragraph 17 upon information and belief.

18. Defendants admit the allegations of Paragraph 18 upon information and belief.

19. In response to Paragraph 19, Laurens would crave reference to Article IV of the February 14, 2002 contract with Dr. Brown and deny any allegation that is inconsistent therewith. Further responding, Laurens would generally admit the allegation that it made subsidy payments to Dr. Brown and that a portion of those payments were forgiven pursuant to the Subsidy Contract.

20. Paragraph 20 states a legal conclusion to which no response is necessary. To the extent a response is necessary, Laurens would crave reference to the terms and conditions of the Subsidy Contract and deny any allegations inconsistent therewith.

21. In response to Paragraph 21, Defendants admit only that according to her medical records, on December 18, 2008, Mrs. McCord was admitted to Laurens County Hospital for a surgery to be performed by Dr. Brown. As part of the admissions process, Mrs. McCord executed several documents including consent forms and a Conditions of Admission form, the terms and conditions of which are incorporated herein by reference. Defendants deny any allegation in Paragraph 21 that is inconsistent therewith.

22. The allegations of Paragraph 22 are denied. See also Defendants' Motion for Summary Judgment.

23. Defendants generally admit the allegations of Paragraph 23.

24. In response to the first sentence of Paragraph 24, Defendants admit only that Dr. Brown performed surgery on Mrs. McCord on December 18, 2008. Defendants would crave reference to Mrs. McCord's medical records for the details of that surgery and would deny any allegation that is inconsistent with those records. The remainder of Paragraph 24 contains legal conclusions to which no response is necessary. To the extent a response is necessary, Defendants deny the allegations as stated.

25. In response to the allegations of Paragraph 25, Defendants admit only that according

to her medical records, on February 19, 2009, Mrs. McCord was admitted to Laurens County Hospital for surgery to be performed by Dr. Brown. Defendants would crave reference to Mrs. McCord's medical records for the details of that surgery and would deny any allegation that is inconsistent with those records. As part of the admissions process, Mrs. McCord executed several documents including consent forms and a Conditions of Admission form. The Conditions of Admission is incorporated herein by reference, and Defendants deny any allegation in Paragraph 25 that is inconsistent therewith. The remainder of Paragraph 25 contains legal conclusions to which no response is necessary. To the extent a response is necessary, Defendants deny the allegations as stated.

26. In response to the allegations of Paragraph 26, Defendants admit only that according to her medical records, on April 17, 2009, Mrs. McCord was admitted to Laurens County Hospital for surgery to be performed by Dr. Brown. Defendants would crave reference to Mrs. McCord's medical records for the details of that surgery and would deny any allegation that is inconsistent with those records. As part of the admissions process, Mrs. McCord executed several documents including consent forms and a Conditions of Admission form. The Conditions of Admission is incorporated herein by reference, and Defendants deny any allegation in Paragraph 26 that is inconsistent therewith. The remainder of Paragraph 26 contains legal conclusions to which no response is necessary. To the extent a response is necessary, Defendants deny the allegations as stated.

27. Paragraph 27 contains legal conclusions to which no response is necessary. To the extent a response is necessary, Defendants are without sufficient information to admit or deny the allegations; therefore, the allegations are denied.

28. In response to Paragraph 28, Laurens admits only that it billed Mrs. McCord for the services she received. Laurens would crave reference to those bills for the exact amounts that were

billed. As to the remaining allegation in Paragraph 28, Laurens admits only that according to its records, Mrs. McCord currently has an accounts-receivable balance of zero for the relevant services rendered.

29. Paragraph 29 contains a legal conclusion to which no response is necessary. To the extent a response is necessary, Defendants would admit only that the claims likely would have been covered under the JUA Policy had they been timely made.

30. Paragraph 30 contains a legal conclusion to which no response is necessary. To the extent a response is necessary, Defendants would admit only that upon information and belief, Plaintiffs have obtained default judgments against Dr. Brown in civil actions Defendants were not parties to.

31. In response to Paragraph 31, Defendants admit only that according to her medical records, on May 29, 2008, Mrs. Sherfield was admitted to Laurens County Hospital for a surgery to be performed by Dr. Brown. As part of the admissions process, Mrs. Sherfield executed several documents including consent forms and a Conditions of Admission form, the terms and conditions of which are incorporated herein by reference. Defendants deny any allegation in Paragraph 31 that is inconsistent therewith.

32. In response to the first sentence of Paragraph 32, Defendants admit only that Dr. Brown performed surgery on Mrs. Sherfield on May 29, 2009. Defendants would crave reference to Mrs. Sherfield's medical records for the details of that surgery and would deny any allegation that is inconsistent with those records. The remainder of Paragraph 32 contains legal conclusions to which no response is necessary. To the extent a response is necessary, Defendants deny the allegations as stated.

33. Paragraph 33 contains legal conclusions to which no response is necessary. To the extent a response is necessary, Defendants are without sufficient information to admit or deny the

allegations; therefore, the allegations are denied.

34. In response to Paragraph 34, Laurens admits only that it billed Mrs. Sherfield for the services she received. Laurens would crave reference to those bills for the exact amounts that were billed. As to the remaining allegation in Paragraph 34, Laurens admits only that according to its records, Mrs. Sherfield currently has an accounts-receivable balance of zero for services rendered related to this action.

35. Paragraph 35 contains a legal conclusion to which no response is necessary. To the extent a response is necessary, Defendants would admit only that the claims likely would have been covered under the JUA Policy had they been timely made.

36. Paragraph 36 contains a legal conclusion to which no response is necessary. To the extent a response is necessary, Defendants would admit only that upon information and belief, Plaintiffs have obtained default judgments against Dr. Brown in civil actions Defendants were not parties to.

37. In response to Paragraph 37, Defendants would crave reference to the JUA Policy as it speaks for itself. Defendants deny any allegation that is inconsistent with the specific terms and conditions of the JUA Policy.

38. In response to Paragraph 38, Defendants would crave reference to the JUA Policy as it speaks for itself. Defendants deny any allegation that is inconsistent with the specific terms and conditions of the JUA Policy. Plaintiffs' characterization of a "claims-made" policy states a legal conclusion to which no response is necessary. To the extent a response is necessary, Defendants would generally admit the allegations upon information and belief.

39. The allegations in Paragraph 39 are denied.

40. The allegations in Paragraph 40 are vague and ambiguous. Plaintiffs do not appear to be making a factual statement, but rather appear to be stating their own personal opinion to which

no response is necessary.

41. Paragraph 41 states a legal conclusion to which no response is necessary. To the extent a response is necessary, Defendants deny the allegations as worded.

42. The allegations of Paragraph 42 are denied.

43. Paragraph 43 states legal conclusions to which no response is necessary. To the extent a response is necessary, Defendants would admit only that Plaintiffs claims arose while the JUA Policy was in effect.

44. Defendants generally admit the allegations of Paragraph 44 upon information and belief.

45. The allegations of Paragraph 45 are denied.

46. In response to Paragraph 46, Defendants admit only that it had the ability to suspend or terminate Dr. Brown's privileges if he failed to comply with the Medical Staff Bylaws. As to the Subsidy Contract, Defendants would defer to the terms and conditions therein and deny any allegations inconsistent therewith. To the extent alleged, Defendants specifically deny that Dr. Brown was not in compliance with the Medical Staff Bylaws or the Subsidy Contract in regards to the requirement to maintain insurance.

47. The allegations of Paragraph 47 are vague and ambiguous as it is not clear whether they are referring specifically to Dr. Brown or to all physicians; therefore, the allegations are denied as worded.

48. The allegations of Paragraph 48 are denied.

49. Defendants are without sufficient information to admit or deny the allegations of Paragraph 49 as stated. Defendants would admit only that they are aware of other patients who have made claims against Dr. Brown.

50. Defendants object to and move to strike the allegations contained in Paragraphs 50-

55 on the basis that they contain confidential peer review information. Further responding without waiving said objection, Defendants admit only that a peer review investigation into Dr. Brown was initiated in November 2009, which ultimately resulted in Dr. Brown agreeing to relinquish certain privileges.

51. In response to Paragraph 56, Defendants admit only upon information and belief that the Risk Manager did not directly communicate with the Manager of Medical Staff Services regarding the peer review investigation.

52. The allegations of Paragraph 57 are vague and ambiguous in that it is not clear what Plaintiffs mean by "at this time." Therefore, the allegations are denied as worded.

53. The allegations of Paragraph 58 are denied.

54. The allegations of Paragraph 59 are denied.

55. The allegations of Paragraph 60 state a legal conclusion to which no response is necessary. To the extent a response is necessary, Defendants defer to the terms and conditions of the JUA policy, which are incorporated herein by reference, and deny any allegations inconsistent therewith.

56. The allegations of Paragraph 61 are vague and ambiguous in that it is not clear when Plaintiffs contend that Laurens should have known that Dr. Brown changed insurance policies. Further, it appears Plaintiffs are stating their personal opinion rather than making a factual allegation, thus no response is required. To the extent a response is required, Defendants deny the allegations as worded.

57. Paragraphs 62 and 63 appear to be Plaintiffs stating their personal opinions rather than asserting factual allegations, thus no response is required. To the extent a response is required, Defendants deny the allegations as worded.

58. The allegations of Paragraphs 64-66 are denied.

59. In response to Paragraph 67, Laurens admits only that it had no duty to provide patients information or attempt to advise patients on a doctor's medical malpractice liability insurance policy.

60. In response to Paragraph 68, Defendants admit only that upon information and belief Plaintiffs failed to make timely claims to JUA for their alleged injuries. Defendants deny the remaining allegations in Paragraph 68.

FIRST CAUSE OF ACTION

61. To the extent a response is necessary, Defendants incorporate the answers to the previous paragraphs in response to Paragraph 69.

62. Paragraphs 70-72 contain legal conclusions to which no response is necessary. To the extent a response is necessary, the allegations of Paragraph 70-72 are denied.

63. The allegations of Paragraph 73 are denied, including all subparts therein.

64. The allegations of Paragraphs 74 and 75 are denied.

65. In response to Paragraph 76, Defendants only admit upon information and belief that Dr. Brown currently resides outside the United States. The remaining allegations of Paragraph 76 contain a legal conclusion to which no response is necessary. To the extent a response is necessary, the allegations are denied.

66. The allegations of Paragraphs 77 and 78 are denied.

SECOND CAUSE OF ACTION

67. To the extent a response is necessary, Defendants incorporate the answers to the previous paragraphs in response to Paragraph 79.

68. Paragraph 80 contains legal conclusions to which no response is necessary. To the extent a response is necessary, the allegations of Paragraph 80 are denied as stated.

69. The allegations of Paragraph 81, including all subparts therein, are denied.

70. The allegations of Paragraphs 82 – 85 are denied.

71. Defendants deny each and every other allegation, including Plaintiffs' Prayer for Relief, not heretofore expressly explained modified or admitted.

FOR A SECOND DEFENSE

72. Defendants allege and would show that at all times relevant to this action each was a governmental entity health care facility within the meaning of the South Carolina Tort Claims Act, S.C. Code Ann. § 15-78-10, et seq. (1976, as amended) and are, therefore, entitled to all rights, privileges, defenses, limitations, and immunities afforded by the Act and afforded by the doctrine of sovereign immunity, as is retained by the Act.

73. Defendants allege that Plaintiffs' claims for actual damages are either governed or limited by the provisions of § 15-78-120(a) of the South Carolina Tort Claims Act.

74. Defendants allege that Plaintiffs may not recover punitive damages in accordance with § 15-78-120(b) of the South Carolina Tort Claims Act.

FOR A THIRD DEFENSE

75. Defendants would show that Plaintiffs' Complaint fails to state facts sufficient to constitute a cause of action under any of the causes of action asserted and, therefore, Plaintiffs may not recover herein.

FOR A FOURTH DEFENSE

76. Defendants would show that Plaintiffs' claims are barred by the applicable statute of limitations.

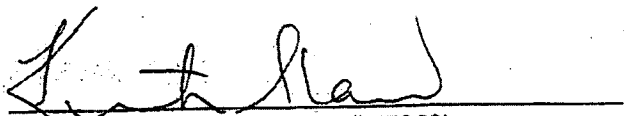
FOR A FIFTH DEFENSE

77. Defendants would show the damages sustained by Plaintiffs were due to the negligence, recklessness, willfulness, and wantonness of Plaintiffs and that such negligence, recklessness, willfulness, and wantonness was greater than the alleged negligence on the part of

Defendants, such negligence and recklessness admitted solely for the purposes of this paragraph, and acted as a direct and proximate cause of the damages claimed by Plaintiffs. Therefore, Plaintiffs are barred from recovering under the principles of comparative negligence. However, should it be determined that any negligence or recklessness on the part of Defendants was greater than that of Plaintiffs, any recovery which Plaintiffs prove must be reduced by the amount of Plaintiffs' negligence, which Defendants pray should be determined by special interrogatories to be answered by the jury.

WHEREFORE, having fully answered, Defendants pray that, consistent with the Court's order granting summary judgment, this case be dismissed with costs, and for such other and further relief as this Court may deem just and proper.

Respectfully submitted by,



Kenneth N. Shaw (S.C. Bar # 77859)
J. Ben Alexander (S.C. Bar # 15323)
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Attorneys for Defendants
Laurens County Healthcare System and Greenville Health System

February 23, 2017

STATE OF SOUTH CAROLINA COUNTY OF LAURENS Chris Katina McCord, Christopher McCord, Janice Sherfield, and Jerry Sherfield, Plaintiffs, v. Laurens County Health Care System and Greenville Health System, Defendants.	IN THE COURT OF COMMON PLEAS C.A. No.: 2014-CP-30-250 ***Certificate of Service***

I HEREBY CERTIFY that a copy of **Defendants' Answer to Plaintiff's Second Amended Complaint** was served upon counsel of record by depositing true and accurate copies thereof in the United States Mail, proper postage affixed thereto, on the 23rd day of February, 2017, addressed to:

Joseph G. Wright
McGowan, Hood & Felder, LLC
PO Drawer 1778
Anderson, SC 29622-1778

HAYNSWORTH SINKLER BOYD, P.A.

Julee Lyons
Paralegal to Kenneth N. Shaw

Greenville, SC

STATE OF SOUTH CAROLINA COUNTY OF LAURENS Chris Katina McCord, Christopher McCord, Janice Sherfield, and Jerry Sherfield, Plaintiffs, v. Laurens County Health Care System and Greenville Health System, Defendants.	IN THE COURT OF COMMON PLEAS C.A. No.: 2014-CP-30-250 **Defendants Supplemental Response to Plaintiffs' Initial Requests for Admission**

Defendants supplement their responses to Plaintiffs' Initial Requests for Admission as follows:

GENERAL OBJECTIONS

Defendants object to each and every one of the Requests for Admission to the extent that they request information that is protected by the attorney-client privilege, is considered attorney work-product, was prepared in anticipation of litigation, was created or generated after and/or as a result of this lawsuit being filed, or is protected by the peer review privilege. By responding to the Requests for Admission, Defendants are not conceding that Plaintiffs have stated a cause of action, are not waiving any other objections to discovery, or any objections to admissibility of evidence. Subject thereto,

5. Do you admit that representatives of Laurens Hospital and McCord and Sherfield entered into a contract for each of the following surgeries:

a. McCord December 18, 2008 surgery;
b. McCord February 19, 2009 surgery;
c. McCord April 17, 2009 surgery; and
d. Sherfield May 29, 2009 surgery?

RESPONSE: Defendants object to this Request to the extent it calls for a legal conclusion and/or an application of the law to the facts. Subject thereto and upon further consideration of the applicable law, Defendants would admit that the Conditions of Admission documents executed by Plaintiffs prior to each of the above referenced surgeries constituted unilateral contracts whereby Plaintiffs agreed, among other things, to "guarantee payment of all charges incurred for the account of the patient," to be "responsible for any charges not covered by insurance, Medicare, Medicaid, or other

ATTACHMENT 1

benefits," and to "pay the account of the hospital, in accordance with the regular rates and terms of the hospital." The Conditions of Admission documents speak for themselves and Defendants deny that the documents create any duties or obligations beyond those clearly set forth within the four corners of the documents.

Respectfully submitted,

Kenneth N. Shaw SC Bar 77859
J. Ben Alexander S.C. Bar 15323
HAYNSWORTH SINKLER BOYD, PA
PO Box 2048
Greenville, SC 29602
(864) 240-3200
kshaw@hsblawfirm.com
Attorneys for Defendants

Dated: 2/9/16
Greenville, SC

STATE OF SOUTH CAROLINA COUNTY OF LAURENS Chris Katina McCord, Christopher McCord, Janice Sherfield, and Jerry Sherfield, Plaintiffs, v. Laurens County Health Care System and Greenville Health System, Defendants.	IN THE COURT OF COMMON PLEAS C.A. No.: 2014-CP-30-0250 ***Certificate of Service***

I HEREBY CERTIFY that a copy of Defendants' Supplemental Response to Plaintiffs' Initial Requests for Admission were served upon all counsel of record on this date by depositing in the United States Mail, proper postage affixed thereto, true and accurate copies thereof.

COUNSEL SERVED:

Joseph G. Wright
McGowan, Hood & Felder, LLC
PO Drawer 1778
Anderson, SC 29622-1778

HAYNSWORTH SINKLER BOYD, PA

Amy M. Clark

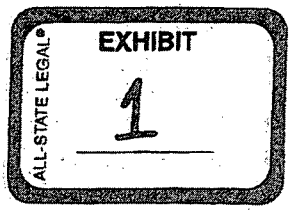
Dated: 2/9/16
Greenville, SC

CHRIS KATINA McCORD

MEDICAL BILLS

LAURENS COUNTY HEALTH CARE SYSTEM

TOTAL $56,962



ATTACHMENT 2

1	2	3a PAT. CNTL #	732400XX001B	4 TYPE OF BILL
LAURENS COUNTY HEALTH CA		b MED REC #	926460	0111
22725 HIGHWAY 76E		5 FED. TAX NO.	6 STATEMENT COVERS PERIOD FROM / THROUGH	7
CLINTON SC 293257527		570823499	121908 122008	748
864-833-9100				

8 NT NAME		9 PATIENT ADDRESS	
b MCCORD CHRIS K		a PO BOX 426	
		b GRAY COURT	c SC d 29645 e

10 BIRTHDATE	11 SEX	12 ADMISSION DATE	13 HR	14 TYPE	15 SRC	16 DHR	17 STAT	CONDITION CODES 18 19 20 21 22 23 24 25 26 27 28	29 ACDT STATE	30
12041972	F	121908	14	3	1	11	01			

31 OCCURRENCE CODE	DATE	32 OCCURRENCE CODE	DATE	33 OCCURRENCE CODE	DATE	34 OCCURRENCE CODE	DATE	35 OCCURRENCE SPAN CODE	FROM	THROUGH	36 OCCURRENCE SPAN CODE	FROM	THROUGH	37
42	122008													

38 MCCORD CHRIS 3392 HWY 92 GRAY COURT SC 29645		39 VALUE CODES CODE	AMOUNT	40 VALUE CODES CODE	AMOUNT	41 VALUE CODES CODE	AMOUNT
	a	02	000	23	8000	80	10(
	b						
	c						
	d						

42 REV. CD.	43 DESCRIPTION	44 HCPCS / RATE / HIPPS CODE	45 SERV. DATE	46 SERV. UNITS	47 TOTAL CHARGES	48 NON-COVERED CHARGES	49
0110	ROOM-BOARD/ PRIVATE	815.00		1	81500		
0250	PHARMACY			16	82200		
0250	SELF ADM DRUGS			14	58400		
0258	IV SOLUTIONS			8	48600		
0270	MED-SURG SUPPLIES NON ST			1	8600		
0272	STERILE SUPPLIES			15	47400		
0278	OTHER IMPLANTS			3	849100		
0300	LAB/OTHER			1	1800		
0300	LAB			2	23000		
0360	OR SERVICES			1	991400		
0370	ANESTHESIA			7	120900		
0410	RESPIRATORY THER			2	5400		
0710	RECOVERY ROOM			1	79600		
0001	PAGE 01 OF 01		CREATION DATE 122908	TOTALS	2397900		

50 PAYER NAME	51 HEALTH PLAN ID	52 REL. INFO.	53 ASG. BEN.	54 PRIOR PAYMENTS	55 EST. AMOUNT DUE	56 NPI	1982600714
401 BLUE CROSS BLUE SH	570823499	Y	Y		2310970	57 OTHER	570823499
						PRV ID	

58 INSURED'S NAME	59 P REL	60 INSURED'S UNIQUE ID	61 GROUP NAME	62 INSURANCE GROUP NO.
MCCORD CHRIS	18	ZCW064654265802	BCBS	

63 TREATMENT AUTHORIZATION CODES	64 DOCUMENT CONTROL NUMBER	65 EMPLOYER NAME
0830508553189		BLAIRWOOD

66 DX																					68
	61801	Y	61804	Y	6256	Y	6186	Y													
	9		I		J		K		L		M		N		O		P		Q		

69 ADMIT DX	70 PATIENT REASON DX				71 PPS CODE	72 ECI				73	030
61801	a	b	c			a	b	c			

74	PRINCIPAL PROCEDURE CODE	DATE	OTHER PROCEDURE CODE	DATE	b. OTHER PROCEDURE CODE	DATE	75
	121908		5979	121908			
	d. OTHER PROCEDURE CODE	DATE	e. OTHER PROCEDURE CODE	DATE	f. OTHER PROCEDURE CODE	DATE	

76 ATTENDING	NPI 1932164332	QUAL 1G	H61153
LAST BROWN		FIRST BYRON	
77 OPERATING	NPI 1932164332	QUAL 1G	H61153
LAST BROWN		FIRST BYRON	
78 OTHER	NPI	QUAL	
LAST		FIRST	
79 OTHER	NPI	QUAL	
LAST		FIRST	

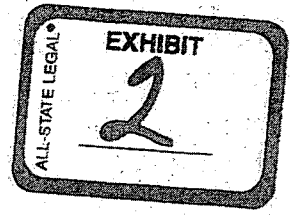
80 REMARKS 401 BLUE CROSS BLUE	81CC a B3 282N00000X
P O BOX 100300	b
	c
COLUMBIA SC 292020000	d

JANICE SHERFIELD

MEDICAL BILLS

LAURENS COUNTY HEALTH CARE SYSTEM

TOTAL $51,269.00



1	2	3a PAT. CNTL #	4 TYPE OF BILL
LAURENS COUNTY HEALTH CA		772675XX001C1	
22725 HIGHWAY 76E		b. MED. REC. # 902420	0111
CLINTON SC 293257527		5 FED. TAX NO.	6 STATEMENT COVERS PERIOD FROM THROUGH
864-833-9100		570823499	052909 053009

7: 748

8 PATIENT NAME	9 PATIENT ADDRESS
a	a 103 COPELAND ST
b SHERFIELD JANICE K	b CLINTON c SC d 29325 e

10 BIRTHDATE	11 SEX	12 ADMISSION DATE	13 HR	14 TYPE	15 SRC	16 DHR	17 STAT	18	19	20	21	CONDITION CODES 22	23	24	25	26	27	28	29 ACDT STATE	30
05231968	F	052909	10	3	1	10	01													

31 CODE	31 OCCURRENCE DATE	32 CODE	32 OCCURRENCE DATE	33 CODE	33 OCCURRENCE DATE	34 CODE	34 OCCURRENCE DATE	35 CODE	35 OCCURRENCE SPAN FROM THROUGH	36 CODE	36 OCCURRENCE SPAN FROM THROUGH	37

38 SHERFIELD JANICE K
103 COPELAND ST

CLINTON SC 29325

	39 CODE	39 VALUE CODES AMOUNT	40 CODE	40 VALUE CODES AMOUNT	41 CODE	41 VALUE CODES AMOUNT
a	02	000	80	100	23	8000
b						
c						
d						

42 REV. CD.	43 DESCRIPTION	44 HCPCS / RATE / HIPPS CODE	45 SERV. DATE	46 SERV. UNITS	47 TOTAL CHARGES	48 NON-COVERED CHARGES	49
0110	ROOM-BOARD/ PRIVATE	815.00		1	81500		
0250	PHARMACY			17	91100		
0258	IV SOLUTIONS			10	70200		
0270	MED-SURG SUPPLIES NON ST			6	435400		
0272	STERILE SUPPLIES			32	289200		
0278	OTHER IMPLANTS			1	239600		
0300	LAB/OTHER			1	1800		
0300	LAB			2	23000		
0360	OR SERVICES			1	1281100		
0370	ANESTHESIA			12	175900		
0410	RESPIRATORY THER			4	10800		
0637	SELF ADM DRUGS			10	29900		
0710	RECOVERY ROOM			1	79600		
0001	PAGE 01 OF 01		CREATION DATE 060509	TOTALS	2809100		

50 PAYER NAME	51 HEALTH PLAN ID	52 REL. INFO	53 ASG BEN.	54 PRIOR PAYMENTS	55 EST. AMOUNT DUE	56 NPI	57 OTHER PRV ID
B77 UNITED HEALTHCARE	570823499	Y	Y		2799100	1982600714	570823499

58 INSURED'S NAME	59 P REL	60 INSURED'S UNIQUE ID	61 GROUP NAME	62 INSURANCE GROUP NO.
SHERFIELD JANICE K	18	921701465	UNITED	701125

63 TREATMENT AUTHORIZATION CODES	64 DOCUMENT CONTROL NUMBER	65 EMPLOYER NAME
2722607758		STERILITE CORP

66											66
IDX	61801	9982	61804	6256							
9											

69 ADMIT DX	70 PATIENT REASON DX			71 PPS CODE	72 ECI				73	030
61801										

74	PRINCIPAL PROCEDURE CODE	DATE	OTHER PROCEDURE CODE	DATE	b. OTHER PROCEDURE CODE	DATE	75
	7050	052909	5781	052909	5732	052909	
c. OTHER PROCEDURE CODE	DATE	d. OTHER PROCEDURE CODE	DATE	e. OTHER PROCEDURE CODE	DATE		

80 REMARKS	81CC a		
B77 UNITED HEALTHCA	a	B3	208D00000X
P O BOX 740800	b		
	c		
ATLANTA GA 303740800	d		E/B

76 ATTENDING	NPI 1932164332	QUAL 0B	23020
LAST BROWN		FIRST BYRON	
77 OPERATING	NPI 1932164332	QUAL 0B	23020
LAST BROWN		FIRST BYRON	
78 OTHER	NPI	QUAL	
LAST		FIRST	
79 OTHER	NPI	QUAL	
LAST		FIRST	

UB-04 CMS-1450 APPROVED OMB NO. 0938-0997

THE CERTIFICATION ON THE REVERSE APPLY TO THIS BILL AND ARE MADE A PART HEREOF.

THIS AGREEMENT IS SUBJECT TO ARBITRATION PURSUANT TO S.C. CODE SECTION 15-48- 10, ET. SEQ. AS MODIFIED HEREIN

LEASE AND CONTRIBUTION AGREEMENT BETWEEN LAURENS COUNTY HEALTH CARE SYSTEM AND GREENVILLE HEALTH SYSTEM

This LEASE AND CONTRIBUTION AGREEMENT (this "Agreement") is made, effective as of the 1st day of July, 2013, by and between Laurens County Health Care System (the "Lessor") and Greenville Health System (the "Lessee").

WITNESSETH:

WHEREAS, Lessor is the successor, through consolidation, to the Laurens Hospital System and the Clinton Hospital System, which were separate special purpose districts of the State of South Carolina;

WHEREAS, by Ordinance No. 147 (the "Ordinance") adopted by the Laurens County Council, the governing body of Laurens County, on August 9, 1982, Laurens Hospital System and Clinton Hospital System were consolidated, pursuant to Section 6-11-410, et seq., of the South Carolina Code of Laws, to form Lessor as one countywide special purpose district;

WHEREAS, Lessor is charged pursuant to the Ordinance with the responsibility to provide adequate hospital facilities in the geographic area of Lessor;

WHEREAS, in fulfilling its aforementioned responsibility, Lessor is authorized and empowered under the Ordinance to lease its hospital facilities to an eleemosynary corporation incorporated under the laws of South Carolina or other organization to operate the hospital;

WHEREAS, Lessee is not-for-profit, tax-exempt organization and political subdivision of the State of South Carolina, established in 1947 by the General Assembly of the State of South Carolina pursuant to Act No. 432 of the Acts and Joint Resolutions of the General Assembly;

WHEREAS, Lessee is a comprehensive, integrated delivery system which owns and operates acute care hospitals, including a tertiary referral hospital and community hospitals, and related specialty health care facilities;

WHEREAS, Lessee employs more than 600 physicians who provide a continuum of care to people in Lessee's service area and beyond;

WHEREAS, Lessor has determined that the public health needs of Laurens County can best be met by entering into an arrangement with Lessee, whereby Lessee will lease certain assets from Lessor and provide high quality healthcare services to the people of Laurens County;

WHEREAS, Lessor has chosen to faithfully fulfill its duties and responsibilities under the Ordinance by affiliating with Lessee as provided herein; and,

WHEREAS, Lessor and Lessee wish to enter into this Agreement, pursuant to which Lessor shall lease its assets to Lessee, and Lessee shall assume the operations and liabilities of Lessor and provide high quality healthcare services to the people of Laurens County as part of Lessee's integrated delivery system.

ATTACHMENT 3

(vi) All books, records and other information collected and maintained in connection with the Leased Facilities including, without limitation, patient records and employee records;

(vii) All judgments, choses in action and intangibles owned by the Lessor and related to the Leased Facilities;

(viii) All trade names, service marks and trademarks used by the Lessor, whether or not registered;

(ix) All insurance reserves and trust agreements;

(x) All licenses, permits and approvals, including certificate of need approvals, held by or issued to the Lessor, which are necessary or desirable for the use, occupancy and operation of the Leased Facilities, to the extent such licenses, permits and approvals may lawfully be assigned to or assumed by Lessee;

(xi) All assumable Medicare and Medicaid provider numbers for the Leased Facilities and all clinical laboratory improvement amendment numbers for the Leased Facilities;

(xii) All Lessor's leasehold interests, including but not limited to, leased medical office buildings or space;

(xiii) All assets of Lessor used in the operation of Hospital and other health care facilities and not listed above and not otherwise classified as Leased Facilities, including but not limited to, any leased medical office buildings or space.

The foregoing shall be collectively referred to herein as the "Operating Assets." Upon the transfer of any of the Operating Assets to Lessee pursuant to this Section, the term "Operating Assets" shall mean all Operating Assets theretofore received by Lessee.

(b) All of the hospital, health care, administrative and related activities conducted as of the Commencement Date hereof or in the past by the Lessor in the course of owning and operating the Leased Facilities, all of which shall be collectively referred to herein as the "Existing Operations."

(c) Notwithstanding anything to the contrary in this Section 2.2, Lessor shall retain an amount of cash not to exceed $100,000.00 (the "Cash Retention"), which amount shall be excluded from the definition of Operating Assets. Lessor shall use the Cash Retention to open a banking or other financial account in its name ("Lessor's Bank Account"), and shall apply such Cash Retention to expenses incurred in connection with entering into this Agreement and any related transactions (collectively, the "Transaction Expenses"). Any funds to be deposited by Lessee into Lessor's Bank Account pursuant to the annual budget for the Leased Facilities as provided in Article 3 hereof shall be reduced by the amount of the Cash Retention, if any, remaining after Lessor pays all Transaction Expenses.

SECTION 2.3. Assumption of Liabilities. Effective as of the Commencement Date and continuing until the expiration or earlier termination of this Agreement, and except as otherwise provided elsewhere in this Agreement, Lessee assumes, and agrees to perform and discharge: (i) any and all liabilities and obligations of the Lessor related to the Leased Facilities, Operating Assets and Existing Operations which exist as of the Commencement Date (all of which liabilities shall be collectively referred to herein as the "Assumed Liabilities").

STATE OF SOUTH CAROLINA) IN THE COURT OF COMMON PLEAS
)
COUNTY OF LAURENS) C.A. FILE NO. 11-CP-30-1141

Chris Katina McCord and Christopher McCord,

Plaintiffs,

vs.

Byron A. Brown, MD, and Laurens County Obstetrics and Gynecology, LLC, a South Carolina Limited Liability Corporation,

Defendants.

LAURENS COUNTY CLERK OF COURT

ORDER FOR JUDGMENT

Based upon the pleadings, orders and aforementioned documents and the numerous hearings held by the undersigned regarding this litigation against Byron A. Brown, MD and Laurens County Obstetrics and Gynecology, LLC, I find Byron A. Brown, MD is in default of my Order dated November 5, 2013 and in contempt of court.

ACCORDINGLY, and in compliance with *Rule 55, South Carolina Rules of Civil Procedure*, I hereby rule and order as follows:

a. the Answers of Byron A. Brown, MD and Laurens County Obstetrics and Gynecology, LLC are hereby struck from the court record;

b. judgment by default is entered against Byron A. Brown, MD and Laurens County Obstetrics and Gynecology, LLC and in favor of Chris Katina McCord and Christopher McCord; and

c. a hearing is to be scheduled by the Clerk of Court at an appropriate date and time to determine the amount of damages by the Court.

IT IS SO ORDERED.

March 11, 2014
Greenwood, South Carolina

Judge, Eighth Judicial Circuit

A TRUE COPY OF ORIGINAL
Lynn W. Lancaster
Laurens County CCCP & GS

EXHIBIT 5

ALL-STATE LEGAL®

181

ATTACHMENT 4

LYNN W. LANCASTER

STATE OF SOUTH CAROLINA	)	IN THE COURT OF COMMON PLEAS
	)	
COUNTY OF LAURENS	)	C.A. FILE NO. 11-CP-30-1141

2014 OCT 20 A 10:56

Chris Katina McCord and Christopher McCord,	)	
Plaintiffs,	)	LAURENS COUNTY CLERK OF COURT
vs.	)	AMENDED JUDGMENT
Byron A. Brown, MD, and Laurens County Obstetrics and Gynecology, LLC, a South Carolina Limited Liability Corporation,	)	
Defendants.	)	

A hearing was held before the undersigned the 11th day of March, 2014 to determine damages. Based upon the evidence presented, I found and ordered the judgment to be entered in favor of Chris Katina McCord and Christopher McCord and against Byron A. Brown, MD and Laurens County Obstetrics and Gynecology, LLC as follows:

	Chris Katina McCord	
Economic Loss	$1,101,832.00	
Non-economic Loss	$ 378,625.00	
Judgment for Chris Katina McCord		**$1,480,457**

	Christopher McCord	
Economic Loss	$ none	
Non-economic Loss	$ 50,000.00	
Judgment for Christopher McCord		**$ 50,000**

I further found and ordered that the respective judgments exceed the Offers of Judgment made by Plaintiffs on December 29, 2011 (to wit: Chris Katina McCord $750,000 and Christopher McCord $50,000). Accordingly in compliance with *Rule 18, South Carolina Rules of Civil Procedure,* an amount equal to eight percent interest computed on the amount of the award from the date of the offer to the entry of judgment which shall be added to the above total judgment. This amount is $260,235.95 for Chris Katina McCord and $8,789.04 for Christopher McCord. (See attached computation from G. Richard Thompson, PhD dated March 24, 2014.)

Thus, the total judgment for Chris Katina McCord is $1,740,692.95 and the total judgment for Christopher McCord is $58,789.04.

IT IS SO ORDERED.

Oct 16, 2014
~~August~~ Greenwood, South Carolina

Judge, Eighth Judicial Circuit

G. RICHARD THOMPSON, PH.D.
P.O. BOX 1203
CLEMSON, SOUTH CAROLINA 29633

March 24, 2014

Mr. Jay F. Wright
McGowan, Hood & Felder, LLC
P.O. Drawer 1778
Anderson, SC 29622

Dear Mr. Wright;

At your request I have calculated interest for Ms. Chris Katina McCord on the sum of $1,480,157 at the rate of eight percent (8%) per annum for the period 12/29/11 to 3/11/14. This amount is $260,235.95.

Likewise, at your request I have calculated interest for Mr. Christopher McCord on the sum of $50,000 at the rate of eight percent (8%) per annum for he period 12/29/11 to 3/11/14. This amount is $8,789.04.

Very truly yours,

G. Richard Thompson, Ph.D.

GRT/tec.

VOICE: (864) 654-6494
FAX: (864) 624-

STATE OF SOUTH CAROLINA) IN THE COURT OF COMMON PLEAS
)
COUNTY OF LAURENS) C.A. FILE NO. 11-CP-30-1141

Chris Katina McCord and Christopher McCord,

Plaintiffs,

vs.

Byron A. Brown, MD, Laurens County Obstetrics and Gynecology, LLC, a South Carolina Limited Liability Corporation, American Medical Systems, Inc., a Delaware Corporation and wholly owned subsidiary of Endo Pharmaceuticals, Inc., a Delaware Corporation,

Defendants.

LYNN W. LANCASTER
2012 JAN -6 A 10:23
LAURENS COUNTY
CLERK OF COURT

OFFER OF JUDGMENT
(Rule 68 SCRCP)

TO: DEFENDANTS BYRON A. BROWN, MD AND LAURENS COUNTY OBSTETRICS AND GYNECOLOGY, LLC:

Chris McCord, Plaintiff, by and through her undersigned attorneys, hereby submits an Offer of Judgment pursuant to Rule 68 of the *South Carolina Rules of Civil Procedure* to the Defendants Byron A. Brown, M.D. and Laurens County Obstetrics and Gynecology, LLC in the amount of $750,000.00, in accordance with South Carolina Code § 15-35-400, reserving all rights against any party responsible for her injuries whether presently named as a party defendant or not. If this Offer of Judgment is not accepted in writing within twenty (20) days, it will be statutorily rejected.

This Offer of Judgment is made this 29th day of December 2011.

Joseph G. Wright, III
McGowan, Hood & Felder, LLC
P. O. Drawer 1778
Anderson, SC 29622-1778
(864) 225-6228
(864) 231-9011 FACSIMILE
jwright@mcgowanhood.com

STATE OF SOUTH CAROLINA	)	IN THE COURT OF COMMON PLEAS
	)	
COUNTY OF LAURENS	)	C.A. FILE NO. 11-CP-30-1141
Chris Katina McCord and Christopher McCord, Plaintiffs, vs. Byron A. Brown, MD, Laurens County Obstetrics and Gynecology, LLC, a South Carolina Limited Liability Corporation, American Medical Systems, Inc., a Delaware Corporation and wholly owned subsidiary of Endo Pharmaceuticals, Inc., a Delaware Corporation, Defendants.	)	OFFER OF JUDGMENT (Rule 68 SCRCP)

TO: DEFENDANTS BYRON A. BROWN, MD AND LAURENS COUNTY OBSTETRICS AND GYNECOLOGY, LLC:

Christopher McCord, Plaintiff, by and through his undersigned attorneys, hereby submits an Offer of Judgment pursuant to Rule 68 of the *South Carolina Rules of Civil Procedure* to the Defendants Byron A. Brown, M.D. and Laurens County Obstetrics and Gynecology, LLC in the amount of $50,000.00, in accordance with South Carolina Code § 15-35-400, reserving all rights against any party responsible for her injuries whether presently named as a party defendant or not. If this Offer of Judgment is not accepted in writing within twenty (20) days, it will be statutorily rejected.

This Offer of Judgment is made this 29th day of December 2011.

Joseph G. Wright, III
McGowan, Hood & Felder, LLC
P. O. Drawer 1778
Anderson, SC 29622-1778
(864) 225-6228
(864) 231-9011 FACSIMILE
jwright@mcgowanhood.com

STATE OF SOUTH CAROLINA) IN THE COURT OF COMMON PLEAS

COUNTY OF LAURENS) C.A. FILE NO. 11-CP-30-1141

Chris Katina McCord and Christopher McCord,

Plaintiffs,

vs. JUDGMENT

Byron A. Brown, MD, and Laurens County Obstetrics and Gynecology, LLC, a South Carolina Limited Liability Corporation,

Defendants.

LYNN W. LANCASTER
2014 MAR 11 P 4:36
LAURENS COUNTY
CLERK OF COURT

A hearing was held before the undersigned this 11 day of March, 2014 to determine damages. Based upon the evidence presented, I hereby find and order the judgment to be entered in favor of Chris Katina McCord and Christopher McCord and against Byron A. Brown, MD and Laurens County Obstetrics and Gynecology, LLC as follows:

	Chris Katina McCord	
Economic Loss	$1,101,832.00	
Non-economic Loss	$ 378,625.00	
Judgment for Chris Katina McCord		**$1,480,457**

	Christopher McCord	
Economic Loss	$ none	
Non-economic Loss	$ 50,000.00	
Judgment for Christopher McCord		**$ 50,000**

I further find and order that the respective judgments exceed the Offers of Judgment made by Plaintiffs on December 29, 2011 (to wit: Chris Katina McCord $750,000 and Christopher McCord $50,000). Accordingly in compliance with *Rule 18, South Carolina Rules of Civil Procedure,* an amount equal to eight percent interest computed on the amount of the award from the date of the offer to the entry of judgment which shall be added to the above total judgment. This amount is $ 1,480,457 for Chris Katina McCord and $ 50,000 for Christopher McCord.

IT IS SO ORDERED.

March 11, 2014
Greenwood, South Carolina

Judge, Eighth Judicial Circuit

A TRUE COPY OF ORIGINAL
Lynn W. Lancaster
Lynn W. Lancaster
Laurens County CCCP & GS

STATE OF SOUTH CAROLINA) IN THE COURT OF COMMON PLEAS
)
COUNTY OF LAURENS) C.A. FILE NO. 12-CP-30-753

LYNN W. LANCASTER
2014 MAR 11 P 4:34
LAURENS COUNTY CLERK OF COURT

Janice Sherfield and Jerry Sherfield,)
)
Plaintiffs,)
) JUDGMENT
vs.)
)
Byron A. Brown, MD, and Laurens)
County Obstetrics and Gynecology, LLC,)
a South Carolina Limited Liability)
Corporation,)
)
Defendants.)
)

A hearing was held before the undersigned this 11th day of March, 2014 to determine damages. Based upon the evidence presented, I hereby find and order that judgment be entered in favor of Janice Sherfield and Jerry Sherfield and against Byron A. Brown, MD and Laurens County Obstetrics and Gynecology, LLC as follows:

Janice Sherfield

Economic loss $ 1,089,955

Non-economic loss $ 378,625

Judgment for Janice Sherfield $ 1,468,580

Jerry Sherfield

Economic Loss $ 0

Non-economic loss $ 50,000

Judgment for Jerry Sherfield $ 50,000

IT IS SO ORDERED

ALL-STATE LEGAL® EXHIBIT 6

March 11, 2014
Greenwood, South Carolina

Judge, Eighth Judicial Circuit

A TRUE COPY OF ORIGINAL
Lynn W. Lancaster
Lynn W. Lancaster
Laurens County CCCP & GS

STATE OF SOUTH CAROLINA) IN THE COURT OF COMMON PLEAS
)
COUNTY OF LAURENS) C/A. FILE NO. 12-CP-30-753
)
Janice Sherfield and Jerry Sherfield,)
)
Plaintiffs,)
) ORDER FOR JUDGMENT
vs.)
)
Byron A. Brown, MD, and Laurens)
County Obstetrics and Gynecology, LLC,)
a South Carolina Limited Liability)
Corporation,)
)
Defendants.)

LYNN W. LANCASTER
2014 MAR 11 P 4:54
LAURENS COUNTY
CLERK OF COURT

Based upon the pleadings, orders and aforementioned documents and the numerous hearings held by the undersigned regarding this litigation against Byron A. Brown, MD and Laurens County Obstetrics and Gynecology, LLC, I find Byron A. Brown, MD is in default of my Order dated November 5, 2013 and in contempt of court.

ACCORDINGLY, and in compliance with *Rule 55, South Carolina Rules of Civil Procedure*, I hereby rule and order as follows:

a. the Answers of Byron A. Brown, MD and Laurens County Obstetrics and Gynecology, LLC are hereby struck from the court record;

b. judgment by default is entered against Byron A. Brown, MD and Laurens County Obstetrics and Gynecology, LLC and in favor of Janice Sherfield and Jerry Sherfield; and

c. a hearing is to be scheduled by the Clerk of Court at an appropriate date and time to determine the amount of damages by the Court.

IT IS SO ORDERED.

March ~~February~~ 11, 2014
Greenwood, South Carolina

Judge, Eighth Judicial Circuit

A TRUE COPY OF ORIGINAL
Lynn W. Lancaster
Lynn W. Lancaster
Laurens County CCCP & GS

CONDITIONS OF ADMISSION

GENERAL DUTY NURSING: The hospital provides only general duty nursing care. Under this system nurses are called to the bedside of the patient by a signal system. If the patient is in such condition as to need continuous or special family duty nursing care, such must be arranged by the patient or legal representative. The hospital is not responsible for failure to provide the same and is hereby released from any and all liability arising from the fact that said patient is not provided with such additional care.

IMAGERY: I understand that photographs, videotapes, digital, or other images may be recorded to document my care, and I consent to this. I understand that Laurens County Health Care System will retain the ownership rights to these photographs, videotapes, digital, or other images, but that I will be allowed access to view them or obtain copies. I understand that these images will be stored in a secure manner that will protect my privacy and that they will be kept for the time period required by law or outlined in Laurens County Health Care System's policy. Images that identify me will be released and/or used outside the institution only upon written authorization from me or my legal representative.

MEDICAL AND SURGICAL CONSENT: The patient's care is under the direction of the attending physicians and the hospital is not responsible for any act or omission of the physicians. The undersigned consents to any x-ray examination, laboratory procedure, anesthesia, debridement, biopsy, medical or surgical treatment or hospital services rendered the patient under the general and special instructions of the physician. The undersigned recognizes that most medical staff members furnishing services to the patient, including the radiologists, pathologist, anesthesiologists, and the like (are) independent contractors and not employees of the hospital.

ASSIGNMENT OF INSURANCE BENEFITS AND THIRD PARTY CLAIMS: I/we hereby guarantee payment of all charges incurred for the account of the patient and hereby assign any hospital benefits, major medical benefits, PIP benefits, sick benefits, or injury benefits due because of any insurance policy and the proceeds of all claims resulting from the liability of the third party payable by any person, employer or insurance company to or for the patient unless we pay account in full upon discharge. If eligible for Medicare, I request Medicare services and benefits. I understand I am responsible for any charges not covered by insurance, Medicare, Medicaid, or other benefits.

ASSIGNMENT OF PHYSICIAN BENEFITS: In the event that I, the patient in addition to hospital benefits, am entitled to physician or physicians benefits of any type whatsoever, arising out of a policy of insurance insuring me or any other party's liability to me, I hereby assign said benefits to any physician rendering care or treatment during this stay or outpatient visits, to be applied to my bill.

FINANCIAL AGREEMENT: The undersigned agrees he signs as agent or as patient that in consideration of the services to be rendered to that patient, he hereby individually obligates himself to pay the account of the hospital, in accordance with the regular rates and terms of the hospital. Should the account be referred to an attorney for collection, the undersigned shall pay reasonable attorney's fees and collection expense. All delinquent accounts may bear interest at the legal rate. I do hereby appoint the Hospital as my true lawful attorney to act in my behalf to collect the above mentioned claims and to give full and final receipt for me for all amounts so collected, and to endorse for me any checks made payable to me for benefits or claims collected under the above agreements. In the event insurance benefits exceed the actual amount of hospitalization, I hereby authorize and direct the Hospital to apply any overpayment that I may otherwise be entitled to the payment of any debt at the Hospital for myself, my spouse, or my children or any other account for which I am responsible.

[redacted] MEDICAL INFORMATION: I hereby authorize the Hospital and the Physician to furnish necessary information from the medical record requested by [redacted], its designated agency, or sponsoring third parties (to include Medicare and Medicaid) whose benefits have been assigned for purposes of [redacted] may be transmitted in writing or verbally for the sole purpose to receive benefit payment for services rendered. During my [redacted] I authorize my treating physicians to direct copies of my medical records to other physicians as they deem necessary for continuity of [redacted].

[redacted]: The hospital is not responsible for personal property retained in the patient's room and will not be responsible for any personal [redacted] unless it is accepted for safekeeping by the hospital and receipts are issued therefore.

[redacted] PERSONNEL, EMPLOYEES AND OTHERS: I consent to appropriate tests for the presence of infection, such as, but not limited to, the Hepatitis B virus or HIV, as necessary for the protection of others. I authorize the withdrawal of blood or other body fluids for this purpose.

[redacted]

Check the following statement that pertains to you:

_____ I HAVE executed an Advance Directive
_____ A Living Will
_____ Designation of a Health Care Surrogate
_____ Durable Power of Attorney for Health Care
X I HAVE Not executed an Advance Directive (A Living Will, Durable Power of Attorney For Health Care Designation of a Health Care Surrogate).
_____ I WOULD like additional information concerning Advance Directives.

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_____ I acknowledge that the LAURENS COUNTY HEALTH CARE SYSTEM cannot be responsible for PRE-CERTIFICATION. It is the responsibility of the patient and/or the patient's physician.

X I acknowledge that I have received the Lewis Blackman Patient Safety Information Sheet of the LAURENS COUNTY HEALTH CARE SYSTEM, which sets forth the ways in which I may contact my attending physician, addresses the practice of clinical trainees, and provides a list of abbreviations utilized on LCHCS name badges.

X I acknowledge that I have read (or have had read to me) the conditions of admission. I understand and consent to the conditions.

_____ Have you fallen in past 3 months? _____ Do you feel dizzy? _____ Do you need a wheelchair to complete your testing today?

At Risk for Falls- Green wrist band applied

Patient: [redacted] DOB: [redacted]

Account Number: [redacted] Medical Record Number: [redacted]

Chris McCord

2/18/2009 DATE — TERESSA A FRANES WITNESS — PT OR AUTHORIZED REP — RELATIONSHIP TO PT

EXHIBIT 8 ALL-STATE LEGAL

DATE — WITNESS — PT OR AUTHORIZED REP — RELATIONSHIP TO PT

Wednesday, February 18, 2009 11:11 / TAF

ATTACHMENT 5

Laurens C nty HealthCare System

CONDITIONS OF ADMISSION

GENERAL DUTY NURSING: The hospital provides only general duty nursing care. Under this system nurses are called to the bedside of the patient by a signal system. If the patient is in such condition as to need continuous or special family duty nursing care, such must be arranged by the patient or legal representative. The hospital is not responsible for failure to provide the same and is hereby released from any and all liability arising from the fact that said patient is not provided with such additional care.

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ASSIGNMENT OF INSURANCE BENEFITS AND THIRD PARTY CLAIMS: I/we hereby guarantee payment of all charges incurred for the account of the patient and hereby assign any hospital benefits, major medical benefits, PIP benefits, sick benefits, or injury benefits due because of any insurance policy and the proceeds of all claims resulting from the liability of the third party payable by any person, employer or insurance company to or for the patient unless we pay account in full upon discharge. If eligible for Medicare, I request Medicare services and benefits. I understand I am responsible for any charges not covered by insurance, Medicare, Medicaid, or other benefits.

ASSIGNMENT OF PHYSICIAN BENEFITS: In the event that I, the patient in addition to hospital benefits, am entitled to physician or physicians benefits of any type whatsoever, arising out of a policy of insurance insuring me or any other party's liability to me, I hereby assign said benefits to any physician rendering care or treatment during this stay or outpatient visits, to be applied to my bill.

FINANCIAL AGREEMENT: The undersigned agrees he signs as agent or as patient that in consideration of the services to be rendered to that patient, he hereby individually obligates himself to pay the account of the hospital, in accordance with the regular rates and terms of the hospital. Should the account be referred to an attorney for collection, the undersigned shall pay reasonable attorney's fees and collection expense. All delinquent accounts may bear interest at the legal rate. I do hereby appoint the Hospital as my true lawful attorney to act in my behalf to collect the above mentioned claims and to give full and final receipt for me for all amounts so collected, and to endorse for me any checks made payable to me for benefits or claims collected under the above agreements. In the event insurance benefits exceed the actual amount of hospitalization, I hereby authorize and direct the Hospital to apply any overpayment that I may otherwise be entitled to, to any account that may exist at the Hospital for myself, my spouse, or my children or any other account for which I am responsible.

RELEASE OF MEDICAL INFORMATION: I hereby authorize the Hospital and the Physician to furnish necessary information from the medical record requested by my insurance company, its designated agency, or sponsoring third parties (to include Medicare and Medicaid) whose benefits have been assigned for purposes of benefit payment. This information may be transmitted in writing or verbally for the sole purpose to receive benefit payment for services rendered. During my hospitalization at the Hospital, I authorize my treating physicians to direct copies of my medical records to other physicians as they deem necessary for continuity of care while an inpatient.

PERSONAL VALUABLES: The hospital is not responsible for personal property retained in the patient's room and will not be responsible for any personal property of the patient unless it is accepted for safekeeping by the hospital and receipts are issued therefore.

TESTING TO PROTECT HOSPITAL EMPLOYEES AND OTHERS: I consent to appropriate tests for the presence of infection, such as, but not limited to, the Hepatitis B virus or HIV, if deemed necessary for the protection of others. I authorize the withdrawal of blood or other body fluids for this purpose.

THE FOLLOWING INFORMATION CONCERNING ADVANCE DIRECTIVES:

Check the following statements that pertain to you:

_____ I HAVE executed an Advance Directive
_____ A Living Will
_____ Designation of a Health Care Surrogate
_____ Durable Power of Attorney for Health Care
__X__ I HAVE Not executed an Advance Directive (A Living Will, Durable Power of Attorney For Health Care Designation of a Health Care Surrogate).
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_____ At Risk for Falls- Green wrist band applied

Patient: MCCORD CHRIS K DOB: 12/04/1972

Account Number: 765217 Medical Record Number: 928480

2/18/2009	TERESSA A FRANKS		
DATE	WITNESS	PT OR AUTHORIZED REP	RELATIONSHIP TO PT
DATE	WITNESS	PT OR AUTHORIZED REP	RELATIONSHIP TO PT

y HealthCare System

CONDITIONS OF ADMISSION

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[illegible] understand that photographs, videotapes, digital, or other images may be recorded to document my care, and I consent to this. I understand that Laurens [illegible] Care System will retain the ownership rights to these photographs, videotapes, digital, or other images, but that I will be allowed access to view them or [illegible]. I understand that these images will be stored in a secure manner that will protect my privacy and that they will be kept for the time period required by law or [illegible] Laurens County Health Care System's policy. Images that identify me will be released and/or used outside the institution only upon written authorization from [illegible] my legal representative.

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Patient: MCCORD CHRIS K DOB: 12/04/1972

Account Number: 762145 Medical Record Number: 926493

4/16/2009	NADINE M MINTEER	[signature]	SELF
DATE	WITNESS	PT OR AUTHORIZED REP	RELATIONSHIP TO PT
DATE	WITNESS	PT OR AUTHORIZED REP	RELATIONSHIP TO PT

Laurens County HealthCare System

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X I acknowledge that I have read (or have had read to me) the conditions of admission. I understand and consent to the conditions.

EXHIBIT 9

ALL-STATE LEGAL®

Patient: SHERRELD,JANICE K DOB: 05/25/1968

Account Number: 772675 Medical Record Number: 902420

Janice Sherfield

7/27/2009 DATE | PEGGY A HARRIS WITNESS | PT OR AUTHORIZED REP | RELATIONSHIP TO PT

DATE | WITNESS | PT OR AUTHORIZED REP | RELATIONSHIP TO PT

Wednesday, May 27, 2009 11:02 / PAH

Page 1

State of South Carolina)
)
County of Laurens)

Chris Katina McCord, Christopher McCord, Janice Sherfield, and Jerry Sherfield,

Plaintiffs,

vs.

Laurens County Health Care System and Greenville Healthcare System,

Defendants.

14-CP-30-250

30(b)(6) Deposition

of

Laurens County Health Care System

(Lynn Reaves and Sandra Thompson)

Date: January 6, 2016

Time: 10:12 a.m. - 12:39 p.m.

Location: Laurens County Health Care System
22725 Highway 76 East
Clinton, South Carolina

Reported by
Vickie M. Hester, CVR

Page 2

APPEARANCES

For the Plaintiffs: Joseph G. Wright, III, Esq.
Jay F. Wright, Esq.
McGowan, Hood & Felder, LLC
Post Office Drawer 1776
Anderson, South Carolina 29622

For the Defendants: Kenneth N. Shaw, Esq.
Haynsworth Sinkler Boyd, PA
Post Office Box 2048
Greenville, South Carolina 29602

Also present: None

INDEX

Stipulations: 3
Examination of Ms. Reeves by Mr. Wright: 4
Examination of Ms. Reeves by Mr. Shaw: 43
Examination of Ms. Thompson by Mr. Wright: 44

EXHIBITS

(All exhibits were marked by Mr. Wright prior to the deposition, with the exception of Exhibit No. 25 which was later removed and replaced by Exhibit No. 23. All other exhibits were initialed and dated by the Court Reporter at the time they were introduced)

Exhibit No. 16, Deposition Subpoena. 3
Exhibit No. 4B, Medical Staff Bylaws. 8
Exhibit No. 23, Insurance Certificates Face Sheets. 11
Exhibit No. 6, McCord Conditions of Admission. 48
Exhibit No. 9, Sherfield Conditions of Admission. 48
Exhibit No. 24, Letter to Mr. McCord from GHS. 52
Exhibit No. 12, Memo from MAG Mutual. 54
Exhibit No. 17, Affidavit of Sandra Thompson. 58
Exhibit No. 18, Report from Dr. Madis. 59
Exhibit No. 19, List of Charts Pulled. 60

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STIPULATIONS

It is stipulated by and between counsel for the respective parties that all objections are reserved until the time of trial, except as to the form of the questions.

This deposition is being taken pursuant to the South Carolina Rules of Civil Procedure.

- - - -

The reading and signing of this deposition is not waived by the deponents and counsel for the respective parties.

Whereupon,

Lynn Reaves and Sandra Thompson, being duly sworn and cautioned to speak the truth, the whole truth, and nothing but the truth, testified as follows:

MR. WRIGHT: Let me start by noting that we have marked as Exhibit 16 the deposition subpoena in this case.

(Exhibit Number 16 Introduced)

MR. WRIGHT: And the first topic would be regarding professional liability insurance coverage of Byron Brown. And as I understand it, Ms. Reaves is the designee for that. Is that correct?

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MR. SHAW: Are you asking me, or are you asking her?

MR. WRIGHT: You.

MR. SHAW: Me?

MR. WRIGHT: Yeah.

MR. SHAW: Yes, that is correct.

MR. WRIGHT: Okay.

EXAMINATION OF LYNN REAVES

BY MR. WRIGHT:

Q. Ms. Reaves, a little bit of background. Would you give us who your employer is and what your position is?

A. Greenville Health System, and I'm the manager of Medical Staff Services.

Q. The manager of what now?

A. Medical Staff Services.

Q. And what are your primary duties?

A. The credentialing and privileging of physicians.

Q. All right. And how long have you been employed by Laurens Hospital and/or Greenville Hospital System?

A. Twenty-five years.

Q. And when did you become employed by Greenville Hospital System?

A. Two years ago this past July.

Q. Now, in the last 25 years have you held any other

Page 45

A. My current employer is Greenville Health System, and I serve Greenville Health System in the capacity of Manager of Quality Resources where I have responsibility for quality, risk management and onsite compliance.
Q. Manager of Quality Resources.
A. Resources.
Q. And could you explain a little bit more about what your -- your primary duties and responsibilities are?
A. Day to day I manage -- I have a staff of two and a half individuals, two full-time and one part-time. We collect data, review data, analyze data, facilitate performance improvement teams, provide information to physicians regarding evidence-based practice as requested. I also am responsible for risk management where I'm responsible for all of the onsite claims, lawsuits, discovery requests. Also in reviewing charts, conducting case reviews, referrals to -- for physician review. Things like that. And then for the compliance piece, that is regulatory compliance. I'm responsible for insuring that our Joint Commission survey goes well, that the hospital maintains as far as possible compliance with standards and regulations,

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and also with legal compliance.
Q. You've got a full plate.
A. I do.
Q. All right. And how long have you held the position of Manager of Quality Resources or similar positions?
A. Well, the Manager of Quality Resources was -- became my job title when we affiliated with Greenville Health System on July 1st, 2013. Prior to that when I was employed directly by Laurens County Health Care System I was the administrator for quality and risk and compliance. That probably -- and I'm just estimating because I'm not good at dates. I had held that position for probably ten years prior to affiliation.
Q. And in the position that you held for ten years prior to the affiliation, is that basically the same duties and responsibilities?
A. Yes.
Q. Now, you mentioned Joint Commission. Could you explain what Joint Commission is?
A. Joint Commission is a regulatory agency. It is not a direct governmental body. It is a private, not for profit 501(c)(3) that CMS grants deeming status to, and they survey hospitals on a tri-annual basis

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for CMS.
Q. All right. And the certification that's given by Joint Commission means what to the hospital?
A. It means that we are eligible to participate in the Medicare and Medicaid Program, any governmental-funded programs.
Q. Okay. Which is pretty important?
A. Oh, yes. Yes.
Q. All right. As far as government regulations, that would be DHEC regulations?
A. It could be.
Q. Does DHEC issue regulations governing the operation of a hospital in South Carolina?
A. They do. They have Regulation 61 -- I think it's 61-17 that regulates licensure of hospitals.
Q. And you're responsible for insuring compliance to DHEC regulations?
A. Yes.
Q. What about federal regulations; are there federal regulations also?
A. Yes. There are the CMS Conditions of Participation for participation in Medicare and Medicaid programs. And those are directly tied in with Joint Commission standards as well.
Q. Okay. And what was your -- your position in 2008-

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2009, you had the same responsibilities?
A. Yes.
Q. Could you give us your education background?
A. Okay. I graduated high school in 1975 in Lexington, Alabama, Lexington High School. I have attended Auburn University for a brief period of time. Then attended University of North Alabama. Also attended Newberry College. And I'm currently a student at Walden University in my final semester I guess you would say with a -- working on a degree -- Bachelor's of Science in Healthcare Management.
Q. Okay. And when -- when were you first employed with Laurens Hospital?
A. 1993.
Q. Okay. Now, as far as the items on the 30(b)(6) notice, let me talk with you about the conditions of admission form.
A. All right.
Q. All right. And I'm going to show you Exhibit 8. I think it's already been marked, but I'm going to mark it again. And Exhibit 9.
(Exhibit Numbers 8 and 9 Introduced)
Q. And to identify those for the record, Conditions of Admission 8 relate to Ms. McCord with a date of 2/18/09. And then the second one, the date of

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4/16/09. Correct?
A. Correct.
Q. And as far as Exhibit Number 9, it's with Janice Sherfield with a date of 5/27/09.
A. Yes.
Q. Okay. Now, let's talk about Ms. McCord's conditions of admission, 2/18/09.
A. All right.
Q. But before we do that, there was a surgery on February the 18th, '09. And I believe that -- that the information we have is that for all of these surgeries -- and I'll show you your answer to Exhibit Number -- I mean Interrogatory Number 5. For all the surgeries it was requested that a conditions of admission form be executed, correct?
A. Correct.
Q. And that according to the request for production 13, a diligent search was made but the hospital has been unable to locate a 12/18/08 condition of admissions form; is that correct?
A. That's correct.
Q. But would you agree that more probably than not the conditions of admission form was signed for the 12/18/08 McCord surgery?
A. I would agree with that, yes.

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Q. Okay. Now, relating to the -- to the conditions of admission form that you have in front of you, I think they're all basically the same except for the signatures, it has on here where I've highlighted all the places that it relates to Laurens County Health Care System.
A. Uh-huh. Yes, sir.
Q. And it appears that this is a form that was prepared by or at the direction of Laurens County Health Care System; is that correct?
A. That would be correct.
Q. Okay. Now, as far as specific date, I'm not really concerned about that. But do you know approximately when this form was drafted or prepared by or on behalf of Laurens County Health Care System?
A. This form was in use when I came here in 1993.
Q. 1993. All right. Now, Exhibit Number 8 has the witness signing as Teressa A. Franks. Do you see that?
A. Yes.
Q. Now, is Nurse -- or Mrs. Franks -- was she an employee or is she now an employee of Laurens County Health Care System or Laurens -- let me back up. You're an employee of who? Greenville

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Hospital System or --
A. Currently, yes.
Q. Currently. Okay. Was she an employee of Laurens County Health Care System at the time she signed this?
A. I don't specifically know.
Q. Okay. The next one is Nadine Mintern who is a witness on 4/16/09.
A. Yes.
Q. Was she an employee of Laurens County Health Care System?
A. In that case I do know this individual, and yes, she was.
Q. Okay. And then for Mrs. Sherfield, Exhibit Number 9, Peggy A. Harris, was she an employee of Laurens County Health Care System?
A. I'm not familiar with that individual, so I'm not sure.
Q. Would you agree that the policy or intention of Laurens County Health Care System is to have a representative or employee of Laurens County Hospital sign as a witness for these documents?
A. That is the practice, yes.
Q. Okay. Now, let me show you what's been marked as Exhibit 24.

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(Exhibit Number 24 Introduced)
Q. I thought I had an extra one of these. Now, this is a document -- well, let me -- let me go to this first. Exhibit 22 are the answers to interrogatories. And I'm going to show you the answer to Interrogatory Number 9. And I'm also going to show you the verification. You -- you verified these answers to the best of your ability as being true and accurate, correct?
A. Correct.
Q. Okay. And then in Number 9 it states that -- that the amount of $190 was garnished from the income tax return of Mrs. McCord for Laurens County Hospital; is that correct?
A. That's what it says, yes.
Q. Okay. And then in Interrogatory Number 11 the sum of $100 was garnished from the state tax return of Mr. and Ms. Sherfield for Laurens Hospital?
A. That's what this says, yes.
Q. And you believe these to be true, correct?
A. I believe those to be true, yes.
Q. Okay. And now the one you have in front of you, Exhibit 24, in your position are you aware that -- that a claim for $2400 -- $2,476.38 was made against the income tax refunds for Mr. and Mrs.

STATE OF SOUTH CAROLINA IN THE COURT OF COMMON PLEAS

COUNTY OF LAURENS C.A. NO.: 2014-CP-30-0250

CHRIS KATINA McCORD, CHRISTOPHER McCORD, JANICE SHERFIELD, AND JERRY SHERFIELD,

PLAINTIFFS,

V.

LAURENS COUNTY HEALTH CARE SYSTEM AND GREENVILLE HEALTH SYSTEM,

DEFENDANTS.

DEPOSITION OF JOHN CHARLES HYDE, II, Ph.D.

Taken at the instance of the Defendants on Tuesday, April 5, 2016, in the offices of Edwards Reporting, Inc., 435 Katherine Drive, Suite A, Flowood, Mississippi, beginning at 12:54 p.m.

APPEARANCES:

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the -- when you said only financial harms that they're suffering, then I went off on the clinical side.

Q. (By Mr. Shaw) And what I meant by that --

A. Okay.

Q. -- is harms suffered as a result of what you claim to be the hospital's breach of the duty owed to them.

A. Well, the harm there is, like I've said, they are enjoined, or they do -- do not have recourse to go after the financial coverage that should have been afforded to them by requiring Brown -- Dr. Brown to have adequate coverage. So that's -- all they're trying to get from the hospital is the -- the amount that should have been covered under Brown's policy.

Q. All right. Doctor, I think that's all I've got for you.

A. Thanks.

MR. WRIGHT: Let me ask you a few questions.

THE WITNESS: Sure.

EXAMINATION BY MR. WRIGHT:

Q. Dr. Hyde, when I -- during your answers to my questions, would you -- if you're asked for opinions, would you confine your opinions to a reasonable degree of certainty in the field of hospital administration?

A. I will and I always do, so, yes, sir.

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Q. Okay. Now, just so you know -- and I want you to take this as a fact -- the JUA policy is not a consent policy. Okay?

A. Okay.

Q. JUA can settle the policy without the physician's consent.

A. Okay.

Q. The MagMutual policy is a consent policy --

A. Okay.

Q. -- if that comes up.

MR. SHAW: Well, I object to that because I don't know where that's in any sort of record that I have. I don't have a copy of any of those policies.

MR. WRIGHT: Yeah, you do.

MR. SHAW: The full policies?

MR. WRIGHT: Yeah.

MR. SHAW: None of that has been produced to me.

MR. WRIGHT: They're in the exhibits. I sent you a copy of all the exhibits.

MR. SHAW: Of the full policy?

MR. WRIGHT: Yeah. Uh-huh. I'll show you.

Q. (By Mr. Wright) Now, you were asked about the Institute of Medicine publication. And that would be Exhibit 13. According to the 1999 Institute of Medicine

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publication "To Err is Human," how many hospital deaths per year are caused from physician negligence?

A. Anywhere from 44,000 to 98,000.

Q. Okay. Now, does that cover patients who do not die but suffer serious injuries from medical errors such as was suffered by Ms. McCord and Ms. Sherfield?

A. No. That's only deaths. It's not injuries or any level or significance of injury.

Q. Ten years later -- and this is Exhibit 14 -- the Inspector General for the Department of Health and Human Services issued a report. Do you have that report in front of you?

A. I do. And I'm reading it right now. I'm looking at it.

Q. And how many deaths from Medicare patients per year?

A. Let me get to that. My copy is highlighted. This isn't.

Q. Well, we'll come back to that.

A. Well, I'm -- I'm getting close to it. I just -- I'm sorry. I had to -- yeah, if you would, I'll keep on looking.

Q. All right. Do you consider the report of the Inspector General for the Department of Health and Human Services to be reliable?

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A. Extremely reliable. Yes, sir.

Q. Do you consider the report "To Err is Human" to be reliable?

A. I do.

Q. The next article is Exhibit 15, the Journal of Patient Safety.

A. Yes.

Q. And do you consider that report to be reliable?

A. I do.

Q. And in that document, is it true that it's been estimated that between 210,000 and 440,000 patients suffer some type of preventable harms in U.S. hospitals that contribute to their death?

A. Yes. That's the results section that says that.

Q. Okay. Now, Dr. Hyde, in your opinion -- as an expert in the field of hospital administration, is it your opinion that there has been and is an epidemic of medical negligence causing serious injuries and deaths to patients in the hospitals in the United States?

A. Absolutely. You look at the progression and you see that it's continually going up and -- and also realize the fact that there's underreporting going on.

Q. Dr. Hyde, in your professional opinion, based upon the fact there is an epidemic of medical malpractice

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that's causing serious deaths and injuries in the United States, is it the common practice of hospitals to require physicians to carry and maintain professional liability insurance?

A. Yes. I'm sorry. I was waiting. It's definitely not only a requirement, it's prevailing and -- and, like I said before, I've never seen a hospital that didn't require that that was open more than two days.

Q. Dr. Hyde, in your professional opinion, is one of the purposes for the hospital requiring that professional liability insurance be carried by surgeons that operate at a hospital is to benefit and protect innocent patients who are injured while in the hospital due to the negligent conduct of the surgeons to have a means to recover damages for injuries wrongfully inflicted upon them?

A. Yes, sir. That's one of the benefits and one of the -- one of the requirements to have.

Q. All right. Let me turn your attention to the public policy of South Carolina.

A. Okay. Do I have that as an exhibit, or are you just going to --

Q. No.

A. Okay. Okay.

Q. Yeah. We're going to get to it.

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A. Okay.

Q. As far as public policy of South Carolina, do you have an opinion whether the public policy of South Carolina requires hospitals to monitor patient care through oversight?

A. Absolutely.

MR. SHAW: Objection.

THE WITNESS: Sorry.

A. I absolutely do.

Q. (By Mr. Wright) And have you reviewed the regulations of the South Carolina Department of Health and Environmental Control, regulation 61-16?

A. Yes, sir. I've got that in front of me -- or will have.

Q. Let me -- hang on just a second.

A. I've got that short form somewhere.

Q. Dr. Hyde, I'm referring to section 202 of the DHEC regulations that state that "The governing board shall be the supreme authority in the hospital responsible for the management control of the hospital and appointment of medical staff." In your opinion, is that the board of directors of the hospital?

A. It is the governing board.

Q. And next section -- next sentence, is it a requirement under the law of South Carolina for the

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hospital to have a written set of bylaws for the operation of the hospital?

A. Yes, it is. That's a requirement.

Q. And is a further requirement, in your professional opinion, that the chief administrative officer of the hospital shall be responsible for the administration of the facility and shall see that all the bylaws and amendments are complied with?

A. Yes, sir.

Q. Is that a state law?

A. It is. It's a state law through DHEC, D- --

MR. SHAW: Objection.

Q. (By Mr. Wright) Now, if you would, Doctor, turn to Exhibit 4-A, which is a portion of the --

A. I've got it, the medical staff bylaws.

Q. -- medical staff bylaws. And in the preamble to the medical staff bylaws on page 4 --

A. I've got it somewhere. Sorry.

Q. Here you are. You can tag along.

A. Okay.

Q. Is it a requirement of these bylaws for the medical staff to concentrate on quality patient care under the ultimate authority of the board?

MR. SHAW: Objection.

A. Yes, sir.

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Q. (By Mr. Wright) And these bylaws, according to the preamble, were established by whom?

A. By the board and approved by the board.

Q. Okay. And that's the governing body of the hospital; is that correct?

A. Correct. The supreme authority, according to South Carolina law and/or rules and regulations.

Q. And according to item 3.2.1 of the medical staff bylaws, as far as the requirement for continuing appointment to the medical staff under item E is the requirement that the physicians' privilege shall have and maintain valid professional liability insurance coverage?

A. Yes, sir.

Q. Now, in this particular case, you've been asked some questions about the insurance policy at issue, which was a claims-made policy; is that correct?

A. Yes.

Q. In your professional opinion, if the claims-made policy is not -- if the protection under the claims-made policy is not continued by the physician, is that maintaining the insurance coverage?

A. No.

MR. SHAW: Objection.

A. It's -- it's failure to maintain a continuous insurance or insurability and protection.

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Q. (By Mr. Wright) All right. All right. So in this particular case, as it's been pointed out, the insurance coverage that was available to Ms. McCord and Ms. Sherfield was subsequently divested of them because the insurance coverage that Dr. Brown subsequently obtained either did not obtain extended coverage endorsement or prior claims endorsement, correct?

A. That -- that's absolutely --

MR. SHAW: Objection.

A. -- correct.

THE WITNESS: Sorry.

MR. SHAW: That's all right. I didn't understand that question, so I was objecting.

Q. (By Mr. Wright) Let me restate it. In this particular case, do you have an opinion whether or not the insurance coverage that was at one time available for Ms. McCord under her three surgeries and Ms. Sherfield under her surgery was not maintained because there was no subsequent purchase of expanded coverage endorsement or prior claims endorsement by Dr. Brown?

A. Absolutely correct. That's -- that's the reason that they did not have coverage, because he had failed to buy those --

Q. In your --

A. -- limits.

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Q. Yeah. In your professional opinion as a hospital administrator, would you consider that fact where the insurance coverage became divested as being a violation of the medical staff bylaws?

A. Absolutely. It's clear that it says have in effect at all times the minimum professional liability insurance. And it -- that is a de facto violation if it does not cover part of the -- the patient population that this individual had.

Q. All right. Let me ask you to look at Exhibit number -- I think it's 7, the subsidy contract.

A. Yes, sir. Got it.

Q. Dr. Byde, look at -- that's the contract between Laurens County Hospital and whom?

A. And Dr. Byron Brown.

Q. And, Dr. Hyde, if you would, look at article 5, I believe.

A. I've got it. Termination.

Q. Well, let me ask you to go over to article 6.

A. Okay.

Q. Does this article require that physician to maintain professional liability insurance?

A. It does.

Q. In what amounts?

A. In the amount of 1 million per claim or 3 million aggregate.

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Q. Okay. All right. Now, if you would, look over on article 2A on page 2.

A. I've got it.

Q. Where it says, "Throughout the term of the agreement and the repayment period" -- which we'll get into a little bit later -- "the physician, Dr. Brown, must comply with all provisions of the medical staff bylaws of the hospital as well as other policies and procedures, rules, and regulations." Do you see that?

A. I do.

Q. Now, in your opinion, did Dr. Brown comply with provisions of the medical staff bylaws and this contract by maintaining the insurance and the required minimum limits?

A. No. He failed to comply. I think it's a breach of the contract.

Q. All right, sir. And under article 5, item 3 under there, if the hospital -- if the physician fails to maintain the professional liability insurance, it gets canceled, then what is the right of the hospital?

A. Well, bottom line is they can cancel the contract -- "may elect to terminate or cancel the contract."

Q. All right. And, if you note in article 4 where

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it says "Repayment," do you see that where the subsidy will be forgiven at a rate prorated out for ten years, 1 --

A. I do see ten years, 120 months.

Q. Yeah. Now, if you would, turn over to Exhibit 29. And what is the amount that the hospital was waiving of that debt of Dr. Brown each month?

A. $5,370 per month.

Q. And as of May the 31st, 2011, which is a little bit over a year and a half later, what is the amount that's owed by Dr. Brown to the hospital?

A. $257,781.

Q. In your professional opinion, did the hospital have the right that if Dr. Brown did not maintain the insurance, to require the full amount of the $257,000 to be repaid?

A. Yes. It's stipulated in the contract. They terminate the contract and then ask for whatever the outstanding balance was at that time.

Q. When you testified earlier about the hospital had right to require Dr. Brown to purchase the other insurance to be in compliance, if they had not -- if Dr. Brown had not purchased that and they had requested it, could the full amount of the indebtedness been called upon and set to repayment by Dr. Brown?

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A. Yes. That $257,000, odd cents -- or odd dollars.
Q. All right. Now, Exhibit Number 35, if you would, look at that.
A. Yes.
Q. This is a check, Premium Financing Specialists, Inc. Dr. Hyde, in your professional opinion, was that a financing mechanism that Dr. Brown could have used to pay the premiums as he had in the past?
A. Yes. It basically is somebody paying it at once and then getting paid to take periodic payments and charge interest.
Q. Okay. I'm going to skip over a lot of that because of time. Now, you were asked about the document, Conditions of Admission. And that would be either Exhibit 7 or Exhibit 8, so, if you would, turn to that.
A. Sure. It's number 8.
Q. Okay. Now, you're aware from the testimony of Ms. Reeves that this document was prepared by employees of Laurens County Hospital?
A. That was my understanding that it was, yes. And that's my recollection of her testimony.
Q. All right.
MR. SHAW: I'm sorry. Whose testimony?
MR. WRIGHT: Reeves, I think.

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MR. SHAW: I don't think she testified to that. Might have been Sandra Thompson, but I don't --
Q. (By Mr. Wright) Okay. Well, one of them testified to that. And I believe she testified it had been in existence since 1993.
A. I recall it being testified to. I didn't remember who. It was one of the two, but, yes.
Q. All right. Now, did Laurens County Hospital choose to list all of the services that it provides in that document or did it just refer to all services that may be rendered?
A. I think it -- to me, it was a blanket reference --
Q. Let me show you right there.
A. It says, "The undersigned agrees he signs as agent in consideration of services to be rendered." It doesn't say just -- it said all services, or I take that to be services, period, including everything.
Q. All right. So I'll ask you again. Did -- the hospital, when it was drawing this agreement up, did it choose to delineate all of the different services that it was going to provide to Ms. McCord or Ms. Sherfield, or did it just refer generally to all services?
A. Generally all. It didn't specify or have a laundry list of everything.

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Q. Based upon your background, training, and experience, in your opinion, when hospitals enter into contracts with their patients, do the hospitals -- are the hospitals required to comply with all state laws and regulations?
A. Absolutely.
Q. In your professional opinion, when a hospital enters into a contract with its patients, is the hospital required to comply with all federal laws and regulations?
A. Absolutely. Yes, sir. That apply to them, of course.
Q. Dr. Hyde, in your professional opinion, when a hospital enters into a contract with its patients, is it required to comply with regulations and promulgations set forth by its accreditation agency, the Joint Commission?
A. Yes.
Q. Dr. Hyde, when a hospital enters into a contract with its patient, is there a requirement that the hospital comply with the medical staff bylaws that it has drawn up, it has approved, the medical staff has approved, and that relate specifically to portions that affect the rights and safety of the patient?
MR. SHAW: Objection.
A. Again, absolutely they're required to do that.
Q. (By Mr. Wright) Dr. Hyde, in your professional

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opinion, as part of the contract, is the hospital required to comply with contracts that it enters into with physicians, surgeons that are going to perform operations on the patients, and when those provisions in the contract comply -- I mean relate to the health, safety, welfare, or legal rights of the patient? Are they required to comply with those?
A. Again, yes, sir.
Q. And, Dr. Hyde, in your professional opinion, did the hospital comply with the requirements of state law, which was the adoption of the bylaws, that the bylaws required that the physicians have and maintain professional liability insurance?
MR. SHAW: Objection.
Q. (By Mr. Wright) Did the hospital comply with that?
MR. SHAW: Objection.
A. No. They failed to comply with that section of the expecta- -- of the bylaws and also the requirement by the state that they -- that they are bound to apply -- or comply -- comply with the bylaws.
Q. (By Mr. Wright) And how about, in your professional opinion, did the hospital comply with the obligations under the contract with the physician requiring that physician to maintain insurance coverage

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that would have covered and maintained Ms. McCord and Ms. Sherfield?

A. No. They failed to comply with that also.

Q. Okay. Dr. Hyde, in your professional opinion, do you have an opinion -- or let me back up. Dr. Hyde, in your professional opinion, is the fact that the governing board of the hospital required in its bylaws, the medical staff bylaws that were prepared by the medical staff, to require all physicians to maintain minimum insurance, and the hospital required, in this particular case, Dr. Brown, that it was giving money to, to maintain insurance -- professional liability insurance in minimum amounts of 1 million and 3 million, is that an indication, in your opinion, of the importance of professional liability insurance in a hospital setting so that injured parties, through no fault of their own, would have a means to recover a portion of their injuries?

MR. SHAW: Objection.

A. Of course it is. It's obvious to me that that's -- they fulfilled on paper their obligation that they were going to do it, but they failed to do that.

Q. (By Mr. Wright) Let me ask you a few questions about the relationship between hospitals and their patients.

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A. Sure.

Q. Now, patients that go into the hospital for surgery to be performed, how would you classify that as far as potential problems that may occur or benefits to the patient?

A. Well, the patient enters any hospital with the expectation that the hospital is going to provide care at the standard of care, they're going to require their physicians to perform according to their standard of care, they're going to require the physicians and other -- any other staff member to do what's required of them vis-à-vis bylaws, rules and regulations, standards, laws, federal, state regulations. But the patient has expectation that the hospital is going to take care of them and mandate the compliance of all the individuals that work there, whether or not they're employed or not, that they're going to perform a way -- according to the way they should vis-à-vis standards and/or policies, procedures, bylaws, rules and regulations.

Q. It's been said by some that the primary consideration of the hospital and the hospital staff is for the safety of the patient. Do you agree with that statement?

MR. SHAW: Objection.

A. Well, I do. And it goes back to Hippocrat- -- the Hippocratic Oath saying "Above all, do no harm." So we're set with the fact that we've got to mandate our compliance and mandate others' compliance that we're not going to have any harm to the patient. So safety is a corollary of no harm -- or quality is a corollary of no harm.

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Q. (By Mr. Wright) And as far as the medical staff bylaws that refer to the quality of patient care, is that the same phrase, quality of patient care, used in hospital journals and Joint Commission statements as far as the way the hospital is supposed to render treatment and services to patients?

A. It's about as universal as you can get. It's across all of the -- all of the above and more. It's -- that's what we're in the business for, quality of care and to try to do no harm to the patient and protect them.

Q. Okay. Do you consider the protection of the patient to include the fact of having the hospital monitor and require maintaining professional liability insurance by the surgeons that perform surgery in the hospital?

A. I do. And, obviously, everybody else does because it's -- it's a uni- -- I guess it's a generality and uniformity across every place I know of that mandates medical staff, like this facility did, have adequate and

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appropriate liability coverage for medical malpractice.

Q. All right. Dr. Hyde, do you have an opinion whether or not it is common practice or common occurrence, I guess you would say, for people that undergo surgery that could have a serious effect on their quality of life and even life or death? Does that usually happen in hospitals?

MR. SHAW: Objection.

A. It does. I didn't get all of that question, if you could sort of give me a different way. But I --

Q. (By Mr. Wright) As far as when people -- when the patients go into the hospital --

A. Okay.

Q. -- they put themselves in an environment -- or I'm asking you is it common for them to put themselves into an environment whereby they undergo surgery that could have a substantial effect, either positive or negative, on their future quality of life and even life and death?

A. Oh. I see the question now. Yes, sir. They're putting their lives, bodies, everything in our hands espec- -- expecting that we're going to take care of them; that we're going to do whatever it takes to make sure that we can try to comply with that. I say "try." Things can occur. But, yet, if somebody undergoes

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anesthesia, they may be close to death -- if they have a body cavity opened up, they're close to death. They're expecting us to give them quality outcomes and safety and security.

Q. When you referred earlier to a special relationship, is this what -- would this be embodied in your definition of a special relationship?

A. I was getting ready to add that. The special relationship -- we're not talking about buying tires or cars or something that -- or a Coke versus Pepsi. We're talking about a special relationship between somebody that knows very little about what's going on and somebody that knows so much about what's going on. So there is a knowledge differential.

And it gets back to what I was trying to say, agency theory. The patient is truly making the physician or the hospital an agent because they don't have the wherewithal to understand all of what's going to happen to them or all the hazards they could encounter during this process. So that -- and I've seen this before, not in South Carolina but other states and other documents that say this is a very specialized or special consideration arrangement. So, therefore, you have that expectation from both parties because of, like I said, knowledge differential of what's going on and the

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severity of the outcome potential.

Q. Dr. Hyde, in addition to the hospital drawing up and preparing the contract, do you have an opinion which one of the parties -- either the hospital or the ladies, patients -- is the sophisticated party in that relationship?

A. Oh, I definitely have an opinion of that.

Q. And what is that?

A. That, like I was trying to say earlier about patients, patients may be sophisticated in a lot of things, but they're not sophisticated in health care or medical care or hospital care. Again, it's that knowledge differential where the sophistication lies with a facility, not with the patient. So, therefore, the patient is not expected to know what happened to them, what caused what happened to them, or even what's going to happen to them in best circumstances during that procedure. They have entrusted to this special group their lives, bodies, whatever, and hoping that the group does what the group is supposed to. In this case, the group would be hospital employees and/or physicians.

Q. All right, sir. Now, I believe you testified you read the deposition of Ms. Reeves, the manager of medical staff services?

A. Yes, sir, I did.

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Q. And do you recall she testified she's responsible for making sure that physicians complied with the insurance requirements set forth in the medical staff bylaws?

A. I did see that, yes, sir.

Q. Dr. Hyde, in your professional opinion, do you consider that the manager of the medical staff services was properly trained or educated concerning medical malpractice insurance policies when she did not know the difference of the coverages between a claims-made policy and an occurrence policy?

MR. SHAW: Objection.

A. I didn't think that -- from what her deposition told me after reading it -- that she knew much about this process at all and didn't know the nuances of what it takes to be able to catch different major issues long before they blow up in your face.

Q. (By Mr. Wright) Do you have an opinion whether or not you think -- do you have an opinion whether or not she was properly trained or educated concerning medical malpractice insurance policies when she testified that no one from the hospital ever explained or informed her of the difference between claims-made policy and occurrence policy?

MR. SHAW: Objection.

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A. Yeah. I can't see what education or training she had, if anything, to not know that fundamental of a difference in question. That's one of the fundamental questions when it comes to insurance; what type? What's the difference? What does it mean? I was, again, appalled just that somebody didn't have that knowledge that was doing this role.

Q. (By Mr. Wright) Do you think she was properly trained when she did not know the necessity of extended coverage reporting, nor the necessity of prior acts coverage, nor what either one of those meant?

A. No. I did not think she was properly trained.

Q. In your opinion, was she properly trained or educated when she did not know the effect of the change in insurance companies on existing potential claims of patients injured at Laurens County Hospital by the malpractice of Dr. Brown? Was she properly trained?

A. No, I -- she was not properly trained.

Q. In your opinion, was she properly trained and did she properly follow up when she had questions when she never asked the insurance companies to explain coverage even though the insurance policies advised interested persons to contact the company for further information?

A. Again, no, she was not properly trained,

LAURENS COUNTY HEALTH CARE SYSTEM

MEDICAL STAFF
BYLAWS

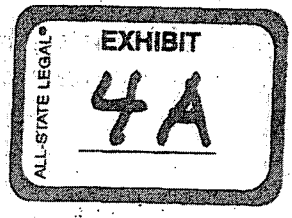
AS APPROVED BY THE MEDICAL STAFF

LAURENS COUNTY HEALTH CARE SYSTEM

AUGUST 24, 2009

AS APPROVED BY THE BOARD OF TRUSTEES

AUGUST 24, 2009



ATTACHMENT 8

ARTICLE I

NAME

The physicians, osteopaths, and dentists who have been appointed to the Medical Staff and granted Clinical Privileges to attend to patients in the Hospital shall be collectively known as The Medical Staff or Staff of Laurens County Health Care System.

ARTICLE II

PURPOSES AND RESPONSIBILITIES

2.1 **Purposes**

The purposes of the Staff are:

2.1.1 To ensure that all patients admitted to or treated in any of the facilities, departments, or services of the Hospital shall receive the quality of patient care that is achievable commensurate with community resources available;

2.1.2 To be accountable to the Board for ensuring an optimal level of professional performance of all LIPs authorized to practice in the Hospital through the appropriate delineation of Clinical Privileges and through an ongoing review and evaluation of each LIP's performance in the Hospital;

2.1.3 To provide oversight of care, treatment and services provided by the members of the Medical Staff, assure uniform quality of patient care treatment and services and be accountable to the Board for same;

2.1.4 To be accountable to the Board for reporting the results of organizational performance improvement activities conducted in accordance with the Hospital's committee designated to improve organizational performance;

2.1.5 To provide an appropriate educational setting that will assist in maintaining patient care standards and that will lead to continuous advancement in professional knowledge and skill;

2.1.6 To initiate and maintain rules and regulations for the proper functioning of the Staff;

2.1.7 To provide a method whereby issues concerning the Staff and Hospital may be discussed by the Staff with the Board and the President/CEO; and

2.1.8 To create any other purposes that may be determined necessary, from time to time, by agreement between the Board and the Staff.

2.2 **Responsibilities**

The responsibilities of the Staff are:

2.2.1 To account and report to the Board concerning organizational performance improvement activities in the Hospital;

2.2.2 To assure the qualifications and competence of LIPs through a credentialing procedure, including mechanisms for appointment and reappointment and the delineation of Clinical Privileges;

2.2.3 To implement, if necessary, a continuing education program based primarily on the type and nature of care offered by the Hospital and the needs and findings demonstrated through the organizational performance improvement program;

2.2.4 To review the utilization of Hospital resources based on the requirements of the Hospital's utilization review plan;

2.2.5 To evaluate and monitor the quality of patient care.

2.2.6 To initiate and pursue Professional Review Actions with respect to LIPs when warranted;

2.2.7 To develop and monitor compliance with these Bylaws, the Rules and Regulations of the Staff, and other Hospital policies, all as may be in effect and as may be from time to time amended;

2.2.8 To assist in identifying community health needs, to assist in setting appropriate institutional goals, and to recommend programs to meet those needs and goals;

2.2.9 To assure that the same level of care will be provided for all patients receiving a similar service, regardless of the location in which the service is provided;

2.2.10 To participate in the on call coverage of unassigned patients;

2.2.11 To carry out other responsibilities which may be added from time to time by agreement between the Board and the Staff; and

2.2.12 To exercise the authority granted by these Bylaws as necessary to adequately fulfill the foregoing responsibilities.

ARTICLE III

STAFF APPOINTMENT

3.1 **Nature of Appointment**

Staff appointment is a privilege extended by the Hospital and is not a right of any LIP. Staff Appointment and Clinical Privileges shall be extended only to professionally

competent LIPs who continuously meet the qualifications, standards, and requirements set forth in these Bylaws. Appointment to the Staff shall confer on the appointee only such Clinical Privileges and Prerogatives as have been granted by the Board in accordance with these Bylaws. No LIP shall admit or provide services to patients in the Hospital unless he or she is appointed to the Staff or has been granted Privileges in accordance with the procedures set forth in Article X of these Bylaws. This requirement also applies to those physicians in administrative positions who desire Medical Staff membership and to those physicians who provide medical services to Hospital patients by contract.

3.2 Qualifications for Appointment

3.2.1 Basic Qualifications

The following shall be requirements for initial and continuing appointment to the Medical Staff:

(a) LIPs shall possess an unrestricted license to practice medicine, osteopathy, dentistry, or podiatry in the State of South Carolina;

(b) LIPs shall document their experience, background, training, demonstrated ability, and physical and mental health status with sufficient adequacy to demonstrate to the Staff and Board that any patient treated by them will receive care of the generally recognized professional level established by the Hospital and that they are qualified to provide a needed service within the Hospital;

(c) LIPs shall be determined, on the basis of documented references, to adhere strictly to the legally enforceable ethics of their respective professions, to work cooperatively with others, and to be willing to participate in the discharge of Staff responsibilities;

(d) LIPs shall have a record free from current Medicare/Medicaid/ TRICARE sanctions. Practitioners shall furnish all information concerning felony convictions, and any and all allegations or convictions of criminal activity related to his or her professional practice, that would raise questions of criminal propensity or undesirable conduct;

(e) LIPs shall maintain valid professional liability insurance coverage in the amounts deemed necessary by the Board from time to time and shall provide a current certificate of insurance as recommended;

(f) LIPs (with the exception of pathologists and radiologists) shall have valid and unrestricted South Carolina and Federal Drug Enforcement Administration registrations;

(g) LIPs shall be eligible for full Staff membership or Clinical Privileges only after the results of a query to the National Practitioner Data Bank have

hearing or appeal. An applicant who has received an adverse decision regarding an application shall not be allowed to reapply for a period of two (2) years after notice of such decision is sent.

7.2.4 Statement of Release and Immunity From Liability

The following are express conditions applicable to any applicant, to any person appointed to the Staff, and to anyone having or seeking Privileges to practice his or her profession in the Hospital during his or her term of appointment or reappointment. In addition, these statements shall be referenced on the application form, and by applying for appointment, reappointment, or Clinical Privileges the applicant expressly accepts these conditions during the processing and consideration of his or her application, regardless of whether he or she is granted the desired appointment, reappointment, or Privileges:

(a) The applicant or appointee extends permission to, and releases from liability, this Hospital and its representatives (and any third party which provides information in connection with the application, as long as the information is provided in good faith and without significant misstatements) with respect to any and all civil liability which might arise from any acts, communications, reports, recommendations, or disclosures involving an applicant or appointee, performed, made, requested, or received by this Hospital and its representatives, to, from, or by any third party, including other appointees to the Staff, concerning:

(1) activities relating, but not limited, to:

1. appointment or Clinical Privileges, including Temporary Privileges;

2. reappraisals undertaken for reappointment or for increase or decrease in Clinical Privileges;

3. reduction or suspension of Clinical Privileges or revocation of Staff appointment, or any other disciplinary sanction;

4. suspension;

5. appellate reviews;

6. focused professional practice evaluations and ongoing professional practice evaluations;

7. Hospital and Medical Staff, Departmental, service or committee activities relating to the quality or patient care or the professional conduct of an appointee to the Staff or of any individual granted Privileges to practice in the Hospital; and

applicant's fitness for appointment to the Medical Staff. At least four (4) of the six (6) professional references shall be provided by physicians who practice in the same medical specialty and who exercise substantially similar Clinical Privileges for which the LIP is applying. Professional references for physicians practicing for the first time after completing his or her residency program should typically be provided by the applicant's academic supervising physicians. Special circumstances regarding the ability of the LIP to provide such professional references shall be considered on a case by case basis by the appropriate Department Chairman.

Professional references refer, as appropriate, to the applicant's relevant training and/or experience, current competence, fulfillment of obligations as a member of a Medical Staff, and any effects of health status on performance and/or Privileges to be recommended.

7.2.9 Information on Liability Insurance Coverage:

Information as to whether the applicant currently has professional liability insurance coverage in the amount determined from time to time by the Board. New applicants must provide proof of malpractice insurance for the last ten (10) years.

7.2.10 Information of Affiliations with Other Hospitals or Facilities

The names and locations of all hospitals and other health care facilities where applicant currently has clinical privileges to provide patient care.

7.2.11 A criminal background check shall be conducted on each new applicant.

7.2.12 The application shall require the applicant to provide accurate answers concerning the following items. The applicant shall agree to immediately notify the Medical Staff Office in writing should any of the information regarding these items change during the period of their Medical Staff membership or Privileges. If the applicant provides information identifying a problem with any of the following items, the applicant will be required to submit a written explanation of the circumstances involved.

(a) Have any disciplinary actions been initiated or are any pending against you by any state licensure board?

(b) Has your license to practice in any state ever been relinquished, denied, limited, suspended, or revoked, whether voluntarily or involuntarily?

(c) Have you ever been asked to surrender your license?

(d) Have you ever been suspended, sanctioned, or otherwise restricted from participating in any private, federal, or state health insurance program (for example, Medicare, TRICARE, or Medicaid)?

(t) Have any judgments or settlements been made against you in professional liability cases?

(u) Recent photograph of the applicant to verify identity.

(v) Results of any previously mandated drug testing and other health testing in relation to Privileges requested.

(w) Proof of certification by the Educational Commission for Foreign Medical Graduates (ECFMG) for all foreign school graduates.

7.3 **Processing the Application**

7.3.1 Applicant's Burden

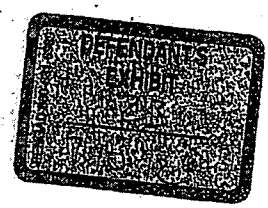
The applicant shall signify his or her willingness to appear for interviews in regard to his or her application and have the burden of producing adequate information for a proper evaluation of his or her experience, background, training, demonstrated ability, previous performance, physical health status, and, upon request of the MEC or the Board, mental health status, and of resolving any doubts about these or any of the other basic qualifications specified in Section 3.2.1.

7.3.2 Exclusivity Policy:

Applications for initial appointment or for Clinical Privileges related to Hospital facilities or services covered by exclusive agreements will not be accepted or processed unless submitted in accordance with the existing contract or agreement with the Hospital. Non-acceptance of an application based on this Section 7.3.2 shall not entitle the applicant to the procedural rights as provided in Article X and in the Fair Hearing Procedures, because such action is not based upon the competency or professional conduct of the applicant.

7.3.3 Verification of Information

The applicant shall deliver a completed application to the President/CEO, who shall in timely fashion seek to collect or verify (from primary sources whenever possible) the references, licensure, training/experience, competence and other qualification evidence submitted in the application. Upon receipt of an application, the President/CEO or his designee shall make a query to the National Practitioner Data Bank for the purpose of reviewing the applicant's record. The President/CEO or his designee shall seek comments from the applicant's residency director concerning the applicant's competency to perform the Clinical Privileges requested, and the President/CEO shall also seek to obtain information from at least one personal reference in each place where the applicant has trained for at least six months, as well as from each hospital where the applicant currently has Privileges. The President/CEO shall promptly notify the applicant of any problems in obtaining the information required and it shall then be the applicant's



AGREEMENT

THIS AGREEMENT IS SUBJECT TO ARBITRATION

AGREEMENT made this 14th day of February, 2002 by and between Byron Brown, M. D. (hereinafter referred to as "Physician") and Laurens County Health Care System hereinafter referred to as "Hospital").

WITNESSETH

WHEREAS, Physician is an OB/GYN having his medical degree in the State of South Carolina; and

WHEREAS, Hospital is a political subdivision of the State of South Carolina charged with the responsibility of providing quality health care to the citizens of Laurens County; and,

WHEREAS, Hospital has performed an assessment of the existing needs of the Laurens County community, and the assessment indicates there exists within the community a demand for physicians trained in the specialty of OB/GYN to efficiently and conveniently satisfy patient care needs;

WHEREAS, Physician is licensed to practice medicine in South Carolina; and

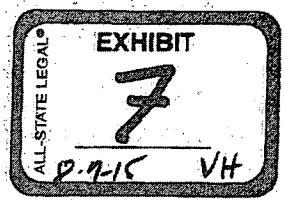
WHEREAS, Physician desires to establish an OB/GYN practice in Laurens County, State of South Carolina and Hospital agrees to assist Physician in establishing the practice in Laurens County, South Carolina;

NOW, THEREFORE, in consideration of the terms, conditions, covenants, agreements and obligations herein stated it is now mutually agreed by and between the parties hereto as follows:

ARTICLE I: OBLIGATIONS OF THE HOSPITAL

A. Contingent upon the Physician's fulfillment of his obligations and this Agreement and subject to the limitations herein set forth, the Hospital agrees to subsidize the net practice collections of Physician for a 36-month period beginning on July 8 2002, 2002, contingent upon approval of credentialling at the hospital and opening of an office in Laurens County, unless otherwise agreed in writing, not to exceed $27,000 per month in any month under this Agreement.

B. The net practice income for the purposes of this Agreement equals all collections by Physician for professional fees and office or hospital practice and any other income from the



practice of medicine, less reasonable, professional expenses attributable directly to Physician necessary to conduct the practice of medicine during the 36-month period. Professional expenses shall include all expenses normally and reasonably associated with the operation of the medical practice directly attributable to Physician and which are deductible for federal income tax purposes, with the exception of the following: contributions to retirement or deferred compensation plans; federal, state, and local income taxes; professional liability insurance.

B. A sample monthly calculation may be as follows:

Net practice collections	$10,000
Subsidy amount	$27,000
Hospital payment	$17,000

In the event net practice income for any month exceeds $27,000, one-half (1/2) of the excess shall be paid by Physician to Hospital to be applied against subsidy amounts already advanced, or the following month's subsidy shall be reduced by a like amount.

ARTICLE II: PHYSICIAN OBLIGATION

A. Establishment of Practice and Time Commitment:

1. On or before July 8, 2002, the Physician shall establish his practice in Laurens County, South Carolina. Physician shall, in good faith and with due diligence, pursue the practice on a full-time basis for at least 40 hours per weeks for 48 weeks per year to include office and hospital practice and shall, in good faith, use his best efforts to develop a successful practice. Physician shall maintain reasonable hours so that the practice can be developed. He will maintain his license to practice medicine in South Carolina, and his provisional/active status on the medical staff in good standing throughout the term of this Agreement and repayment period and shall comply with all provisions of the medical staff By-laws of the Hospital as well as any other policies, procedures, rules, and regulations issued by the Hospital which govern its medical staff.

2. Physician hereby covenants and agrees to furnish and to make available to Hospital a reporting by the 10th day following the prior month ended, or as soon as practical after month-end. The report will consist of gross billings, gross collections, professional expenses, net practice income or net practice loss, records of deposits to the account of Physician and his banking institution, office visits and hospital visits. Any subsidy payment due to Physician shall be paid on or before the 15th day of the month for the preceding month, provided the first

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payment shall be due Aug. 15, 2002.

3. Physician hereby authorizes the Hospital to conduct an audit of Physician's books and records upon reasonable notice during normal business hours.

4. Physician agrees to provide his best efforts to bill within a reasonable time period after services are rendered and will make attempts to collect receivables as expediently as possible.

5. The Physician must treat Medicaid and Medicare patients, and do so in a nondiscriminatory manner.

6. Physician agrees to provide services based on an on-call rotation to all patients he is requested by other Physicians in Laurens County to see at the Laurens County Hospital for purposes of consultation, emergency services, or otherwise, regardless of type of insurance or patient's ability to pay.

7. No benefit or payment hereunder shall, in any way, be based upon referral of patients or be volume sensitive.

8. The Physician shall exercise diligence to assist the Hospital in controlling the costs of the Hospital related to medical services including completing medical records on a timely basis and participating in the Hospital's quality assurance, utilization review, and peer review programs.

9. The Physician shall cooperate with the Hospital and shall properly notify the Hospital regarding legal claims, investigations, or lawsuits involving this Agreement or any medical services provided by the Physician.

10. The Physician agrees that, during the term of this Agreement, he will provide professional services to the community and to the Hospital patients including providing periodic medical care within his specialty to medically indigent; reasonable on-call rotation in the emergency room; and presentations to community groups and organizations as appropriate.

ARTICLE III: MOVING EXPENSES

Moving expenses incurred by the Physician's family will be reimbursed by the Hospital in conformance with the provisions of this Agreement. Unless otherwise provided herein reimbursable expenses are limited to expenses associated with moving Physician's household goods and travel, meals and lodging expenses incurred during the move to Physician's new residence. Upon proper documentation, Hospital will reimburse Physician or moving company

based on prior arrangements. Payment for moving expenses will not exceed ten thousand dollars ($10,000.00).

ARTICLE IV: REPAYMENT

The physician shall repay any subsidy made pursuant to this agreement. Hospital has determined that there is a benefit and value to the Hospital and community if physician maintains a private medical practice and office in Laurens County. Therefore, for each month the physician maintains his hospital practice, medical practice, and office in Laurens County after the 3-year term of this Agreement, the Hospital will forgive repayment of 1/120 of the unrepaid subsidy. Any unrepaid subsidy not forgiven shall become immediately due and payable at such time as physician leaves Laurens County or ceases to maintain a private medical practice and office in the county or maintain privileges at Laurens County Hospital. The unpaid subsidy shall bear interest at the rate of Wall Street Journal Prime plus 2% determined as of the 120th month of this Agreement.

ARTICLE V: TERMINATION

Notwithstanding any other provisions contained herein, the Hospital may elect to terminate its obligations set forth in this Agreement upon the happening of any of the following events:

(1) Physician fails to maintain a South Carolina medical license through the suspension or revocation by the State of South Carolina or Physician is placed on probation.

(2) Physician's medical staff privileges at Hospital are terminated or suspended in accordance with the Hospital's Medical Staff By-laws.

(3) Physician's professional liability insurance is canceled.

(4) Physician's application for appointment to Medical Staff at Hospital is denied for whatever reason.

(5) Disability of Physician for more than sixty (60) days.

(6) Written mutual consent of both Hospital and Physician.

(7) Conviction of a felony or a crime of moral turpitude or serious misdemeanor.

(8) Material breach of this Agreement by Physician provided Physician is given written notice of this breach and gives thirty (30) days after notice to cure same.

Should agreement be terminated because of any of the above reasons except for material breach by Hospital or death or long-term disability of Physician, Physician will be required to

repay all subsidy advances immediately. However, the Hospital may allow payments over a period of time at its option. Physician may elect to terminate his obligation contained herein upon the failure of the Hospital to meet any of its obligations as set forth in previous articles of this Agreement. Election to terminate this Agreement by either party must be made in writing and delivered to the respective addresses of the Physician and Hospital.

The Hospital may purchase a life insurance policy in the Physician's name and will serve as beneficiary during the time of the income guarantee and subsequent repayment. After that period, the Physician will be given the option to assume ownership, change the beneficiary and assume payment of the policy.

ARTICLE VI: PROFESSIONAL LIABILITY INSURANCE

The Physician shall furnish to the Hospital proof of insurance. Said policy shall cover professional liability in a minimum amount of $1,000,000 per claim/$3,000,000 aggregate or JUA/PCF coverage. Physician shall furnish to the Hospital evidence that the premium on said policy is prepaid and that said policy is in full force and effect. Further, Physician shall notify his insurance company that if said policy is canceled for any reason, notice of cancellation shall be provided by insurance company to the C.E.O. of the Hospital.

ARTICLE VII. INDEPENDENT CONTRACTOR

It is expressly understood and agreed that Physician is an independent contractor expected and entitled to freely and independently exercise his judgment in accordance with good medical practice in the care and treatment of his patients. Physician shall exercise his skill, learning, intelligence, and experience in evaluation, diagnoses, medication, treatment, and hospitalization of his patients according to his informed judgment and shall not be constrained in the exercise of his independent judgment by the terms or conditions of this Agreement. Physician is free to admit patients to any Hospital of Physician's choice and to maintain staff privileges at other hospitals. Physician is under no obligation to admit patients to Laurens County Hospital. The sole purpose of this Agreement is to induce the Physician to establish his practice in the area of the Hospital because of the Hospital's belief that there are not a sufficient number of OB/GYN Physicians in the area.

ARTICLE VIII: REGULATORY REQUIREMENTS

The Hospital and the Physician will operate at all times in compliance with federal, state and local law, rules, and regulations, the policies, rules and regulations of the Hospital, the

applicable standards of the Joint Commission on Accreditation of Healthcare Organizations and all currently accepted and approved methods and practice of medicine. In the event that there shall be a change in federal or state law (including case law, statute, or regulation) or the interpretation thereof, or in the event facts material to this Agreement, known to one party are not disclosed to the other, or material facts known to either party are later developed, any of which when applied to either of the parties to this Agreement make compliance with Agreement illegal or onerous, then in such event, Physician and Hospital agree, upon written notice from the other, to renegotiate this Agreement, within thirty (30) days of said notice, to bring the Agreement into compliance with federal or state laws or to relieve the onerous aspects hereof. Upon renegotiation of this Agreement under the above, neither party shall have any further obligations to the other except to the extent such further obligations may be set out in a renegotiated agreement.

ARTICLE IX: LAW

The interpretation and enforcement of this agreement shall be governed by the laws of the State of South Carolina.

ARTICLE X: ASSIGNABILITY

The right and obligations of the Hospital hereunder shall enure to the benefit of and be binding upon the successors and assigns of the Hospital. Physician may not assign his rights or obligations under this Agreement without written approval of Hospital, except that the Physician shall be required to assign this Agreement to any corporate entity succeeding to his practice and shall promptly give the hospital notice of such assignment.

ARTICLE XI: AMENDMENTS

Any amendments to this Agreement shall be effective only if in writing and signed by the Hospital and the Physician.

ARTICLE XII: ENTIRE AGREEMENT

This Agreement constitutes the entire Agreement of the parties with respect to the subject matter.

ARTICLE XIII: NO WAIVER

No waiver of a breach of any provision of this Agreement shall be construed to be a waiver of any breach of any other provision. No delay in acting with regard to any breach of any provision of this Agreement shall be construed to be a waiver of such breach.

ARTICLE XIV: AUTHORIZATION FOR AGREEMENT

The execution and performance of this Agreement by Physician and Hospital have been duly authorized by all necessary laws, resolutions or corporate action, and this Agreement constitutes the valid and enforceable obligations of Physician and Hospital in accordance with its terms.

The Hospital has caused its name to be hereunto subscribed by duly authorized officer thereunto and Physician has hereunto subscribed his name as of the day and year first-above written.

ARTICLE XV: APBITRATION

Any dispute, controversy or disagreement arising from this contract shall be submitted to arbitration pursuant to the Uniform Arbitration Act of South Carolina, § 15-48-10 et. Seq.

ARTICLE XVI: ACCESS TO BOOKS AND RECORDS

Upon the written request of the Secretary of Health and Human Services, or the Comptroller General, or any of their duly authorized representatives, the Physician will make available those contracts, books, documents, and records necessary to verify the nature and extent of the costs of providing services under this Agreement. Such inspection shall be available up to four (4) years after the rendering of such services. If the Physician carries out any of the duties of this Agreement through a subcontract with a value of $10,000 or more over a twelve (12) month period with a related individual or organization, the Physician agrees to include this requirement in any such subcontract. This section is included pursuant to and is governed by the requirements of Public Law 96-499, Sec. 952 (Sec. 1861 (b) (1) of the Social Security Act) and the regulations promulgated thereunder. No attorney-client, accountant-client or other legal privileges will be deemed to have been waived by the Hospital or the Physician by virtue of this Agreement.

PHYSICIAN:

Byron Brown, M.D.

Witness:

LAURENS COUNTY HEALTH CARE SYSTEM

By: Michael Kozar
Its: CEO

Witness:

Richard E. D'Alberto

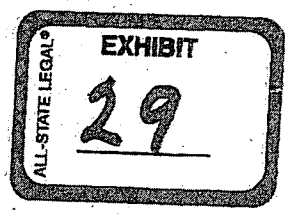
From: Willis Grant
Sent: Friday, May 13, 2011 9:03 AM
To: Richard E. D'Alberto
Subject: Brown physician guarantee

Rich;
Dr. Brown's guarantee, signed 2/14/02 states in Article IV that:
"Therefore, for each month that physician maintains his hospital practice, medical practice, and office in Laurens County after the 3 year term of this Agreement, the Hospital will forgive repayment of 1/120 of the unrepaid subsidy. Any unrepaid subsidy not forgiven shall become immediately due and payable at such time as physician leaves Laurens County or ceases to maintain a private medical practice and office in the county or maintain privileges at Laurens County Hospital. The unpaid subsidy shall bear interest at the rate of Wall Street Journal Prime plus 2% determined as of the 120 month of this Agreement."

Dr. Brown received a 1099 last year for the amount of $64,445, which is $5,370 per month. The current balance outstanding as of May 31, 2011 is $257,781.

My suggestion is to have our atty write a demand letter to Dr. Brown.

Please call me if you want to discuss.
Will



ATTACHMENT 10

CONFIDENTIAL
D'ALBERTO 0029

[redacted]
Post Office Drawer 976 * Clinton, SC 29325

DAN ELMER
CHIEF FINANCIAL OFFICER
Phone: 864-833-9167
Fax: 864-833-9477
E-Mail: delmer@lchcs.org

June 13, 2005

Dr. Byron Brown
700 Plaza Circle, Suite N
Clinton SC 29325

Subject: Contract dated February 14, 2002 – Completion of the 36-month subsidy period.

Dr. Byron Brown

Enclosed please find the final payment under the 36-month subsidy period – pending a detailed report from your accountant on activity (we agreed that this would be the period since you established the solo practice effective 9-20-2004). The Guarantee payments made to you during the 36-month period amounted to a total of $644,447. Under the contract, as you continue to serve patients in Laurens County, a pro-rated-portion of the payment is forgiven over the following ten years. The forgiveness schedule - assuming you meet the continued requirements of the contract would be as follows:

	1099 Taxable Income	
Months	*Calendar Year*	*Income*
7	2005	$37,690
12	2006	$64,440
12	2007	$64,440
12	2008	$64,440
12	2009	$64,440
12	2010	$64,440
12	2011	$64,440
12	2012	$64,440
12	2013	$64,440
12	2014	$64,440
5	2015	$26,897
120	Total	$644,447

If you have any questions or feel the amount of the 1099 is in error, please feel free to contact me.

Sincerely,

Dan Elmer
Chief Financial Officer

CONFIDENTIAL
LCHCS0746

☐ CORRECTED (if checked)

PAYER'S name, street address, city, state, ZIP code, and telephone no.	1 Rents	OMB No. 1545-0115	Miscellaneous Income
Laurens County Hospital PO [illegible] 976 CLINTON, [illegible] CAROLINA 29325	$	2009	
	2 Royalties $	Form 1099-MISC	
	3 Other income $	4 Federal income tax withheld $	
PAYER'S federal identification number: 570823489	RECIPIENT'S identification number: 387-49-6665	5 Fishing boat proceeds $	6 Medical and health care payments $
RECIPIENT'S name, street address (including apt. no.), city, state, and ZIP code: MR. [illegible] BROOM 23265 HIGHWAY 76 EAST CLINTON SC 29325		7 Nonemployee compensation $ 54665.09	8 Substitute payments in lieu of dividends or interest $
		9 Payer made direct sales of $5,000 or more of consumer products to a buyer (recipient) for resale ▶ ☐	10 Crop insurance proceeds $
Account number (see instructions) 09894		11 [illegible]	12 [illegible]
		13 [illegible] (FICA) withheld $	14 [illegible] proceeds paid to an attorney $
15a Section 409A deferrals $	15b Section 409A income $	16 State tax withheld $	17 State/Payer's state no.	18 State income $

Form 1099-MISC — Department of the Treasury - Internal Revenue Service

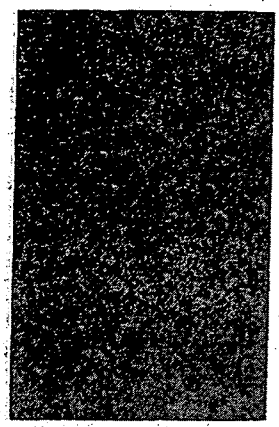
Copy 2
To be filed with recipient's state income tax return, when required.

CONFIDENTIAL
LCHCS 000624

November 1999

INSTITUTE OF MEDICINE

Shaping the Future for Health



TO ERR IS HUMAN:
BUILDING A SAFER HEALTH SYSTEM

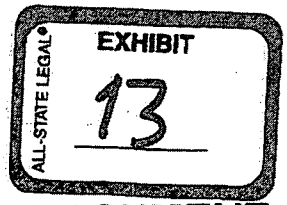
Health care in the United States is not as safe as it should be--and can be. At least 44,000 people, and perhaps as many as 98,000 people, die in hospitals each year as a result of medical errors that could have been prevented, according to estimates from two major studies. Even using the lower estimate, preventable medical errors in hospitals exceed attributable deaths to such feared threats as motor-vehicle wrecks, breast cancer, and AIDS.

Medical errors can be defined as the failure of a planned action to be completed as intended or the use of a wrong plan to achieve an aim. Among the problems that commonly occur during the course of providing health care are adverse drug events and improper transfusions, surgical injuries and wrong-site surgery, suicides, restraint-related injuries or death, falls, burns, pressure ulcers, and mistaken patient identities. High error rates with serious consequences are most likely to occur in intensive care units, operating rooms, and emergency departments.

Beyond their cost in human lives, preventable medical errors exact other significant tolls. They have been estimated to result in total costs (including the expense of additional care necessitated by the errors, lost income and household productivity, and disability) of between $17 billion and $29 billion per year in hospitals nationwide. Errors also are costly in terms of loss of trust in the health care system by patients and diminished satisfaction by both patients and health professionals. Patients who experience a long hospital stay or disability as a result of errors pay with physical and psychological discomfort. Health professionals pay with loss of morale and frustration at not being able to provide the best care possible. Society bears the cost of errors as well, in terms of lost worker productivity, reduced school attendance by children, and lower levels of population health status.

A variety of factors have contributed to the nation's epidemic of medical errors. One oft-cited problem arises from the decentralized and fragmented nature of the health care delivery system--or "nonsystem," to some observers. When patients see multiple providers in different settings, none of whom has access to complete information, it becomes easier for things to go

Errors...are costly in terms of loss of trust in the health care system by patients and diminished satisfaction by both patients and health professionals.



ATTACHMENT 11

Department of Health and Human Services

OFFICE OF
INSPECTOR GENERAL

ADVERSE EVENTS IN HOSPITALS: NATIONAL INCIDENCE AMONG MEDICARE BENEFICIARIES

Daniel R. Levinson
Inspector General

November 2010
OEI-06-09-00090

ALL-STATE LEGAL®
EXHIBIT
14

ATTACHMENT 12

EXECUTIVE SUMMARY

OBJECTIVES

To estimate the national incidence of adverse events for hospitalized Medicare beneficiaries, assess the preventability of such events, and estimate associated costs to Medicare.

BACKGROUND

The term "adverse event" describes harm to a patient as a result of medical care, such as infection associated with use of a catheter. The term "never events" refers to a specific list of serious events, such as surgery on the wrong patient, that the National Quality Forum (NQF) deemed "should never occur in a health care setting." The Tax Relief and Health Care Act of 2006 mandates that the Office of Inspector General report to Congress regarding the incidence of never events among Medicare beneficiaries, the payment for services in connection with such events, and the Centers for Medicare & Medicaid Services (CMS) processes to identify events and deny payment.

We selected a nationally representative random sample of 780 Medicare beneficiaries from all beneficiaries discharged during October 2008. Physician reviewers determined (1) whether an adverse event occurred, (2) whether the event was on the NQF list of Serious Reportable Events or the Medicare list of hospital-acquired conditions (HAC), (3) what the level of harm was to the patient, and (4) whether the event was preventable. To establish an estimated adverse event incidence rate, we included events on the NQF and the HAC lists and events resulting in the most serious harm as defined by a patient harm index (prolonged hospital stay, permanent harm, life-sustaining intervention, or death). We also determined the cost to Medicare for hospital care resulting from the events. Lastly, we identified additional events that resulted in temporary patient harm but were not comparable to the more serious events in our overall rate and assessed their preventability and cost.

FINDINGS

An estimated 13.5 percent of hospitalized Medicare beneficiaries experienced adverse events during their hospital stays. Of the nearly 1 million Medicare beneficiaries discharged from hospitals in October 2008, about 1 in 7 experienced an adverse event that met at least 1 of our criteria (13.5 percent). This rate projects to an estimated

134,000 Medicare beneficiaries experiencing at least 1 adverse event in hospitals during the 1-month study period. We calculated incidence rates for adverse events that met our three criteria: 0.6 percent of beneficiaries had an NQF Serious Reportable Event, 1.0 percent had a Medicare HAC event, and 13.1 percent experienced an adverse event resulting in the four most serious categories of patient harm. An estimated 1.5 percent of Medicare beneficiaries experienced an event that contributed to their deaths, which projects to 15,000 patients in a single month.

An additional 13.5 percent of Medicare beneficiaries experienced events during their hospital stays that resulted in temporary harm. Temporary harm events are those that require intervention but do not cause lasting harm. Although many cases represent fairly minor occurrences, such as hypoglycemia, others were classified as temporary harm only because the patients were in the hospital for lengthy periods as a result of other, more serious, diagnoses, allowing hospitals enough time to address the harm prior to discharge. Additionally, 28 percent of beneficiaries who experienced adverse events also had temporary harm events during the same stay.

Physician reviewers determined that 44 percent of adverse and temporary harm events were clearly or likely preventable. Physicians determined that 44 percent of all events were preventable and 51 percent were not preventable. (For the remaining 5 percent of events, physicians were unable to make determinations.) Events related to surgery or procedures were less likely to be preventable than other types of events, such as hospital-acquired infections. Preventable events were linked most commonly to medical errors, substandard care, and lack of patient monitoring and assessment. Physician reviewers assessed events as not preventable when they occurred despite proper assessment and care or when the patients were highly susceptible to the events due to health status. Nearly all events on the NQF and Medicare lists were assessed as preventable, a key criterion of both lists.

Hospital care associated with adverse and temporary harm events cost Medicare an estimated $324 million in October 2008. Sixteen percent of sample beneficiaries in the Medicare Inpatient Prospective Payment System who experienced events incurred additional Medicare costs as a result. The added costs equate to an estimated 3.5 percent of Medicare's expenditure for inpatient care during October 2008. To give these figures an annual context,

3.5 percent of the $137 billion Medicare inpatient expenditure for FY 2009 equates to $4.4 billion spent on care associated with events. Two-thirds of Medicare costs associated with events were the result of entire additional hospital stays necessitated by harm from the events. Additionally, these Medicare cost estimates do not include additional costs required for followup care after the sample hospitalizations.

RECOMMENDATIONS

As the Federal Government's principal agency for protecting the health of Americans, the Department of Health & Human Services (HHS) is uniquely positioned to lead national efforts to reduce adverse events in hospitals. As part of a national strategy to improve health care quality mandated by the Patient Protection and Affordable Care Act (ACA), HHS is to identify areas that have the potential for improving health care quality. Because many adverse events we identified were preventable, our study confirms the need and opportunity for hospitals to significantly reduce the incidence of events. A number of agencies within HHS share responsibility for addressing this issue, most prominently the Agency for Healthcare Research and Quality (AHRQ) as a coordinating body for efforts to improve health care quality and CMS as an oversight entity and the Nation's largest health care payer.

Therefore, we recommend the following:

AHRQ and CMS should broaden patient safety efforts to include all types of adverse events. This broader definition would apply to a number of activities, including setting priorities for research, establishing guidelines for hospital reporting, developing prevention strategies, measuring health care quality, and determining payment policies.

AHRQ and CMS should enhance efforts to identify adverse events. Identifying adverse events assists policymakers and researchers in directing resources to the areas of greatest need, setting clear goals for improvement, assessing the effectiveness of specific strategies, holding hospitals accountable, and gauging progress in reducing incidence.

- AHRQ should sponsor periodic, ongoing measurement of the incidence of adverse events.
- AHRQ should continue to encourage hospital participation with Patient Safety Organizations, entities intended to receive adverse

event reports from hospitals, and forward the information to a national AHRQ database.

- CMS should use Present on Admission Indicators in billing data to calculate the frequency of adverse events occurring within hospitals.

CMS should provide further incentives for hospitals to reduce the incidence of adverse events through its payment and oversight functions. The ACA makes several changes to the HAC policy, including allowing the Secretary of HHS to expand the list of HACs. The ACA gives the HAC policy greater significance by using the list of HACs to implement Medicare payment penalties, create performance measures, and prohibit Medicaid payments for associated care. The conditions of participation for Medicare and Medicaid require that hospitals have programs to demonstrate quality improvement where evidence shows practices can improve outcomes.

- CMS should strengthen the Medicare HAC policy, such as by expanding the policy to include more events that harm beneficiaries.

- CMS should look for opportunities to hold hospitals accountable for adoption of evidence-based practice guidelines.

AGENCY COMMENTS

We received comments on the draft report from AHRQ and CMS. AHRQ concurred with our recommendations, stating that adverse events affect hospital patients at an "alarming rate" and that it must continue working to improve patient safety. AHRQ stated that it intends to foster continued improvement in both identifying and reducing adverse events through operational programs, research efforts, and further collaboration with other agencies. CMS also concurred with our recommendations, stating that it is committed to the reduction of adverse events in hospitals and other health care settings and that although it has taken significant steps to address these issues, more work needs to be done. CMS stated that it will "aggressively pursue" broadening the scope and definition of patient safety efforts to be more inclusive of various types of adverse events and more closely monitor and address hospital quality of care. CMS also outlined several current and planned efforts to both create incentives and provide support for patient safety improvements by hospitals.

We made minor changes to the report based on technical comments.

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INTRODUCTION

OBJECTIVES

To estimate the national incidence of adverse events for hospitalized Medicare beneficiaries, assess the preventability of such events, and estimate associated costs to Medicare.

BACKGROUND

Statutory Mandate and Office of Inspector General Response

The Tax Relief and Health Care Act of 2006 (the Act) requires that the Office of Inspector General (OIG) report to Congress regarding the incidence of "never events" among Medicare beneficiaries; the extent to which the Medicare program paid, denied payment, or recouped payment for services furnished in connection with such events; and the processes that the Centers for Medicare & Medicaid Services (CMS) uses to identify such events and deny or recoup payment.[1] OIG is also to make recommendations for such legislation and administrative action as OIG determines is appropriate. (For relevant text of the Act, see Appendix A.) To meet the requirements of the Act, OIG released a series of reports beginning in 2008 and will publish additional reports based on ongoing work.[2]

Adverse Events in Hospitals

Following a review of Medicare policies and expenditures, as well as consultation with CMS and the Agency for Healthcare Research and Quality (AHRQ), we chose to focus our work on inpatient acute care hospitals. For fiscal year (FY) 2009, Medicare costs for inpatient care were $137 billion, constituting 28 percent of total expenditures.[3] As a condition of participation in the Medicare and Medicaid programs, Federal regulations require that hospitals develop and maintain Quality Assessment and Performance Improvement (QAPI) Programs.[4] As a

[1] Tax Relief and Health Care Act of 2006, P.L. 109-432 § 203.

[2] The studies in the series published to date are: *Adverse Events in Hospitals: Overview of Key Issues*, OEI-06-07-00470; *Adverse Events in Hospitals: State Reporting Systems*, OEI-06-07-00471; and *Adverse Events in Hospitals: Case Study of Incidence Among Medicare Beneficiaries in Two Counties*, OEI-06-08-00220, all published in December 2008; *Adverse Events in Hospitals: Public Disclosure of Information About Events*, OEI-06-09-00360, January 2010; and *Adverse Events in Hospitals: Methods for Identifying Events*, OEI-06-08-00221, March 2010.

[3] CMS, *2009 CMS Statistics Book*, Table III.6, Office of Research, Development, and Information, CMS Pub. No. 03497, December 2009, p. 30.

[4] 42 CFR § 481.21.

part of their QAPI programs, hospitals must "track medical errors and adverse patient events, analyze their causes, and implement preventive actions."[5] Federal regulations do not require specific program characteristics. The QAPI provisions also require that hospitals establish programs to demonstrate improvement in quality indicators for which there is evidence that practices will improve outcomes.[6] As an additional quality effort, Quality Improvement Organizations (QIO) contract with CMS to assist hospitals in improving the quality of care for Medicare beneficiaries, including addressing patient safety issues.[7]

A variety of terms, lists, and definitions are used to identify health care events that result in patient harm. For purposes of the Act, the term "never event" means an event that is listed and endorsed as a serious reportable event by the National Quality Forum (NQF)[8] as of November 16, 2006.[9] The NQF uses the term "serious reportable events" to describe a specific list of events associated primarily with patient death or serious disability that are both egregious and preventable, concluding that they "should never occur in a health care setting." These became known as "never events." (For a list of NQF Serious Reportable Events, see Appendix B.) The NQF list is often used by patient advocates and health care payers in establishing patient safety policies.[10] The health care community now uses the term "adverse event" more commonly than "never event" to refer to harm experienced by a patient as a result of medical care. After consulting with congressional committee staff in 2007, we expanded our approach to be consistent with patient safety research and industry trends.

As used in this study, an adverse event is defined as harm to a patient as a result of medical care or in a health care setting. Although an adverse event indicates that the care resulted in an undesirable clinical

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[5] 42 CFR § 482.21(c)(2).

[6] 42 CFR § 482.21(a)(1).

[7] CMS, *QIO Overview*, last modified January 2010. Accessed at http://www.cms.hhs.gov/QualityImprovementOrgs/ on September 29, 2010.

[8] NQF is a public-private membership organization created to develop and implement a national strategy for health care quality measurement and reporting.

[9] The Act, § 203(d). The NQF list is available online at http://www.qualityforum.org.

[10] As an example, The Leapfrog Group, a national nonprofit focused on patient safety issues, encourages hospitals to adopt policies to address Serious Reportable Events. *Leapfrog Group Position Statement on Never Events*, updated November 11, 2009. Accessed at http://www.leapfroggroup.org/for_hospitals/leapfrog_hospital_survey_copy/never_events on September 29, 2010.

outcome and may involve medical errors, adverse events do not always involve errors, negligence, or poor quality of care and are not always preventable.[11] Research and policy to improve patient safety and reduce the incidence of adverse events often focus on identifying and addressing systemic problems that may lead to patient harm and avoid labeling the event as an outcome of negligence or poor quality. Additionally, researchers, policymakers, and health care entities sometimes adopt different standards for distinguishing between degrees of patient harm in determining whether they classify an occurrence as an adverse event. Thus, entities tracking events may find different results depending on the list used to identify and classify events.

The National Coordinating Council for Medication Errors Reporting and Prevention (NCC MERP) Index for Categorizing Errors can be used to classify adverse events by level of patient harm. The NCC MERP Index was initially developed to categorize the effect of medication errors and considers whether the occurrences had an effect on the patients and, if so, how harmful they were. The index includes categories for circumstances or occurrences that presented a risk but did not cause harm, often referred to as "near misses," and those that caused harm. Table 1 shows the NCC MERP Index for Categorizing Errors.

Table 1: The NCC MERP Index for Categorizing Errors

Level	Description	Event
A	Circumstances or events occurred that had the capacity to cause error.	Harm does not reach patient
B	Error occurred but did not reach the patient.	
C	Error occurred that reached the patient but did not cause patient harm.	
D	Error occurred that reached the patient and required monitoring to preclude harm or confirm that it caused no harm.	
E	Error occurred that may have contributed to or resulted in temporary harm and required intervention.	Harm reaches patient
F	Error occurred that may have contributed to or resulted in harm and required an initial or prolonged hospital stay.	
G	Error occurred that contributed to or resulted in permanent patient harm.	
H	Error occurred that required intervention to sustain the patient's life.	
I	Error occurred that may have contributed to or resulted in patient death.	

Source: NCC MERP Index for Categorizing Errors, Press Release, *Medication Errors Council Revises and Expands Index for Categorizing Errors: Definitions of Medication Errors Broadened*, June 12, 2001.

[11] R.M. Wachter, *Understanding Patient Safety*, McGraw-Hill, 2008.

Researchers have used the NCC MERP index for measuring and distinguishing other types of adverse events, rather than only medication errors. For example, the Institute for Healthcare Improvement (IHI), a nonprofit organization that advises hospitals regarding health care quality, uses a modified version of the NCC MERP index to measure the degree of patient harm, regardless of whether the harm was the result of an error.[12]

Present on Admission Indicators and Medicare's Hospital-Acquired Conditions Policy

Medicare reimbursement to acute care hospitals through the Inpatient Prospective Payment System (IPPS) is generally determined by grouping codes representing patient conditions into Diagnosis-Related Groups (DRG) based on the average cost of care for patients with similar conditions.[13] Hospitals may submit Medicare claims under IPPS using nine diagnosis codes and six procedure codes for each hospital stay. Historically, if a Medicare beneficiary experienced an adverse event that resulted in assignment of a more costly DRG, CMS paid the higher DRG.[14]

Beginning October 1, 2007, hospitals are required to assign a Present on Admission (POA) Indicator to each principal and secondary diagnosis for acute IPPS claims for all discharges.[15] This was an initial step in complying with the Deficit Reduction Act of 2005 (DRA), which required CMS to select at least two hospital-acquired conditions (HAC) for which hospitals would not be paid higher Medicare reimbursement.[16]

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[12] F.A. Griffin and R.K. Resar, *IHI Global Trigger Tool for Measuring Adverse Events*, Institute for Healthcare Improvement Innovation Series 2007, pp. 4–5.

[13] CMS, *Acute Inpatient PPS Overview*, last modified Feb. 22, 2010. The ICD-9-CM system assigns diagnoses and procedure codes associated with hospital stays and is maintained jointly by CMS and the National Center for Health Statistics. Accessed at http://www.cms.gov/AcuteInpatientPPS/01_overview.asp on September 29, 2010.

[14] CMS, Press Release, *Eliminating Serious, Preventable, and Costly Medical Errors – Never Events*, May 18, 2006.

[15] CMS, CMS Manual System, Change Request 5679 (July 20, 2007). To effectuate the use of POA indicators, the FY 2008 IPPS rule implemented a more specific list of DRGs called Medicare Severity Diagnosis-Related Groups (MS-DRG). MS-DRGs split some of the prior DRGs into two or three classes based on the presence of a complication or comorbidity. FY 2008 IPPS Final Rule, 72 Fed. Reg. 47130, 47138 (Aug. 22, 2007).

[16] DRA, P.L. 109-171 § 5001(c)(1), Social Security Act (SSA), § 1886(d)(4)(D), 42 U.S.C. § 1395ww(d)(4)(D).

In response, CMS issued regulations outlining a policy to deny hospitals higher payment for hospital admissions complicated by any of 10 categories of HACs.[17] The DRA required that the conditions meet the following criteria:

- conditions that are high cost, high volume, or both;
- conditions that, when present as a secondary diagnosis, result in assignment of a case to a DRG that has a higher payment;
- conditions that could be reasonably prevented by using readily available evidence-based guidelines; and
- conditions that are identifiable based on one or more unique diagnosis codes.[18]

Effective October 1, 2008, CMS began denying hospitals higher payment for care associated with these conditions.[19] Examples of HACs include catheter-associated urinary tract infections and patient injury because of a fall. For the full list of Medicare HACs, see Appendix C.

Determining the Incidence of Adverse Events

Research indicates that identifying adverse events retrospectively is a complex and difficult task, requiring extensive clinical knowledge, adequate documentation, and subjectivity on the part of the researcher.[20] Medical records review is often considered the most definitive method for detecting adverse events because it can provide detail about both the adverse event and the circumstances, such as the patient's condition prior to and following the event.[21] However, medical records reviews can be costly, requiring hospital staff to make records available and substantial effort by physicians or other clinicians to review them. To limit physician medical records reviews required to identify adverse events, cases can be screened to identify potential

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[17] FY 2008 IPPS Final Rule, 72 Fed. Reg. 47130, 47202 (Aug. 22, 2007); and FY 2009 IPPS Final Rule, 73 Fed. Reg. 48434, 48471–48491 (Aug. 19, 2008).

[18] SSA, § 1886(d)(4)(D)(iv).

[19] FY 2009 IPPS Final Rule, 73 Fed. Reg. 48434, 48471–48472 (Aug. 19, 2008); CMS, CMS Manual System, Change Request 6189 (Oct. 3, 2008).

[20] E.J. Thomas and L.A. Peterson, *Measuring Errors and Adverse Events in Health Care*, Journal of General Internal Medicine, 18(1), 2003, pp. 61–67.

[21] E.J. Thomas, D.M. Studdert, and T.A. Brennan, *The Reliability of Medical Record Review for Estimating Adverse Event Rates*, Annals of Internal Medicine, 136(11), June 2002, pp. 812–816.

adverse events using other methods, such as nurse reviews of medical records and analysis of POA indicators in hospital claims data.

Nurse review of medical records. Medical records screening can identify potential adverse events based on information in the medical records. The IHI Global Trigger Tool (GTT) uses a review of medical records to identify "triggers" that could signal patient harm, thereby identifying potential adverse events. A trigger could be a description of the harm itself or a reference that indicates harm occurred (such as a return to surgery). The review is designed to be completed by nurse reviewers, with the results then confirmed or refuted by a physician. Barriers to medical records screening include incomplete records and high labor costs for review.

Analysis of POA indicators. Automated computer programs can review Medicare billing data, specifically the POA indicator codes assigned to each diagnosis, to identify conditions that developed during hospital stays and possibly constitute adverse events. Although these programs enable examination of large numbers of hospital stays, barriers exist to POA analysis, including inaccurate or incomplete data. CMS's POA coding requirement began in October 2007, and the accuracy and completeness of hospital coding of POA indicators have not yet been validated. Additionally, conditions can be acquired in hospitals that are not related to medical care and therefore not adverse events.

OIG case study. Prior to this study, we conducted a case study of the incidence of adverse events occurring during October 2008 for a random sample of 278 Medicare beneficiaries' hospital stays in 2 counties.[22] We estimated that 15 percent of Medicare beneficiaries in the two counties experienced events meeting at least one of the following criteria: events on the NQF list of Serious Reportable Events; events on Medicare's list of HACs; or events involving prolonged hospital stays, permanent harm, life-sustaining intervention, or death (classified as F-I level of harm on the NCC MERP index). An additional 15 percent of beneficiaries experienced events involving temporary harm (classified as E level of harm on the NCC MERP index). The case study served in part to test the usefulness of various methods for identifying adverse events. We found that, combined, nurse screening of medical records and analysis

[22] OIG, *Adverse Events in Hospitals: Case Study of Incidence Among Medicare Beneficiaries*, OEI-06-08-00220, December 2008.

of POA indicator codes in billing data identified 94 percent of occurrences that physicians ultimately determined to be adverse or temporary harm events.[23]

Determining the Preventability of Adverse Events

To provide additional context regarding adverse events, some researchers have assessed whether adverse events were preventable and described the circumstances associated with events. A 2008 review of eight preventability studies found that the median percentage of adverse events judged preventable was 43.5 percent.[24] Assessing preventability can provide greater understanding of the causes of adverse events, which can be used to develop actionable solutions to the systemic problems that lead to events. Also, preventability is a statutory criterion of Medicare's nonpayment policy for HACs; CMS was required to select only conditions that can be "reasonably prevented by using readily available evidence-based guidelines."[25]

Reducing the Incidence of Adverse Events

Reducing the incidence of adverse events in hospitals is a critical component of efforts to improve patient safety and quality care. The Institute of Medicine (IOM) report, *To Err Is Human: Building a Safer Health System*, focused widespread attention on the problem of adverse events. IOM cited two studies that used medical records reviews to identify adverse events and assess whether events were preventable. IOM concluded that preventable adverse events caused "at least 44,000 and perhaps as many as 98,000 deaths in hospitals each year" and outlined a national plan to address adverse events.[26]

As part of its plan, IOM recommended the creation of a nationwide system for the collection of standardized adverse event data by State governments. As reported by OIG, 25 States and the District of Columbia had adverse event reporting systems in 2008, 11 of which

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[23] OIG, *Adverse Events in Hospitals: Methods for Identifying Events*, OEI-06-08-00221, March 2010.

[24] E.N. De Vries, M.A. Ramrattan, et al., *The Incidence and Nature of In-Hospital Adverse Events: A Systematic Review*, British Medical Journal – Quality and Safety in Health Care, 17(3): 216–23, June 2008.

[25] SSA, § 1886(d)(4)(D)(iv), 42 CFR § 412.10; FY 2008 IPPS Final Rule, 72 Fed. Reg. 47130, 47202 (Aug. 22, 2007).

[26] L.T. Kohn, J.M. Corrigan, and M.S. Donaldson, eds., *To Err Is Human: Building a Safer Health System, A Report of the Committee on Quality of Health Care in America*, p. 102, IOM, National Academy Press, 2000.

used the NQF list of Serious Reportable Events or a modified version of the list to define what events are reportable.[27] To date, no national adverse event reporting system exists and there are no Federal standards regarding State systems.

Following the IOM report, the Federal Government formed the Center for Quality Improvement and Patient Safety (CQuIPS) within AHRQ to provide national leadership in improving patient safety. In a 2009 report, AHRQ identified its core agency objectives for CQuIPS as developing a solid evidence base, designing useful tools for providers, and disseminating information for implementation.[28] As mandated by Congress, AHRQ releases an annual report to the Nation about health care quality that is produced by CQuIPS and includes measures of patient safety.[29] The National Healthcare Quality Report includes measures of the incidence of certain types of adverse events, using data from sources such as the Medicare Patient Safety Monitoring System (MPSMS), an AHRQ-CMS collaborative effort to identify adverse events through analyses of medical records and Medicare claims data for beneficiaries' hospital stays.[30] AHRQ is also responsible for implementation and oversight of the certification process for Patient Safety Organizations (PSO) created by the Patient Safety Act and Quality Improvement Act of 2005.[31] PSOs are in the early stages of development, but are intended to receive adverse event reports from hospitals and forward the information to a national AHRQ database from which CQuIPS will analyze aggregated data. AHRQ developed a set of event definitions and reporting tools known as the Common Formats, which PSOs can choose to use and which contain data elements that AHRQ determined are important for a complete and

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[27] OIG, *Adverse Events in Hospitals: State Reporting Systems*, OEI-06-07-00471, December 2008.

[28] AHRQ. *Advancing Patient Safety: A Decade of Evidence, Design, and Implementation*, AHRQ Publication No. 09(10)-0084, November 2009. Accessed at http://www.ahrq.gov/qual/advptsafety.htm on September 29, 2010.

[29] Healthcare Research and Quality Act of 1999, P.L. 106-129 § 2(a); Public Health Service Act (PHSA). § 913, 42 U.S.C. § 299b-2.

[30] D.R. Hunt, N. Verzier, et al., "Fundamentals of Medicare Patient Safety Surveillance: Intent, Relevance, and Transparency," *Advances in Patient Safety*, 2005, p. 105. Accessed at www.ahrq.gov/downloads/pub/advances/vol2/Hunt.pdf on September 29, 2010.

[31] The Secretary of Health and Human Services (Secretary) delegated authority to AHRQ to make these determinations, as well as to fulfill other requirements of the Patient Safety Act. Patient Safety and Quality Improvement Act of 2005, P.L. 109-41 § 2, PHSA, § 924, 42 U.S.C. § 299b-24; 73 Fed. Reg. 70732 (Nov. 21, 2008).

useful adverse event report.[32] A variety of organizations are eligible to become PSOs, including hospital associations, hospital chains, and patient safety consulting groups.[33] For a 2009 OIG study, staff from selected PSOs reported barriers that could limit hospital participation in PSOs and questioned the usefulness of submitting data for aggregation.[34] Finally, the American Recovery and Reinvestment Act of 2009 appropriated $300 million to AHRQ to sponsor and disseminate research that compares the effectiveness of clinical care options, the purpose of which is to promote evidence-based medical care.[35]

In March 2010, Congress passed health care reform legislation in the form of the Patient Protection and Affordable Care Act (ACA).[36] The ACA includes a number of provisions to take effect over multiple years, including expanded funding and authority to the Department of Health and Human Services (HHS) to address health care quality issues. Among the initial efforts to implement the ACA, the Secretary is to establish a national strategy for quality improvement in health care by January 1, 2011.[37] The law requires that the strategy address eight national priority areas, one of which is to improve patient safety.[38] It also increases funding to CQuIPS for research grants to explore best practices.[39] Among its payment provisions, the ACA expands the Medicare HAC policy to mandate hospital payment penalties for high rates of HACs,[40] create new quality measures,[41] and require State Medicaid agencies to deny higher reimbursement for care associated with HACs.[42]

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[32] AHRQ, *Common Formats for Patient Safety Data Collection and Event Reporting, Notice of Availability: Common Formats Version 1.0*, September 2, 2009. Accessed at http://www.pso.ahrq.gov/formats/commonfmtv1_0fr.htm on October 12, 2010.

[33] PHSA, § 924(b), 42 U.S.C. § 299b-24(b).

[34] OIG, *Adverse Events in Hospitals: Public Disclosure of Information About Events*, OEI-06-09-00360, January 2010.

[35] American Recovery and Reinvestment Act of 2009, P.L. 111-5, Division A, Title VIII.

[36] ACA, P.L. 111-148, was signed into law on March 23, 2010, after we had completed data collection and analysis for this study.

[37] P.L. 111-148 § 3011, PHSA, § 399HH, 42 U.S.C. § 280j.

[38] P.L. 111-148 § 3011, PHSA, § 399HH(a)(2)(B)(vii), 42 U.S.C. § 280j(a)(2)(B)(vii).

[39] P.L. 111-148 § 3501, PHSA, §§ 933 and 934.

[40] P.L. 111-148 § 3008(a), SSA, § 1886(p), 42 U.S.C. § 1395ww(p).

[41] P.L. 111-148 § 3013 inserted new section 931 of the PHSA, 42 U.S.C. § 299b-31, and added section 1890A(e) of the SSA, 42 U.S.C. § 1395aaa-1(e).

[42] P.L. 111-148 § 2702.

METHODOLOGY

Scope

This report estimates the national incidence of adverse events based on a representative sample of Medicare beneficiaries discharged from inpatient acute care hospitals during October 2008. Our results are projectable to all Medicare beneficiaries hospitalized during this period nationwide. To determine the estimated rate of adverse events, we used criteria developed by NQF, CMS, and NCC MERP. We included in the estimated national incidence rate all patient harm that occurred during the hospital stay, regardless of whether it was preventable. Also, the report provides a physician assessment of the extent to which identified events were preventable and analysis of billing data to estimate the cost to the Medicare program for increased reimbursement resulting from all events and preventable events.

Sample Selection

We selected a sample of Medicare beneficiaries from the National Claims History (NCH). Of the 999,645 beneficiaries discharged from acute care hospitals during October 2008, we selected a random sample of 785 beneficiaries. We excluded 5 beneficiaries as ineligible because the hospital was currently under OIG investigation, resulting in a sample of 780 beneficiaries. In July–October 2009, we requested and received medical records from hospitals regarding sample beneficiaries' hospital stays. Fifty-four of the beneficiaries had more than 1 hospital stay during October (50 had 2 stays and 4 had 3 stays). Combined, sample beneficiaries had 838 hospital stays with discharges in October 2008 and an average length of stay of 5.2 days.[43]

Identifying Adverse Events and Determining Preventability

We conducted a two-stage review to identify adverse events experienced by each beneficiary. The first stage used three screening methods to identify cases likely to include an event. This enabled us to reduce the number of cases requiring the second-stage physician review. During the first stage, we identified cases that met one or more of the following conditions: (1) certified medical coders identified codes in the Medicare claims data that were listed as not present on admission, (2) nurse reviewers found evidence of a potential adverse event in the medical

[43] The average length of stay for hospitalized Medicare beneficiaries overall in 2007 was 5.6 days. CMS, *2009 CMS Statistics*, Table IV.1 Medicare Short-stay Hospital Utilization, 2009, Tab 1.

records, or (3) the beneficiary had a hospital admission within 30 days after discharge for his or her last sample hospital stay ending in October 2008.[44]

We identified 420 cases for the second stage of review, which entailed a review of the full medical records by physicians to identify events. To ensure consistency across physician reviewers, we facilitated weekly conference calls during which all physician reviewers discussed cases that either were complex or had possible implications for other cases. We included events experienced by patients during hospital stays or during prior, contiguous outpatient visits (wherein patients were transferred directly from outpatient care to inpatient care within the same facility). For example, we included in our count an adverse event that occurred in a hospital emergency department immediately preceding admission to inpatient care. We did not include events that occurred prior to a beneficiary's arrival on the hospital campus. When an initial event caused a series of related events for the same patient, we collapsed the events into a "cascade event," which counted as a single event.[45] For a glossary of selected clinical terms used to describe events, see Appendix D.

As part of the structured protocol, physician reviewers also determined the extent to which the identified events were preventable. Generally speaking, physicians assessed events as preventable when they determined that harm could have been avoided through improved assessments or alternative actions. Physicians assessed an event as not preventable when they determined that harm could not have been avoided given the complexity of the patient's condition or the care required. The physician protocol used the following response scale for assessing the preventability of events: clearly preventable, likely preventable, clearly not preventable, likely not preventable, and unable to determine. Physicians used their clinical experience and judgment to make preventability determinations. They considered all evidence in

[44] We reviewed records for admissions that occurred within 30 days of the last beneficiary discharge. Therefore, the 30-day window for reviewing readmissions did not span a fixed timeframe but began on the unique final discharge date for each beneficiary with the last possible admission occurring on November 30, 2008 (30 days following the final possible October 31, 2008, discharge).

[45] Based on OIG interviews with IHI staff, IHI defines a cascade event as one in which an initial event causes a series of related events for the same patient and advocates collapsing these into a single event.

the medical records, including the actions of hospital and medical staff and the patient's condition. Assessing an event as *clearly* preventable or *clearly* not preventable required a greater degree of certainty on the part of the reviewer. For detailed information about the methodology for identifying events and determining preventability, see Appendix E.

Data Analysis

We performed analysis and generated estimates about adverse events for three categories: incidence of events, preventability of events, and Medicare cost associated with events. We also calculated separate estimates regarding these categories for temporary harm events. For estimates and corresponding 95-percent confidence intervals for all statistical analyses, see Appendix F.

Adverse event incidence analysis. We calculated the estimated national adverse event incidence rate as the percentage of Medicare beneficiaries with at least one adverse event. We defined adverse events as events that met at least one of the following criteria:

1. the event was on the NQF list of Serious Reportable Events, as the Act mandates;
2. the event was on Medicare's list of HACs for which it denies higher payment; or
3. the event resulted in one of the four most serious categories on the NCC MERP index (classified on the index as F-I):
   - prolonged hospital stay,
   - permanent harm,
   - life-sustaining intervention, or
   - death.

We also calculated individual rates for adverse events on the NQF list, the Medicare HAC list, and events classified as F-I on the NCC MERP index. The overall adverse event incidence rate does not include events that physician reviewers identified as temporary harm events, defined as events that required intervention but did not cause lasting harm (classified as E level harm on the NCC MERP index). We excluded these temporary harm events from our overall rate because we determined, in consultation with physician reviewers, that the effect of these events was not comparable to the more serious events meeting the three criteria. We calculated a separate incidence rate for beneficiaries who experienced only temporary harm events. We projected incidence rates to the population of Medicare beneficiaries discharged from inpatient acute care hospital stays during October 2008.

As an additional measure of adverse event rates, we calculated 2 ratios of adverse event incidence density: events per 1,000 patient days and events per 100 hospital admissions. These measures are commonly used by hospitals and medical researchers.[46] For the resulting metrics and an explanation of the calculation method, see Appendix G.

Preventability analysis. The findings related to preventability are based on determinations made by the physician reviewers for each adverse event and temporary harm event. We calculated percentages for each preventability classification and for different types of events, the results of which are projectable to the population. We also conducted statistical tests to identify differences in preventability rates between adverse events and temporary harm events and across various categories of adverse events, such as medication-related and infection-related events.

Medicare cost analysis. We estimated the cost to Medicare resulting from care associated with adverse events and temporary harm events. This analysis included only Medicare claims that were paid under the IPPS and were subject to the Medicare HAC policy (84 percent of sample beneficiaries).[47] Certified medical coders reviewed the medical records, the medical review protocols, and the associated Medicare claims to identify diagnosis and procedure codes that would not have been included in the claims if the events had not occurred. We then used CMS's MS-DRG Grouper and Medicare Code Editor Version 27 (Grouper) to determine the DRG for the claims and used the FY 2009 IPPS personal computer Pricer (Pricer) to determine the resulting Medicare reimbursement amounts.[48] For each claim, we calculated the DRG and reimbursement amount, including information from the

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[46] K.M. Arias, *Outbreak Investigation, Prevention, and Control in Health Care Settings*, Second Edition, Jones and Bartlett Publishers, 2009, pp. 330–331.

[47] The cost analysis does not include claims for beneficiaries whose Medicare coverage is not paid under the IPPS. This includes Medicare managed care organizations and care provided at hospitals excluded from the Medicare IPPS system, including hospitals in the State of Maryland and some specialty hospitals nationwide, such as cancer treatment centers and critical access hospitals. CMS, *HAC Fact Sheet*. Accessed at http://www.cms.gov/HospitalAcqCond/Downloads/HACFactsheet.pdf on September 29, 2010.

[48] The Grouper software classifies hospital claims into MS-DRG categories expected to have similar hospital resource requirements. MS-DRGs are based on the nine diagnoses associated with HACs and corresponding POA indicators, six procedure codes, and demographic data contained in the NCHs. MS-DRGs typically split into two or three individual classes based on the presence of a complication or comorbidity. This software was developed by CMS and 3M and is sold by the National Technical Information Service. Accessed at http://www.ntis.gov on September 29, 2010.

hospital Medicare claim. We then calculated the reimbursement amount excluding diagnosis and procedure codes that coders determined were the direct result of any adverse event or temporary harm event experienced by the beneficiary. We projected the difference between the two hospital reimbursement amounts to estimate the additional cost to Medicare for care associated with events. When an entire hospital stay was the result of an adverse event, we included the total reimbursement amounts indicated by the Pricer as the cost of the adverse event.

Limitations

Beyond the challenges associated with identifying adverse events and assessing preventability, the methodology presents two specific limitations. First, it is unlikely that the study identified all adverse and temporary harm events within the sample. To the extent that the study did not identify an event, it was likely because the three screening methods failed to flag the case for physician review or because documentation in the medical records was incomplete. Second, cost estimates did not include all costs of care associated with events, excluding stays not covered under the Medicare IPPS, additional hospital stays caused by sample events but occurring after October 2008, additional care outside the hospital (such as followup physician office visits or rehabilitation services), and changes in Medicare outlier payments.[49]

Standards

This study was conducted in accordance with the *Quality Standards for Inspections* approved by the Council of the Inspectors General on Integrity and Efficiency.

[49] Medicare outlier payments are supplemental payments to hospitals for patients who incur extraordinarily high costs. Outlier payments are based on the degree to which costs on a claim exceed specific hospital and MS-DRG fixed-loss thresholds and fluctuate depending on the MS-DRG to which the claim is grouped. The Pricer analysis involved a revision of the MS-DRG. This revision resulted in new outlier payments for three sample cases and increased outlier payments for two sample cases. The revised outlier payments decreased the cost attributed to adverse events in our estimate.

An estimated 13.5 percent of hospitalized Medicare beneficiaries experienced adverse events during their hospital stays

Of the nearly 1 million Medicare beneficiaries discharged from hospitals in October 2008, about 1 in 7 experienced an adverse event (13.5 percent), defined as an event that met at least 1 of the following 3 criteria: the event was on the NQF list of Serious Reportable Events; the event was on Medicare's list of HACs; or the event resulted in 1 of the 4 most serious categories on the NCC MERP index (prolonged hospital stay, permanent harm, life-sustaining intervention, or death). This incidence rate projects to approximately 134,000 Medicare beneficiaries experiencing at least 1 adverse event in hospitals during the study period. Table 2 lists the incidence rate for each of the three criteria.

Table 2: Estimated National Incidence of Adverse Events Among Medicare Beneficiaries Discharged in October 2008

NQF Serious Reportable Events*	0.6%	6,367
Medicare HACs*	1.0%	10,167
NCC MERP F-I Level Events	13.1%	129,890
(Overlap)**	(1.3%)	(12,734)
Total	**13.5%*** **	**133,710**

See Appendix F for confidence intervals.

*Given the small proportions, confidence intervals for projected numbers exceed 50-percent relative precision.

**The 1.3 percent represents beneficiaries who experienced adverse events in more than one category. We counted these beneficiaries only once in determining the overall incidence rate.

***Column does not sum to 13.5 percent because of rounding.

Source: OIG analysis of hospital stays for 780 Medicare beneficiaries discharged in October 2008.

We classified the identified adverse events into four clinical categories: events related to medication (31 percent), events related to ongoing patient care (28 percent), events related to surgery or other procedures (26 percent), and events related to infection (15 percent). Table 3 lists the 128 adverse events found in the sample within these categories. See Appendix H for a list of the events with more complete descriptions, the level of harm patients incurred, and indications of whether the events were on the NQF and HAC lists.

Table 3: Adverse Events Identified Among Sample Medicare Beneficiaries by Clinical Category (n=128)

[illegible]	Number of Events (and Percentage of Total Events)
Events Related to Medication	**31% (40)**
Excessive bleeding	12
Delirium or change in mental status	7
Hypoglycemic event	6
Acute renal insufficiency (kidney failure)	4
Severe hypotension	4
Respiratory complications	4
Severe allergic reactions	3
Events Related to Patient Care	**28% (36)**
Intravenous volume overload	10
Aspiration	8
Deep vein thrombosis or pulmonary embolism	5
Exacerbation of preexisting medical condition	5
Stage III pressure ulcer	3
Breakdown of surgical wound	1
Congestive heart failure	1
Hypoxia (oxygen deficiency)	1
Patient fall with injury	1
Prolonged weakness and dizziness	1
Events Related to Surgery or Other Procedures	**26% (33)**
Excessive bleeding	5
Severe hypotension	4
Respiratory complication	4
Iatrogenic pneumothorax	3
Postoperative ileus	3
Postoperative urinary retention	3
Acute coronary syndrome	2
Blood clot and other occlusion	2
Cardiac complication	2
Cardiac dysrhythmia	1
Delay in surgery because of equipment malfunction	1
Hemorrhage at surgical site	1
Seroma (fluid) following stomach resection	1
Urinary catheter-associated trauma	1
Events Related to Infection	**15% (19)**
Urinary tract infection	5
Vascular catheter-associated infection (central or peripheral line)	4
Other bloodstream infection	4
Respiratory infection	4
Surgical or procedural site infection	2

Source: OIG analysis of hospital stays for 780 Medicare beneficiaries in October 2008.

Of beneficiaries who experienced adverse events, 18 percent had more than one adverse event. Most of the beneficiaries who experienced multiple events had two events, but others had as many as three

unrelated events in the same hospitalization. For example, an elderly heart patient with a history of mental illness experienced three adverse events of different types, including two events that prolonged hospitalization and a third that required life-sustaining intervention. (This beneficiary also experienced three temporary harm events associated with patient care.)

Less than 1 percent of Medicare beneficiaries experienced an event on the NQF list of Serious Reportable Events

An estimated 0.6 percent of Medicare beneficiaries experienced an event on the NQF list, which projects to approximately 6,400 beneficiaries nationally for the study period. The low number of NQF events in the sample is notable because of the prominence of the list as a measure of patient harm and its use by a number of State adverse event reporting systems and other entities. We identified a total of five NQF events in the sample: two medication-related deaths and three Stage III pressure ulcers.[50] One of the medication-related deaths illustrates the nature of the NQF list as a measure of the most egregious preventable outcomes. In this case, a disabled Medicare beneficiary with muscular dystrophy affecting the respiratory system entered the hospital for signs of respiratory failure. Medical staff at the hospital gave the beneficiary a medication known to further suppress respiration, resulting in progressive respiratory distress and subsequent death. Physician reviewers concluded that medical staff administered the wrong medication because they lacked clinical understanding of the patient's unique condition.

Many serious events that we identified were not on the NQF list of Serious Reportable Events, including some events that resulted in patient deaths and serious disability. The NQF list focuses largely on serious disability or death, but is restricted to a specific set of events. Of the 18 adverse events that physician reviewers found to result in serious disability or patient death, only 2 were on the NQF list (i.e., the medication errors resulting in death). The three Stage III pressure ulcers identified in the sample were sufficiently treated prior to

[50] Pressure ulcers are classified into four stages by the National Pressure Ulcer Advisory Panel (NPUAP): Stage I is intact skin with nonblanchable redness; Stage II is a shallow ulcer or blister indicating damage to the epidermis; Stage III is damage extending through all the layers of the skin; and Stage IV is damage through all the layers of the skin and underlying muscle, tendons, or bone. NPUAP, *Pressure Ulcer Stages Revised by NPUAP.* Accessed at http://www.npuap.org on November 12, 2009.

discharge from the hospital and determined by physicians to have caused only temporary harm.

Medicare HACs rarely occurred, affecting just 1 percent of beneficiaries

An estimated 1 percent of hospitalized Medicare beneficiaries experienced Medicare HACs, which projects to approximately 10,000 beneficiaries nationally. We identified a total of nine Medicare HACs experienced by beneficiaries in the sample: five catheter-associated urinary tract infections, two vascular catheter-associated infections of the central line, one patient fall resulting in injury (a compression fracture), and one Stage III pressure ulcer. One beneficiary experienced two of these events, resulting in a total of eight sample beneficiaries with Medicare HACs. Two catheter-associated urinary tract infections caused more substantial harm than is typically associated with this condition: one resulted in a prolonged hospital stay and the other in permanent harm. The two vascular catheter-associated infections of a central line resulted in prolonged hospital stays. None of the nine Medicare HACs identified by physicians on the medical records were included in the associated Medicare claims. In four of the nine cases (all catheter-associated urinary tract infections), diagnosis codes on the claims identified the infections, but they were not the precise codes that CMS uses to identify these HACs. The other five claims had no diagnosis codes related to the HACs. Therefore, the HACs were not identifiable through the claims data that CMS uses to implement the HAC policy.

Thirteen percent of Medicare beneficiaries experienced adverse events classified in the most serious categories on the NCC MERP harm index

Based on our physician medical review, 13.1 percent of Medicare beneficiaries experienced adverse events classified in the four most serious harm categories on the NCC MERP harm index: events resulting in prolonged hospital stay, events resulting in permanent harm, events requiring life-sustaining intervention, and events contributing to death. This rate projects nationally to approximately 130,000 beneficiaries experiencing such adverse events during the study period. Often, adverse events within the same clinical category, such as infection, resulted in a different level of harm depending on the intervention required and the condition of the patient. Table 4 lists the percentage of adverse events in the sample that were classified in the four most serious harm categories and the projected national numbers of events by level of patient harm.

Table 4: Adverse Events Classified as F-I on the NCC MERP Patient Harm Index by Level of Harm

Level of Harm	Percentage of Adverse Events
F level: Requiring prolonged hospital stay	62%
G level: Permanent harm*	5%
H level: Life-sustaining intervention required	23%
I level: Contributing to death*	10%

See Appendix F for confidence intervals.

*Given the small proportions, confidence intervals for projected numbers exceed 50-percent relative precision.

Source: OIG analysis of hospital stays for 780 Medicare beneficiaries discharged in October 2006.

An estimated 1.5 percent of hospitalized Medicare beneficiaries experienced events that contributed to their deaths

Among the 128 adverse events that we identified in the sample, 12 events (9 percent of 128 events) contributed to the deaths of beneficiaries. This projects to an estimated 1.5 percent of hospitalized Medicare beneficiaries experiencing events that contributed to death or approximately 15,000 beneficiaries during the study period. Seven of the twelve deaths were related to medication, either the result of improper administration of medication (wrong drug or wrong dosage) or inadequate treatment of known side effects. The most common type of medication-related death (five deaths) involved excessive bleeding from blood-thinning medication. The two other medication-related deaths involved inadequate insulin management resulting in hypoglycemic coma and respiratory failure resulting from oversedation. Of the five non-medication-related deaths, two were from bloodstream infections; two involved aspiration (which led to pneumonia and cardiac arrest, respectively); and the other involved a ventilator-associated pneumonia. As stated previously, only 2 of the 12 adverse events that contributed to death were on the NQF list and none were Medicare HACs.

Twenty-seven percent of beneficiaries who experienced adverse events had at least one "cascade" event, wherein multiple, related events occurred in succession

The sample included a total of 28 cascade events, defined as adverse events that included a series of multiple, related events. We counted these as single events. These cascade events were some of the most serious adverse events identified in the sample, with nine cases requiring life-sustaining intervention and six cases contributing to death. The most common type of cascade events were events related to

surgery and other procedures (nine events). Two of these events began with excessive bleeding following surgery or a procedure. For example, one beneficiary had excessive bleeding after his kidney dialysis needle was inadvertently removed, which resulted in circulatory shock, a transfer to the intensive care unit, and emergency insertion of a tube into the trachea (windpipe) to ease breathing. When the tube was removed the following day, the patient aspirated (inhaled foreign material into his lungs), which required a life-sustaining intervention.

An additional 13.5 percent of Medicare beneficiaries experienced events during their hospital stays that resulted in temporary harm

An additional 13.5 percent of Medicare beneficiaries experienced events during the study period classified as E level harm on the NCC MERP index, defined as events that required medical intervention but did not cause lasting harm. This rate projects to approximately 134,000 Medicare beneficiaries experiencing temporary harm events during the study period. Of these beneficiaries, 22 percent had more than one unrelated event (the highest occurrence was five unrelated events in a single hospital stay). Additionally, 28 percent of beneficiaries who experienced adverse events (and are included in our primary rate) also had temporary harm events during the same stay.

Events classified as temporary harm represented a wide array of conditions, such as prolonged vomiting and hypoglycemia (see Table 5). The most common events related to medication (42 percent). Although many cases of temporary harm represented fairly minor occurrences, we classified others as temporary because the patients were in the hospital for a lengthy period because of other, more serious, diagnoses, allowing the hospital enough time to address the harm prior to discharge. Physician reviewers indicated that many temporary harm events could have developed into more serious adverse events, but hospitals provided timely intervention. For example, Stage I or Stage II pressure ulcers can escalate quickly to Stage III or Stage IV without proper care[51] and episodes of hypoglycemia can lead to stroke and even death.[52]

[51] J.L. Zeller, C. Lynm, and R.M. Glass, *Pressure Ulcers*, Journal of the AMA, 296(8), August 23/30, 2006, p. 1020. Accessed at http://jama.ama-assn.org on December 1, 2009.

[52] P. Mandava and T. Kent, *Metabolic Disease & Stroke: Hyperglycemia/Hypoglycemia*, Journal of Diabetes Science and Technology, 17, April 4, 2006, p. 8. Accessed at http://emedicine.medscape.com on December 1, 2009.

Table H-2 in Appendix H contains a list of the 174 temporary harm events identified in the sample with more complete descriptions.

Table 5: Temporary Harm Events Identified Among Sample Medicare Beneficiaries by Clinical Category (n=174)

Events Related to Medication	**42% (73)**
Delirium or change in mental status	22
Hypoglycemic event	11
Thrush and other opportunistic infection	7
Allergic reaction or side effect related to skin	6
Gastrointestinal complication	5
Hypotension	5
Dysrhythmia	3
Excessive bleeding	3
Severe headache or dizziness	3
Acute renal failure or insufficiency	2
Allergic reaction to blood or related products	2
Respiratory complication	2
Other events related to medication	2
Events Related to Patient Care	**36% (63)**
Stage I, Stage II, or unstaged pressure ulcer	20
Intravenous volume overload	15
Skin tear, laceration, abrasion, or other breakdown	9
Intravenous infiltrate with symptoms	6
Patient fall with injury	5
Aspiration	3
Failure to treat constipation or obstipation	3
Tachycardia or dysrhythmia	2
Events Related to Surgery or Other Procedures	**18% (32)**
Urinary retention	8
Excessive bleeding	6
Cardiac complication	4
Surgical tear or laceration	3
Urinary catheter-related trauma	3
Prolonged nausea and vomiting	2
Postoperative or postprocedural hypotension	2
Respiratory complication	2
Other events related to surgery or other procedures	2
Events Related to Infection	**4% (6)**
Surgical site infection	2
Bacterial infection	1
Respiratory infection	1
Urinary tract infection	1
Vascular catheter-associated infection	1

Source: OIG analysis of hospital stays for 780 Medicare beneficiaries in October 2008.

Physician reviewers determined that 44 percent of adverse events and temporary harm events were clearly or likely preventable

Physician reviewers assessed the extent to which events were preventable based on information in the medical records, their clinical experience with similar circumstances, research literature about the preventability of specific events, and group discussion to reach consensus. Combining adverse events and temporary harm events, physicians determined that 44 percent were preventable and 51 percent were not preventable.[53] (There was no statistically significant difference between the preventability rates of adverse events and temporary harm events.)[54] For the remaining 5 percent of events, physicians were unable to make determinations because of incomplete documentation in the medical records or extreme complexities in the patients' conditions or in the hospital care provided. Table 6 provides the percentage of events by the physician preventability assessment.

Table 6: Events by Physician Preventability Assessment

Preventable—Harm could have been avoided through improved assessment or alternative actions	44%
Clearly preventable	9%
Likely preventable	35%
Not preventable—Harm could not have been avoided given the complexity of the patient's condition or care required	51%
Clearly not preventable	18%
Likely not preventable	33%
Unable To Determine Preventability	5%

Source: OIG analysis of hospital stays for 780 Medicare beneficiaries discharged in October 2008.

Physician reviewers assessed the preventability of events similarly for three of the four clinical categories (medication, patient care, and infections). However, events related to surgery and other procedures were significantly less likely to be determined preventable than events in the other three clinical categories; only 17 percent of surgical events were

[53] The preventability rate of 44 percent is similar to the rate of 43.5 percent found by a 2008 review of 8 adverse event preventability studies previously referenced on p. 7.

[54] The Cochran-Mantel-Haenszel chi square test was not significant at the 95-percent confidence level (p=0.0568). See Appendix F for detailed preventability statistics for adverse events and temporary harm events.

preventable in contrast to 50 percent or more in each of the other three groups.[55] Physician reviewers indicated that the reasons surgical events were more likely to be assessed as not preventable were the high level of complexity in both the care involved and the patients' conditions. Table 7 provides the percentage of preventable events by clinical category.

Table 7: Preventable Events Within Clinical Categories

Clinical Category	Percentage of Events Assessed as Preventable
Infection	60%
Medication	50%
Patient care	51%
Surgery and other procedures	17%

Source: OIG analysis of hospital stays for 780 Medicare beneficiaries discharged in October 2008.

Within the clinical categories, physician reviewers sometimes gave the same preventability assessment for events with similar characteristics. For example, they assessed 10 of 12 events related to allergic reactions as not preventable. But for other types of events, preventability determinations for similar events differed based on the patients' conditions and risk factors. For example, in two cases of excessive stomach bleeding caused by blood thinners, physicians assessed one event affecting a relatively healthy patient as preventable and the other event affecting a patient with stomach ulcers as not preventable because of the patient's susceptibility. In another case, physician reviewers determined that some pressure ulcers were not preventable because of the poor conditions of the patients and because documentation in the medical records showed that the hospital staff employed appropriate preventive care. However, physicians assessed another pressure ulcer case as preventable because the medical staff declined to order a specialty mattress for an at-risk bedridden patient until after the pressure ulcer had developed, even though the medical record indicated that the specialty bed was available.

[55] The Cochran-Mantel-Haenszel chi square test was significant at the 95-percent confidence level for the overall relationship between preventability and clinical category ($p<0.0001$) as well as for each set of pair-wise comparisons between the surgical category and each of the other three clinical categories ($p<0.01$ for each pair). Preventability rates were 62 percent for infections, 50 percent for medication, and 50 percent for patient care.

Counting only preventable events, the estimated national incidence rate of adverse events among Medicare beneficiaries would be 7.4 percent

The estimated adverse event incidence rate of 13.5 percent is based on all adverse events' meeting one of the three criteria, regardless of whether the events were preventable. Including only the adverse events determined by physician reviewers to be clearly or likely preventable, the estimated incidence rate of adverse events among Medicare beneficiaries would be 7.4 percent. The 13.5 percent rate of additional beneficiaries experiencing temporary harm events would be 6.3 percent if only preventable events were included.

Eleven of the thirteen NQF Serious Reportable Events and Medicare HACs in the sample were preventable, a key criterion of both lists

Although we found few in the sample, all but two adverse events on the NQF and HAC lists were assessed as clearly or likely preventable.[56] After the adverse events on each list were separated, four of the five events on the NQF list were preventable and eight of the nine Medicare HACs were preventable (one event was on both lists). A key criterion of both lists is that the events be largely preventable. The two events on the lists that physicians assessed as not preventable were (1) an NQF event consisting of a pressure ulcer that progressed from Stage I to Stage III in a chronically ill patient with multiple complications and susceptibility to skin breakdown and (2) a Medicare HAC consisting of a compression fracture incurred during a fall by a morbidly obese patient.

Preventable events were most commonly linked to medical errors, substandard treatment, and inadequate patient monitoring or assessment

Physician reviewers selected one or more rationales to support each preventability determination from a list developed by the physician panel. To develop these rationales, physicians gleaned information from medical records, such as clinical staff actions, hospital environmental factors, and patient condition unrelated to the event. Among events assessed as preventable, 58 percent were linked to errors by clinical staff in medical judgment, skill, or patient management. Such errors often involved prescribing or administering the wrong medication. Nearly half of preventable events (46 percent) involved care provided in a substandard way, most frequently because of delay in diagnosis or

[56] The number of NQF and HAC events was too small to test the preventability measure for statistical significance with an acceptable degree of precision or to project the measure to the national sampling frame.

treatment. Table 8 provides physician preventability rationales for events within each assessment category.

Table 8: Events by Physician Preventability Rationales

Preventability Rationale	Percentage of Events
Preventable Events (n=133)	
Error was related to medical judgment, skill, or patient management	58%
Appropriate treatment was provided in a substandard way	46%
The patient's progress was not adequately monitored	38%
The patient's health status was not adequately assessed	23%
Necessary treatment was not provided	17%
Event rarely happens when proper precautions and procedures are followed**	14%
Communication between caregivers was poor**	8%
Facility's patient safety systems and policies were inadequate or flawed**	3%
Breakdown in hospital environment occurred (equipment failure, etc.)**	2%
Nonpreventable Events (n=155)	
Event occurred despite proper assessment and procedures followed	62%
Patient was highly susceptible to event because of health status	50%
Care provider could not have anticipated event given information available	35%
Patient's diagnosis was unusual or complex, making care difficult	29%
Harm was anticipated but risk considered acceptable given alternatives**	14%

See Appendix F for confidence intervals.

*Percentages do not add to 100 because physician reviewers often selected more than 1 rationale.

**Given the small percentages, confidence intervals for projected numbers exceed 50-percent relative precision.

Source: OIG analysis of hospital stays for 780 Medicare beneficiaries discharged in October 2008.

Other common factors associated with preventable events were inadequate monitoring of patients (38 percent) and inadequate assessment of patients (23 percent). These factors often led to delays in treatment and worsening of patient conditions. In several of these cases, patients displayed symptoms of infection but were not given antibiotics until they reached the point of sepsis. In one case, the patient exhibited signs of shock upon arrival at the hospital, but clinical staff did not monitor the patient's blood pressure for the first 8 hours and did not provide related treatment for another 16 hours. This delay caused the patient to experience severe hypotension, requiring life-sustaining intervention.

Physician reviewers assessed events as clearly or likely not preventable when the events occurred despite proper procedures or when the patients were highly susceptible to the events

For 62 percent of the nonpreventable events in our sample, physician reviewers found that care was rendered according to accepted standards of practice. In these cases, physicians determined that the care provided was sufficient and appropriate and that there was no evidence of errors or other problems. This rationale was often given in combination with the second most common factor—that the patients' other conditions made them highly susceptible to the event (50 percent of nonpreventable events). For example, one beneficiary, admitted to the hospital with a bowel obstruction, experienced a surgical cut of the intestine that would have been difficult to avoid because of significant damage to the bowel from prior surgery.

Other common rationales for assessing events as not preventable also focused on the difficulty of providing care. For 35 percent of nonpreventable events, physicians determined that the medical and hospital staff could not have anticipated the events given information available about the patients at the time of care delivery. For 29 percent of nonpreventable events, physicians determined that the patients' diagnoses were unusual or complex, making care particularly difficult. Finally, in 14 percent of nonpreventable cases, the adverse events were anticipated by caregivers, but the harm associated with the adverse events was considered less harmful than not providing care. For example, in four sample cases, patients experienced harm as a result of an overload of intravenous fluid, yet the medical review found that the patients were in such dire need of fluids (e.g., at risk for hypoglycemic shock) that caregivers had little choice but to execute vigorous intravenous fluid replacement despite the risk of overload.

Hospital care associated with adverse events and temporary harm events cost Medicare an estimated $324 million in October 2008

Sixteen percent of sample beneficiaries under the Medicare IPPS who experienced events incurred additional Medicare hospital costs as a result. Most of the additional costs (87 percent) resulted from care associated with adverse events, with temporary harm events generating the remaining costs.[57] These additional costs project to an estimated $324 million, which equates to 3.5 percent of the $9.2 billion that Medicare spent for inpatient care during October 2008.[58] To give these figures an annual context, 3.5 percent of the $137 billion Medicare inpatient expenditure in FY 2009 equates to $4.4 billion spent on care associated with adverse events.[59]

Costs associated with preventable events accounted for an estimated $119 million of the $324 million additional cost, equating to 1.3 percent of the $9.2 billion Medicare inpatient expenditures for the month or about $1.8 billion annually.

Despite this outlay, most events did not affect Medicare costs; none of the Medicare HACs resulted in a higher reimbursement

Of beneficiaries who experienced adverse events or temporary harm events in hospitals covered under the Medicare IPPS, 84 percent did not incur additional costs for care associated with the events. This occurred primarily because many Medicare claims for beneficiaries who experienced events did not include diagnosis or procedure codes relating to the events. When Medicare claims included codes associated with the events, the codes often had no effect on costs because the claims included other costly diagnoses or procedure codes that elevated the reimbursement to equivalent or higher amounts.

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[57] One Medicare claim included codes for two events—one adverse event and one temporary harm event—and incurred an identical payment impact. This claim overlaps both groups and consequently the percentages do not total 100 percent: 87 percent of costs resulted from care associated with adverse events and 15 percent of costs resulted from care associated with temporary harm events.

[58] These cost estimates include only claims under the IPPS, representing 708 sample Medicare claims (85 percent), but do not include costs for the remaining 130 sample beneficiaries (15 percent) who had sample admissions not covered under IPPS.

[59] The annual cost estimate of $4.4 billion is 3.5 percent of the $137 billion Medicare inpatient costs for FY 2009, which assumes the same proportion of costs for adverse events for the other 11 months that we found in October 2008. Annual Medicare inpatient cost figures are from CMS, *2009 CMS Statistics Book*, Table III.6, Office of Research, Development, and Information, CMS Pub. No. 03497, December 2009, p. 30.

None of the nine Medicare HACs identified in the sample resulted in a higher level of Medicare reimbursement. Although the Medicare HAC policy is intended to limit costs associated with the specified events, our review showed that none of the HACs in the sample would have invoked a higher Medicare reimbursement. None of the associated Medicare claims included the specific diagnosis codes that CMS uses to identify HACs. However, even if the codes had been included on the claims, the HAC policy would still not have resulted in payment reductions for these cases because other diagnosis or procedure codes would have elevated the reimbursement to a higher amount.

Two-thirds of Medicare costs associated with events were the result of additional hospital stays necessitated by harm from events

Sixty-five percent of the additional costs to Medicare ($210 million of the $324 million) were the result of entire, additional hospital stays required to treat the harm resulting from the adverse events. In some of these cases, the events occurred during outpatient services at the hospital (such as an emergency room visit or an outpatient surgery) and necessitated unplanned admissions to the inpatient facilities. In other cases, the events occurred during inpatient care and the beneficiaries were released from the hospital, but the aftereffects of the events necessitated subsequent hospital stays within the study period. The average Medicare cost of these additional hospital stays for sample beneficiaries was $13,745, compared with an average additional cost of $5,601 for event-related care that hospitals provided during the initial hospital stay in situations that did not necessitate additional stays.[60, 61]

Medicare cost estimates do not include additional costs required for followup care after the sample hospitalization

Because our cost analysis included only hospital stays that ended during October 2008, Medicare costs associated with care resulting from adverse events and temporary harm events are greater than our estimate. Beneficiaries may have had additional event-related hospital stays beyond our study period and may have incurred expenses to Medicare or personal expenses for followup care not reflected in inpatient claims, such as physician office visits, medication, and rehabilitation services during and after our study period.

[60] Averages reflect only costs greater than zero.

[61] The Student's T-test comparing difference of means was significant at the 95-percent confidence level (p=0.0104).

As an example of an event resulting in subsequent Medicare costs not captured by our cost analysis, one sample beneficiary was initially admitted to the hospital in mid-October 2008 for a stroke. During this hospital stay, he experienced an allergic reaction to medication and was discharged with no additional cost associated with the event. However, following discharge, the allergic reaction progressed to a life-threatening condition known as Stevens-Johnson Syndrome.[62] The beneficiary returned to the hospital during October for treatment, incurring the cost of an entire hospital stay as a result of the event, but was misdiagnosed and again discharged. The patient then incurred two additional hospital stays within the next 30 days to correctly diagnose and treat the condition. The total estimated inpatient cost to Medicare for the latter three hospital stays was $43,050, all necessitated by the event. Only $10,982 of this amount was incurred during the study period and included in our cost estimate. Physician reviewers determined that the medication-related event was preventable because the medication was known to be highly reactive and the condition was not diagnosed correctly, delaying treatment.

[62] This condition typically begins with a skin rash and fever and, if untreated, progresses to an array of conditions constituting serious harm, such as lung damage and renal failure.

RECOMMENDATIONS

In the decade since the IOM report, the need to improve patient safety has received much attention from Federal and State governments, advocacy groups, and the health care industry. Despite this attention, we found that 13.5 percent of Medicare beneficiaries experienced adverse events during their hospital stays in October 2008, most of which resulted in prolonged hospital stays, permanent harm, life-sustaining interventions, or death. An additional 13.5 percent of beneficiaries experienced temporary harm as the result of events. Physician reviewers determined that 44 percent of events were preventable and that preventable events often involved medical errors, substandard care, and inadequate monitoring or assessment of patients. We found that in addition to causing the harm to patients, adverse events and temporary harm events increased costs to Medicare by an estimated $324 million in a single month, or 3.5 percent of Medicare inpatient expenditures, suggesting potential savings from reducing the incidence of events.

As the Federal Government's principal agency for protecting the health of Americans,[63] HHS is uniquely positioned to lead national efforts to reduce adverse events in hospitals. As part of the national strategy to improve health care quality mandated by the ACA, HHS is to "identify areas in the delivery of health care services that have the potential for rapid improvement in the quality and efficiency of patient care."[64]

Because many adverse events that we identified were preventable, our study confirms the need and opportunity for hospitals to significantly reduce the incidence of events. A number of agencies within HHS share responsibility for addressing this issue, most prominently AHRQ as a coordinating body for efforts to improve health care quality and CMS as the Nation's largest health care payer and an oversight entity.

Therefore, we recommend the following:

AHRQ and CMS should broaden patient safety efforts to include all types of adverse events

Efforts to improve patient safety often focus on a small subset of events that harm hospital patients. For example, NQF Serious Reportable Events or Medicare HACs represented only a fraction of

[63] HHS, *HHS Agency Mission Statement*, updated February 2004. Accessed at http://www.hhs.gov/about/ on March 23, 2010.

[64] P.L. 111-148 § 3501.

the adverse events we identified in this report. Additionally, patient safety provisions in the ACA often refer specifically to reducing medical errors, rather than to the broader range of adverse events. AHRQ and CMS should avoid focusing patient safety efforts too narrowly on a small list of specific events, possibly failing to address the wider array of events that lead to most instances of patient harm. Rather, AHRQ and CMS should promote a definition of adverse events that more fully encompasses harm resulting from medical care. This broader definition would apply to a number of patient safety activities, including setting priorities for research, establishing guidelines for hospital reporting of events, developing prevention strategies, measuring health care quality, and determining payment policies.

AHRQ and CMS should enhance efforts to identify adverse events

Identifying adverse events assists policymakers and clinical researchers in directing prevention resources to the areas of greatest need, setting clear goals for improvement, assessing the effectiveness of specific strategies, holding hospitals accountable, and gauging progress in reducing incidence.

- **AHRQ should sponsor periodic, ongoing measurement of the incidence of adverse events.** To facilitate measurement, AHRQ should establish a standard protocol for identifying events and analyzing information about incidence and causes. AHRQ should also consider providing hospitals with methods for measuring their incidence of events, goals for incidence reduction, and benchmarks or other means for comparing rates among providers.

- **AHRQ should continue to encourage hospitals to report to PSOs.** Hospital reporting of adverse event information to PSOs can provide AHRQ with aggregated data about the nature and causes of events. To maximize the usefulness of PSO-reported data for national measurement and analysis, AHRQ should continue working toward establishing standard adverse event definitions and reporting formats and encouraging hospital reporting.

- **CMS should use POA indicators in hospital billing data to calculate the frequency of adverse events occurring within hospitals.** These POA indicator data represent a rich source of information for identifying certain adverse events in claims data. CMS should establish routine methods for using POA indicators to guide patient safety improvement efforts. For example, CMS could direct that

QIOs use POA indicators to monitor hospital rates of specific conditions.

CMS should provide further incentives for hospitals to reduce the incidence of adverse events through its payment and oversight functions

CMS, as both a payer and an oversight entity, is positioned to influence hospitals to provide high-quality care. CMS should explore avenues to reduce the incidence of adverse events through both program participation and payment policy.

- **CMS should strengthen the Medicare HAC policy.** We found that HACs represent a small proportion of preventable events and that they are not always coded as such in Medicare claims. The ACA makes several changes to the HAC policy, including allowing the Secretary to expand the list of HACs. The law also gives the HAC policy greater significance by using the list of HACs to implement Medicare payment penalties, create performance measures, and prohibit Medicaid payments for associated care. Given their low incidence, continued use of the 10 HACs already established by CMS may limit the intended effect of the statute. To strengthen the policy, CMS should consider expanding the list of Medicare HACs to include more conditions that may result in harm to beneficiaries. CMS should also take additional steps to ensure that hospitals accurately code Medicare claims to show when HACs occur, as recommended in our prior report.[65]

- **CMS should look for opportunities to hold hospitals accountable for adoption of evidence-based practice guidelines.** The conditions of participation for Medicare and Medicaid require that hospitals have programs to demonstrate quality improvement where evidence shows practices can improve outcomes. CMS should further influence hospitals to reduce adverse events through enforcement of the conditions of participation. This could include more closely examining patient safety issues through the survey and certification process, as recommended in our prior report.[66] This could also include encouraging hospitals to adopt evidence-based practices shown to prevent adverse events.

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[65] OIG, *Adverse Events in Hospitals: Methods for Identifying Events*, OEI-06-08-00221, March 2010.

[66] Ibid.

South Carolina Medical Malpractice Liability Insurance
Joint Underwriting Association

NOTICE TO POLICYHOLDERS

New Professional Liability Policy

Occurrence Form – SCJUA PD-100 (Ed. 09/03)

Effective October 1, 2003

The Board of Directors of the South Carolina Medical Malpractice Liability Insurance Joint Underwriting Association, with the approval of the South Carolina Department of Insurance, attach herewith a revised policy form that is being issued to all individual healthcare providers, as well as professional associations upon renewal. Please take a moment to read the enclosed policy and the suggestions below and feel free to contact your insurance agent should you have questions. We wish to thank you for selecting the South Carolina Medical Malpractice Liability Insurance JUA as your professional liability carrier. We pledge our continued commitment to serving the healthcare providers of South Carolina.

Suggestions to Policyholder

1. Do not contract any expense; assume any liability; make any settlement; nor agree to a review of a case by any arbitration committee, medicolegal panel or other quasi-judicial body without the consent of the JUA.
2. Retain complete records reflecting dates, diagnosis and treatment. Do not overlook making entries of telephone conversations. Records will refresh your memory and serve as the basis for your defense. Claims may arise many years after services are rendered.
3. Contact the JUA or its representative immediately after any unusual occurrence, accident or mistake in your practice or before attending an inquest in any case which may give rise to a claim against you.
4. Contact the JUA before complying with any request to discuss or make a statement concerning professional services you have rendered if a claim is filed or anticipated. We want to be of service to you.

SC JUA

SCJUA NTP 100 (Ed. 10/03)

EXHIBIT 30

ALL-STATE LEGAL®

ATTACHMENT 14

ASSESSABLE POLICY



South Carolina Medical Malpractice Liability Insurance

Joint Underwriting Association

P.O. Box 128 • Greenville, South Carolina 29602

This Policy is not complete unless a Declarations Page is attached.

PROFESSIONAL LIABILITY POLICY

South Carolina Medical Malpractice Liability Insurance
Joint Underwriting Association

OCCURRENCE COVERAGE FORM

Throughout this policy, the words you, your and Insured refer to the Named Insured shown in the declarations and any other person or entity qualifying as an insured.

In consideration of the receipt of premium, in reliance upon the statements contained in the application and underwriting questionnaire, and the compliance by the Insured with the terms and conditions set forth herein, subject to the declarations attached hereto and made a part hereof, limits of liability, exclusions, conditions and other terms of this Policy, the South Carolina Medical Malpractice Liability Insurance Joint Underwriting Association, herein called the Association, agrees with the Insured as follows:

I. WHO IS THE INSURED

If you are designated in the declarations as:

A. An individual – each individual named in the declarations is an insured and Insuring Agreements, Section II A(1), applies to you.

B. A Partnership, Association or Corporation – the partnership, association or corporation described in the declarations and any member, partner, officer, or director thereof is the insured with respect to acts or omissions arising in the scope and course of the operations of such Partnership, Association or Corporation and Insuring Agreements, Section II A(2), applies to you.

II. INSURING AGREEMENTS

A.

(1) Coverage – Individual Professional Liability

To pay on behalf of the insured all sums which the insured shall become legally obligated to pay as damages because of any claim or claims made against the insured arising out of a medical incident while in the performance of professional services rendered or which should have been rendered, during the policy period, by the insured. The Association shall have the right and duty to defend any suit against the insured alleging damages, even if such suit is groundless, false or fraudulent, but the Association shall have the right to make such investigation and settlement of any claim or suit as may be deemed appropriate by the Association. However, we will have no duty to defend the insured against any "suit" to which this insurance does not apply. The Association shall not be obligated to pay any claim or judgment or to defend any suit after the applicable limit of the Association's liability has been exhausted by payment of judgments or settlements.

If the insured elects coverage for the employees as reflected in the declarations, the Association agrees to pay on behalf of the insured all sums the insured shall be obligated vicariously to pay as damages because of any claim or claims made against the insured arising out of a medical incident which is caused by your employee during the policy period. This coverage applies to all employees, except those listed herein, while acting within the scope of their employment and working under your supervision. This coverage does not apply to the following

employees: physicians, dentists, pharmacists, chiropractors, podiatrists, nurse anesthetists, physician assistants, nurse practitioners, nurse midwives, perfusionists, and surgical techs.

(2) Coverage – Partnership, Association or Corporation Professional Liability

To pay on behalf of the insured all sums which the insured shall become legally obligated to pay as damages because of any claim or claims made against the insured arising out of a medical incident which occurs during the policy period by any person for whose acts or omissions the professional partnership, association or corporate insured is legally liable. This coverage shall not apply with respect to the legal liability for the actions of any physician, dentist, pharmacist, chiropractor, podiatrist, nurse anesthetist, physician assistant, nurse practitioner, nurse midwife, perfusionist, or surgical tech unless they have an individual professional liability policy. The Association shall have the right and duty to defend any suit against the insured alleging damages, even if such suit is groundless, false or fraudulent, but the Association shall have the right to make such investigation and settlement of any claim or suit as may be deemed appropriate by the Association. However, we will have no duty to defend the insured against any "suit" to which this insurance does not apply. The Association shall not be obligated to pay any claim or judgment or to defend any suit after the applicable limit of the Association's liability has been exhausted by payment of judgments or settlements.

B. Supplementary Payments

The Association will pay, in addition to the applicable limit of liability, all expenses incurred by the Association, all costs taxed against the insured in any suit defended by the Association, and all interest on that portion of any judgment up to the amount of the limit of liability shown in the declarations which accrues after entry of the judgment and before the Association has paid or tendered or deposited in court that part of the judgment which does not exceed the limit of the Association's liability thereon.

C. Territory

This policy applies to medical incidents which occur during the policy period within the United States of America, its territories and possessions, or Canada and further providing the insured practices at least eighty-percent (80%) of his time in South Carolina.

III. EXCLUSIONS – CLAIMS NOT COVERED

This insurance does not apply to any claims:

A. Arising from any act, error, or omission committed by any insured that is dishonest, fraudulent, malicious, criminal or deliberately wrongful.

B. Arising from any act, error, or omission which has been prohibited by any licensing body or credentialing organization.

C. Arising from your affiliation with any hospital, sanitarium, clinic with bed and board facilities, nursing home, laboratory, or other business enterprise as an owner, operator, director, medical director or executive officer. This exclusion does not apply to your direct liability for providing, or failing to provide professional services to your patients or as a member of a formal accreditation, standards review or similar professional board or committee, including the directives of such board or committee.

D. Arising from disputes about your fees, including collecting fees from third parties, except that portion of any claim arising from a medical incident.

E. Alleging a refund or credit for fees paid to any insured from any source for professional services rendered by any insured.

F. Arising out of allegations of Medicare, Medicaid, or private insurer fraud.

G. Arising from discrimination on any basis whatsoever.

H. Arising out of any act, error or omission in which you expected or intended injury or damage, regardless of whether you expected or intended the specific injury or damage sustained.

I. Alleging bodily injury or property damage in any way involving the ownership, maintenance or use of an automobile, watercraft or aircraft.

J. For injury or damage to:

- your employees or independent contractor working for you, arising out of his or her work; or any obligation for which the insured or any carrier acting as insurer may be held liable under any workers' compensation, unemployment compensation or disability benefits law or under any similar law;

- the spouse or relative or such employee or independent contractor as a consequence of injury or damage to the employee or independent contractor.

This exclusion applies:

- whether you are liable as an employer or in any other capacity; and
- to any obligation to share damages with or repay someone else who must pay damages because of the injury.

K. Alleging any direct or consequential injury or damage arising out of any:

- refusal to employ;
- termination of employment; or
- coercion, demotion, reassignment, defamation, harassment, humiliation, discrimination, or other employment-related practices, policies, acts, or omissions.

L. Arising from

- a tanning bed, massage therapy, synthetic hair implants, chelation therapy; or
- the prescription of drugs not approved by the FDA, or any other type of experimental or non-standard therapy administered without written informed patient consent.

M. Arising from any type of sexual action, undue familiarity, or sexual disease transmission. Sexual action includes, but is not limited to, any behavior with sexual connotation or purpose -- whether performed for sexual gratification, harassment, assault, molestation, discrimination, intimidation, coercion, or other reason. This exclusion applies even if an alleged cause of the damages was the insured's negligent hiring, placement, training, supervision, act, error or omission.

N. Alleging injury for which you:

- are also insured under a nuclear energy liability policy; or
- would be insured under that policy but for the exhaustion of its limit of liability.

A nuclear energy liability policy is issued by:

- American Nuclear Insurers;
- Mutual Atomic Energy Liability Underwriters;
- Nuclear Insurance Association of Canada; or any of their successors.

O. Arising out of any business relationship between you and any past or present patient, client, employee or employer.

P. Arising out of any unfair trade or collection practice, or arising out of any anti-trust violation or uncompetitive practice.

Q. Alleging property damage to:

- property you own, rent, occupy, borrow or use;
- premises you have sold, given away or abandoned;
- property in your care, custody or control.

R. Alleging bodily injury or property damage on or arising out of premises you own, rent or occupy.

S. Alleging liability of others you assume under any contract or agreement.

T. Arising out of any act for which you did not have a license to perform such act as required by law.

U. Arising out of the performance of professional services while you were under the influence of a drug or intoxicant.

V. Arising out of any act or medical incident covered under any policy in effect before this policy. This exclusion applies whether or not that prior policy has any limits of coverage remaining.

W. Arising out of the actual, alleged, or threatened discharge, dispersal, release, or escape of pollutants, or any direction or request, to test for, monitor, clean up, remove, contain, treat, detoxify, or neutralize pollutants.

X. Caused directly or indirectly by war, including undeclared war, civil war, insurrection, rebellion, revolution, warlike act by a military force or military personnel or destruction or seizure for use for a military purpose.

Y. Alleging any personal or advertising injury.

Z. Arising from any violation of a statute, ordinance or regulation including, but not limited to, the Health Insurance Portability and Accountability Act (HIPAA), and any fines or penalties related thereto. This exclusion does not apply to a claim made by your patient alleging the disclosure of medical information to an unauthorized person or entity.

IV. LIMITS OF LIABILITY

The limit of liability stated in the declarations as applicable to each "claim" is the limit of the Association's liability for loss resulting from any medical incident causing injury or death, regardless of the number of:

1) Persons injured,
2) Claims made,
3) Claimants, or
4) Subsequent related or derivative claims.

The limit of liability stated in the declarations as "annual aggregate" is the total limit of the Association's liability during the policy period.

V. CONDITIONS

A. Insured's Duties

1. The Insured has a duty to notify the Association in writing of any change in the Insured's medical practice. To the extent such change increases the Insured's risk classification, the Association will adjust the premium for this policy and collect the difference in premium as of the date of such change. The Association has the right to adjust premiums at any time based on rates and rating plans in effect at the time.

2. Upon the Insured becoming aware of any medical incident or alleged injury, written notice containing the fullest information obtainable with respect to the circumstances, time and place thereof, and the names and addresses of the injured person and of available witnesses shall be given by or for the Insured to the Association or any of its authorized agents as soon as practicable. The Insured shall promptly take at their expense all reasonable steps to prevent other injury from arising out of the same or similar conditions, but such expense shall not be recoverable under this Policy.

3. If claim is made or suit is brought against the Insured, the Insured shall immediately forward to the Association every demand, notice, summons, complaint or other legal documents received by him or his representative.

4. The Insured shall cooperate with the Association and, upon the Association's request, assist in making settlements, in the defense of suits and in enforcing any right of contribution or right of indemnity against any person or organization who may be liable to the Insured because of bodily injury with respect to which insurance is afforded under this policy. The Insured shall do nothing after loss to prejudice or impair such rights, and shall attend depositions, hearings, and trials and assist in securing and giving evidence and obtaining the attendance of witnesses.

5. The Insured shall in no way alter any medical record after a medical incident has occurred. An addendum to the original record by the Insured which is signed and dated shall not be considered an alteration.

6. The Insured shall not assume any financial obligation or pay out any money without the prior consent of the Association. If the Insured does, it will be at the Insured's own expense.

If you fail to comply with your duties outlined under this policy, your failure to do so may result in the denial of coverage by the Association.

B. Special Verdicts or Special Interrogatories

As a condition of coverage, Insured agrees that Insured's appointed or personal defense counsel, upon request made by Association, shall make a motion to the trial court and otherwise consent to the submission of a special verdict form or special interrogatories to the jury to determine on what causes of action or on what claims a jury's verdict is returned or any other reasonable factual inquiry for the jury as may be determined by the Association.

C. Action Against the Association

No action shall lie against the Association unless, as a condition precedent thereto, there shall have been full compliance with all of the terms of this Policy by the Insured, nor until the amount of the insured's obligation to pay shall have been finally determined either by judgment against the Insured or by written agreement of the claimant and the Association. Any person or organization or the legal representative thereof who has secured such judgment or written agreement shall thereafter be entitled to recover under this Policy to the extent of the

insurance afforded by this Policy. No person or organization shall have any right under this Policy to join the Association as a party in any action against the insured to determine the insured's liability, nor shall the Association be impleaded by the insured or his legal representative. Bankruptcy or insolvency of the insured or of the insured's estate shall not relieve the Association of any of its obligations hereunder.

D. Other Insurance

A medical incident covered under this policy may also be covered under another policy issued to you, or for which you are an insured. This policy will apply in excess of such other coverage no matter how such other coverage is described. On an excess, contingent, or primary basis, this policy will come into effect only after such other insurance has been exhausted. This clause will not apply to coverage which is expressly stated to apply in excess of this specific policy.

When the insurance afforded by this policy and any other insurance both apply to a medical incident on the same basis, whether primary, excess or contingent, the Association shall not be liable under this policy for a greater proportion of the damages than the applicable limit of liability under this policy for such damages bears to the total applicable limits of liability of all valid and collectible insurance for the medical incident.

E. Recovering Damages from a Third Party

You may be able to recover all or part of a loss from someone other than the Association. You therefore must do all that is possible after a loss to preserve any such right of recovery. If the Association makes a payment under this policy, that right of recovery, to the extent of any payments made by the Association on your behalf will belong to us. You will do whatever is necessary, including signing documents, to assist the Association in obtaining that recovery.

F. Policy Changes

This policy contains all the agreements between you and the Association concerning this insurance. The Named Insured in the declarations, or their authorized agent, is authorized to make changes in this policy with the Association's consent. This policy can only be changed by a written endorsement we issue and make a part of this policy.

Notice to any agent or knowledge possessed by any agent or by any other person shall not effect a waiver or a change in any part of this policy or estop the Association from asserting any right under the terms of this policy; nor shall the terms of this policy be waived or changed, except by endorsement issued by the Association to form a part of this policy.

G. Assignment

The interest under this policy of any insured is not assignable without the express written consent of the Association and shall not bind the Association until its consent is endorsed hereon; if, however, the Named Insured shall die, such insurance as is afforded by this policy shall apply to the Named Insured's legal representative, as the Named Insured, but only while acting within the scope of his duties as such.

H. Special Rights and Duties of First Named Insured

You agree that when there is more than one person or organization covered under this policy, the first Named Insured in the declarations shall act on behalf of all of you as to:

- giving and receiving notice of cancellation;
- payment of premiums and receipt of return premiums;
- acceptance of any endorsements to this policy.

I. Special Statutes

Any and all provisions of this policy which are in conflict with the statutes and regulations of the State of South Carolina are understood, declared and acknowledged by this Association to be amended to conform to such statutes and regulations.

J. Declarations

By acceptance of this policy, the Named Insured agrees that the statements in the application, underwriting questionnaire and declarations are the insured's agreements and representations and that this policy is issued in reliance upon the truth of such representations and that this policy and application therefore embody all agreements existing between the Insured and the Association.

K. Licensure

In consideration of the premiums charged, it is a condition precedent to continued coverage that the Insured have a proper Healthcare Providers License and qualifications.

L. Liability for Assessment

Pursuant to the provisions of a Joint Resolution of the South Carolina General Assembly and Regulation R5-75 of the South Carolina Department of Insurance, this policy shall be assessable during the lifetime of the Association, the assessment not to exceed one annual premium at the rate in effect for the policy period for which the assessment is necessary. Failure to pay any assessment made by the Association will result in the termination of coverage for any claims occurring during the policy period assessed and any claims reported after the date of assessment.

M. Sole Agent

The Named Insured in the declarations, or their authorized agent, shall act on behalf of all Insureds with respect to giving and receiving notice of cancellation, accepting any endorsement issued to form a part of this policy and receiving return premium if any, and is charged with the responsibility for notifying the Association of any changes of members, partners, officers, directors or employees or any other change which might affect the insurance hereunder.

N. Cancellation and Non-Renewal Provisions

a) This policy may be cancelled by the Insured by mailing to the Association, or any of its authorized representatives, written notice. The cancellation shall become effective on the date requested by the Insured or the date the notice is received by the Association, whichever is later.

b) This policy may be cancelled by the Association by mailing or delivering written notice to the Insured at the Insured's last known address:

1) at least 10 days prior to the effective date of cancellation if the Insured has failed to pay a premium when due, whether the premium is payable directly to the Association or indirectly under a premium finance plan or extension of credit; or
2) at least 30 days prior to the effective date of cancellation if the Association cancels for any other reason.

This notice shall also be sent to the Insured's agent and shall include the reason(s) for the cancellation.

c) If this policy has been in effect for 90 days or more, or is a renewal policy, the Association may cancel this policy only for one or more of the following reasons:

1) nonpayment of premium;
2) material misrepresentation of fact which, if known to the Association, would have caused the Association not to issue the policy;
3) substantial change in the risk assumed, except to the extent that the Association should reasonably have foreseen the change or contemplated the risk in writing the policy;
4) substantial breaches of contractual duties, conditions, or warranties.

d) If the Insured cancels this policy, earned premium shall be computed in accordance with the standard short rate tables and procedures. If the Association cancels this policy, earned premium shall be computed pro rata. Premium adjustments shall be made within a reasonable period of time after cancellation, but payment or tender of such unearned premium shall not be a condition of cancellation.

e) If the Association elects not to renew this policy, the Association shall mail or deliver written notice of the nonrenewal, including the reason for the nonrenewal, to the Insured at the Insured's last known address and to the Insured's agent not less than 30 days prior to the expiration date provided in the policy.

VI. DEFINITIONS

Unless otherwise stated in a respective coverage part or endorsement, where any of the following terms are found in bold print within this policy, they will have only the meaning shown below:

A. Automobile means a land vehicle, self-propelled or not, a trailer, or a semi-trailer. This includes any machinery or apparatus attached, whether or not subject to motor vehicles registration or designed for use principally on public roads.

B. Bodily injury means bodily harm, sickness, or disease, including death resulting therefrom.

C. Claim(s) means a demand for money damages. Administrative proceedings (including, but not limited to, disciplinary matters) and criminal proceedings are not claims.

D. Declarations means the Declarations Page issued by the Association to the insured, which lists the applicable coverages and coverage amounts.

E. Medical Incident means any act, error, or omission in your providing or failure to provide professional medical services.

Any such act, error or omission, together with all related or concurrent acts, errors or omissions in the furnishing of such services to any one person shall be considered one medical incident, regardless of the length of time or number of contacts such person may have with the insured.

F. Personal or advertising injury means injury arising out of one or more of the following offenses:

- false arrest, detention or imprisonment;
- malicious prosecution;
- the wrongful eviction from, wrongful entry into, or invasion of the right of private occupancy of a room, dwelling or premises that a person occupies, by or on behalf of its owner, landlord or lessor;
- oral or written publication of material that slanders or libels a person or organization or disparages a person's or organization's goods, products or services; or
- oral or written publication of material that violates a person's right of privacy.
- the use of another's advertising idea in your "advertisement"; or
- infringing upon another's copyright, trade dress or slogan in your "advertisement"

G. Policy period means the period commencing on the effective date shown in the declarations. This period ends on the earlier of either the expiration date or the effective date of cancellation of this policy. If any person becomes an insured under this policy after the effective date, the policy period with respect to that person begins on the date they became an insured.

H. Pollutants means any solid, liquid, gaseous, or thermal irritant or contaminant, including: smoke, vapor, soot, fumes, acids, alkalis, chemicals and waste. "Waste" includes material to be recycled, reconditioned or reclaimed.

I. Professional services means those services for which you are licensed, trained and qualified to perform in your capacity as a healthcare provider. Professional services also mean your services as a member of a formal accreditation, standards review, or similar professional board or committee, including the directives of such board or committee.

J. Property damage means (1) physical injury to, or destruction of, tangible property including the loss of use of it; or (2) loss of use of tangible property, which has not been physically injured or destroyed.

K. Suit means a civil proceeding in a court of law or an arbitration proceeding to which the insured is required to submit or to which the insured has submitted with the consent of the Association.

IN WITNESS WHEREOF, we have caused this policy to be signed by our Chairman and countersigned where required by law on the Declarations Page by our duly authorized representative.

Chairman of the Board

PROFESSIONAL LIABILITY POLICY

South Carolina Medical Malpractice Liability Insurance

Joint Underwriting Association

Policy Declarations

ASSESSABLE

CLAIMS MADE

Rewrite of: JBM00560

Policy Number: JBC00041

Item 1. Named Insured and Business Address:

Byron A Brown
700 Plaza Circle Suite N
Clinton, SC 29325

AGENCY

Joe H. Kirby
Attn: Broker
918 West Main Street
Laurens, SC 29360-2645

Item 2. Policy Period: (Mo. Day Yr.)

From 7/9/2008 **To** 7/9/2009

12:01 A.M., standard time at the address of the named insured as stated herein.

Item 3. The limit of the Association's liability shall be as stated herein, subject to all of the terms of this policy having reference hereto.

Coverage	Limits of Liability	Premium
PROFESSIONAL LIABILITY CLAIMS MADE PRIOR ACTS DATE: 07/09/2008	$200,000 EACH CLAIM $600,000 ANNUAL AGGREGATE	$14,004.00

Employees as Additional Insureds: Included

Obstetrics - Gynecology

The following listed forms / endorsements are issued as part of this policy and are incorporated therein.

Forms / Endorsement Schedule:

SC JUA PL-200 (Ed. 10/06)
JUA PD-101A (Ed. 11/05)

EXHIBIT 34 ALL-STATE LEGAL®

COUNTERSIGNATURE DATE:	AUTHORIZED REPRESENTATIVE:	DATE ISSUED: 8/4/2008

Claims Made Policy

South Carolina Medical Malpractice Liability Insurance
Joint Underwriting Association
P. O. Box 128 – Greenville, SC 29602
550 S. Main Street – Suite 600 – Greenville, SC 29601
Phone: 864-240-5400 Fax: 864-240-2750

NOTICE TO POLICYHOLDERS

Professional Liability Policy

Claims Made Coverage Form – SCJUA PL-200 (Ed. 10/06)

The Board of Directors of the South Carolina Medical Malpractice Liability Insurance Joint Underwriting Association attached herewith the Declarations Page and Endorsements (if applicable) of your Claims Made Coverage policy form. Please note that if claims made coverage is discontinued, a Reporting Endorsement ("Tail Coverage") must be purchased to provide coverage for claims which have occurred but not yet reported.

The JUA would like to specifically direct your attention to the **"Insured's Duties"** section which begins on page 7 of the policy form. This section requires an insured to promptly notify the JUA in a wide variety of circumstances, included but not limited to:

- any **change** in your medical practice
- any **knowledge** of an **adverse medical incident** or alleged injury
- any **letter** from an attorney or patient **alleging improper treatment**, requesting medical records, or advising you to notify your insurance carrier
- any **demand, notice, summons, complaint, subpoena or other legal document**
- any **request for records, deposition request** or other **inquiry** as it may relate to an **adverse medical incident** of a patient **regardless of whether it appears that you are being implicated.**

If you are presented with any of these circumstances, please **contact the JUA immediately (864-240-5400)** in order that we may provide you with the appropriate information and assist you if necessary. Failing to do so could jeopardize your insurance coverage or worsen the risk associated with an adverse medical incident.

In addition, with respect to any claim or potential claim, do not discuss the circumstances with anyone until you have received authorization from the JUA. Do not make any alterations or changes to the existing medical or office records.

Thank you for selecting the South Carolina Medical Malpractice Liability Insurance JUA as your professional liability carrier. We pledge our commitment to serving the healthcare providers of South Carolina.

ASSESSABLE POLICY



PROFESSIONAL LIABILITY POLICY

South Carolina Medical Malpractice Liability Insurance

Joint Underwriting Association

CLAIMS MADE COVERAGE FORM

This policy is not complete unless a Declarations Page is attached.
PLEASE REVIEW THIS POLICY CAREFULLY

THIS POLICY IS LIMITED TO LIABILITY FOR ONLY THOSE CLAIMS THAT ARE FIRST MADE AGAINST THE INSURED AND REPORTED TO THE ASSOCIATION DURING THE POLICY PERIOD UNLESS AND TO THE EXTENT THAT AN EXTENDED REPORTING PERIOD OF TIME APPLIES.

Throughout this policy, the words **you, your** and **Insured** refer to the Named Insured shown in the declarations and any other person or entity qualifying as an insured.

In consideration of the receipt of premium, in reliance upon the statements contained in the **application** and in consideration of the compliance by the insured with the terms and conditions set forth herein, subject to the declarations attached hereto and made a part hereof, limits of liability, exclusions, conditions and other terms of this Policy, the South Carolina Medical Malpractice Liability Insurance Joint Underwriting Association, herein called the **Association**, agrees with the **Insured** as follows:

I. WHO IS THE INSURED

If you are designated in the **declarations** as:

A. An individual – each individual named in the **declarations** is an insured and Insuring Agreements, Section II A(1), applies to **you**.

B. A Partnership, Association or Corporation – the partnership, association or corporation described in the **declarations** and any member, partner, officer, or director thereof is the insured with respect to acts or omissions arising in the scope and course of the operations of such Partnership, Association or Corporation and Insuring Agreements, Section II A(2), applies to **you**.

II. INSURING AGREEMENTS

A.

(1) **Coverage – Individual Professional Liability**

To pay on behalf of the **Insured** all sums which the **Insured** shall be legally obligated to pay as **Damages** for **Claims** first made against the **Insured** and reported to the **Association** during the **Policy Period**, or **Extended Reporting Period**, as applicable, arising out of a **medical incident**

while in the performance of **professional services** rendered or which should have been rendered by the **Insured**, or by any person for whose acts the **Insured** is legally responsible, provided always that such **Medical Incident** happens:

a. on or after the effective date shown on the Declarations; or

b. at any time prior to the policy effective date shown on the Declarations, if;

1. such **Medical Incident** happens on or subsequent to the prior acts date on the Declarations and;

2. there is no prior policy or policies which provide insurance (including any Automatic or Optional **Extended Reporting Period** or similar provision of such policies) for such **Medical Incident**, unless the available limits of liability of such prior policy or policies are insufficient to pay any **Medical Incident**, in which event this policy will be specific excess over any such prior coverage, subject to this policy's terms, limits of liability, exclusions and conditions.

The **Association** shall have the right and duty to defend any **Suit** against the **Insured** seeking **Damages** to which this insurance applies even if any of the allegations of the **Suit** are groundless, false or fraudulent. The **Association**, at its option, shall select and assign defense counsel; however, the **Insured** may engage additional counsel, solely at the **Insured's** expense, to associate in their defense of any **Claim** covered hereunder. **Claims Expenses** incurred by the **Association** shall be paid in addition to the applicable limits of liability.

The **Association** shall also have the right to investigate any **Claim** and/or negotiate the settlement thereof, as it deems expedient.

Furthermore, no **Insured** shall admit liability, assume any obligations, incur any costs, charges or expenses or enter into any settlement without the **Association's** written consent.

In no event shall the **Association** be obligated to pay any Damages or **Claim Expenses** or to defend, or continue to defend, any **Suit** after the applicable limit of the **Association's** liability has been exhausted by payment of judgments or settlements.

Employee Coverage Election -- If the **insured** elects coverage for the employees as reflected in the **declarations**, the **Association** agrees to pay on behalf of the **insured** all sums the **insured** shall be obligated vicariously to pay as damages because of any **claim** or **claims** first made against the **Insured** and reported to the **Association** during the **Policy Period**, or **Extended Reporting Period**, as applicable, arising out of a **medical incident** while in the performance of **professional services** rendered or which should have been rendered by the **Insured** and reported to the **Association** during the **Policy Period**, or **Extended Reporting Period**, as applicable, which is caused by your employee. This coverage applies to all employees, except those listed herein, while acting within the scope of their employment and working under your supervision, provided always that such **Medical Incident** happens:

a. on or after the effective date shown on the Declarations; or

b. at any time prior to the policy effective date shown on the Declarations, if;

1. such **Medical Incident** happens on or subsequent to the prior acts date on the Declarations and;

2. there is no prior policy or policies which provide insurance (including any Automatic or Optional **Extended Reporting Period** or similar provision of such policies) for such **Medical Incident**, unless the available limits of liability of such prior policy or policies are insufficient to pay any **Claim**, in which event this policy will be specific excess over any such prior coverage, subject to this policy's terms, limits of liability, exclusions and conditions.

This coverage does not provide a separate limit of coverage for the employees as each employee shall share in the limit of liability for the named insured identified on the declarations of this policy.

This coverage does not apply to the following employees: *physicians, dentists, pharmacists, chiropractors, podiatrists, nurse anesthetists, physician assistants, nurse practitioners, nurse midwives, perfusionists, and surgical techs.*

(2) **Coverage – Partnership, Association or Corporation Professional Liability**

To pay on behalf of the **Insured** all sums which the **Insured** shall be legally obligated to pay as **Damages** for **Claims** first made against the **Insured** and reported to the **Association** during the **Policy Period**, or **Extended Reporting Period**, as applicable, arising out of a **medical incident** while in the performance of **professional services** rendered or which should have been rendered by the **Insured**, or by any person for whose acts or omissions the professional partnership, association or corporate **insured** is legally liable, provided always that such **Medical Incident** happens:

A. on or after the effective date shown on the Declarations; or

B. at any time prior to the policy effective date shown on the Declarations, if;

1. such **Medical Incident** happens on or subsequent to the prior acts date on the Declarations and;

2. there is no prior policy or policies which provide insurance (including any Automatic or Optional **Extended Reporting Period** or similar provision of such policies) for such **Medical Incident**, unless the available limits of liability of such prior policy or policies are insufficient to pay any **Medical Incident**, in which event this policy will be specific excess over any such prior coverage, subject to this policy's terms, limits of liability, exclusions and conditions.

This coverage shall not apply with respect to the legal liability for the actions of any *physician, dentist, pharmacist, chiropractor, podiatrist, nurse anesthetist, physician assistant, nurse practitioner, nurse midwife, perfusionist, or surgical tech* unless they have an individual professional liability policy.

The **Association** shall have the right and duty to defend any **Suit** against the **Insured** seeking **Damages** to which this insurance applies even if any of the allegations of the **Suit** are groundless, false or fraudulent. The **Association**, at its option, shall select and assign defense counsel; however, the **Insured** may engage additional counsel, solely at the **Insured's** expense, to associate in their defense of any **Claim** covered hereunder. **Claims Expenses** incurred by the Company shall be paid in addition to the applicable limits of liability.

The **Association** shall also have the right to investigate any **Claim** and/or negotiate the settlement thereof, as it deems expedient.

Furthermore, no **Insured** shall admit liability, assume any obligations, incur any costs, charges or expenses or enter into any settlement without the **Association's** written consent.

In no event shall the **Association** be obligated to pay any Damages or **Claim Expenses** or to defend, or continue to defend, any **Suit** after the applicable limit of the **Association's** liability has been exhausted by payment of judgments or settlements.

B. **Supplementary Payments**

The **Association** will pay, in addition to the applicable limit of liability, all expenses incurred by the **Association**, all costs taxed against the **insured** in any suit defended by the **Association**, and all interest on that portion of any judgment up to the amount of the limit of liability shown in the **declarations** which accrues after entry of the judgment and before the **Association** has paid or tendered or deposited in court that part of the judgment which does not exceed the limit of the **Association's** liability thereon.

C. **Territory**

This policy applies to medical incidents which occur during the policy period within the United States of America, its territories and possessions, or Canada and further providing the Insured practices at least eighty percent (80%) of his time in South Carolina.

D. **When A Claim Is Deemed First Made**

A **claim** is made the earliest of:

a. when the named insured notifies insurer or insurer's agent in writing of a circumstance involving a particular person which is likely to result in a claim; or
b. when the named insured receives written notice that a **Claim** has been made against a named insured.

All **claims** arising out of the same or related **Medical Incidents** shall be considered as having been made at the time the first such **claim** is made, and shall be subject to the same limit of liability.

III. EXCLUSIONS – CLAIMS NOT COVERED

This insurance does not apply to any **claims**:

A. Arising from any act, error, or omission committed by any **insured** that is dishonest, fraudulent, malicious, criminal or deliberately wrongful.

B. Arising from any act, error, or omission which has been prohibited by any licensing body or credentialing organization.

C. Arising from your affiliation with any hospital, sanitarium, clinic with bed and board facilities, nursing home, laboratory, or other business enterprise as an owner, operator, director, medical director or executive officer.

D. Arising from disputes about your fees, including collecting fees from third parties, except that portion of any **claim** arising from a **medical incident**.

E. Alleging a refund or credit for fees paid to any **insured** from any source for **professional services** rendered by any **insured**.

F. Arising out of allegations of Medicare, Medicaid, or private insurer fraud.

G. Arising from discrimination on any basis whatsoever.

H. Arising out of any act, error or omission in which **you** expected or intended injury or damage, regardless of whether **you** expected or intended the specific injury or damage sustained.

I. Alleging **bodily injury** or **property damage** in any way involving the ownership, maintenance or use of an automobile, watercraft or aircraft.

J. For injury or damage to:

- **your** employee or independent contractor working for **you**, arising out of his or her work; or any obligation for which the **insured** or any carrier acting as insurer may be held liable under any workers' compensation, unemployment compensation or disability benefits law or under any similar law;
- the spouse or relative or such employee or independent contractor as a consequence of injury or damage to the employee or independent contractor.

This exclusion applies:

- whether **you** are liable as an employer or in any other capacity; and
- to any obligation to share damages with or repay someone else who must pay damages because of the injury.

K. Alleging any direct or consequential injury or damage arising out of any:

- refusal to employ;
- termination of employment; or
- coercion, demotion, reassignment, defamation, harassment, humiliation, discrimination, or other employment related practices, policies, acts, or omissions.

L. Arising from

- a tanning bed, massage therapy, synthetic hair implants, chelation therapy; or
- the prescription of drugs not approved by the FDA, or any other type of experimental or non-standard therapy administered without written informed patient consent.

M. Arising from any type of sexual action, undue familiarity, or sexual disease transmission. Sexual action includes, but is not limited to, any behavior with sexual connotation or purpose – whether performed for sexual gratification, harassment, assault, molestation, discrimination, intimidation, coercion, or other reason. This exclusion applies even if an alleged cause of the damages was the insured's negligent hiring, placement, training, supervision, act, error or omission.

N. Alleging injury for which **you**:

- are also insured under a nuclear energy liability policy; or
- would be insured under that policy but for the exhaustion of its limit of liability.

A nuclear energy liability policy is issued by:

- American Nuclear Insurers;
- Mutual Atomic Energy Liability Underwriters;

- Nuclear Insurance Association of Canada; or any of their successors.

O. Arising out of any business relationship between you and any past or present patient, client, employee or employer.

P. Arising out of any unfair trade or collection practice, or arising out of any anti-trust violation or uncompetitive practice.

Q. Alleging property damage to:

- property you own, rent, occupy, borrow or use;
- premises you have sold, given away or abandoned;
- property in your care, custody or control.

R. Alleging **bodily injury** or **property damage** on or arising out of premises you own, rent or occupy.

S. Alleging liability of others you assume under any contract or agreement.

T. Arising out of any act for which you did not have a license to perform such act as required by law.

U. Arising out of the performance of **professional services** while you were under the influence of a drug or intoxicant.

V. Arising out of any act or **medical incident**

1. which has been reported to another insurance carrier prior to the first date coverage is provided under the **policy**;
2. which occurred prior to the first date coverage is provided under this policy, if on such date, the **insured** knew or believed, or had reason to know or believe, that such **medical incident** had occurred;
3. which occurred during a period in which the **insured** was not covered under a policy of professional liability insurance;
4. which occurred during a period in which the **insured** was covered under any policy in effect before this policy. This exclusion applies whether or not that prior policy has any limits of coverage remaining.

W. Arising out of the actual, alleged, or threatened, discharge, dispersal, release, or escape of **pollutants**, or any direction, or request, to test for, monitor, cleanup, remove, contain, treat, detoxify, or neutralize **pollutants**.

X. Caused directly or indirectly by war, including undeclared war, civil war, insurrection, rebellion, revolution, warlike act by a military force or military personnel or destruction or seizure for use for a military purpose.

Y. Alleging any **personal or advertising injury**.

Z. Arising from any violation of a statute, ordinance or regulation including, but not limited to, the Health Insurance Portability and Accountability Act (HIPAA.), and any fines or penalties related thereto.

IV. LIMITS OF LIABILITY

The limit of liability stated in the **declarations** as applicable to each "**claim**" is the limit of the **Association's** liability for loss resulting from any **medical incident** causing injury or death, regardless of the number of:

1) Persons injured,
2) **Claims** made,
3) Claimants, or
4) Subsequent related or derivative **claims**.

The limit of liability stated in the **declarations** as "annual aggregate" is the total limit of the **Association's** liability during the policy period.

V. CONDITIONS

A. Insured's Duties

1. The **insured** has a duty to notify the **Association** in writing within 30 days if the **insured's** medical practice changes so that the **Association** can determine the **insured's** risk classification and what premium is owed to the **Association.** The **Association** will calculate the premium for **insured's** risk classification for this policy using the information available at the time. If the information is incomplete or incorrect, the **Association** will have the right to recalculate the **insured's** premium. The **Association** has the right to adjust premiums at any time based on rates and rating plans in effect at the time.

2. Upon the **insured** becoming aware of any **medical incident** or alleged injury, written notice containing the fullest information obtainable with respect to the circumstances, time and place thereof, and the names and addresses of the injured person and of available witnesses shall be given by or for the **insured** to the **Association** or any of its authorized agents as soon as practicable. The **insured** shall promptly take at their expense all reasonable steps to prevent other injury from arising out of the same or similar conditions, but such expense shall not be recoverable under this Policy.

3. If **claim** is made or suit is brought against the insured, the **insured** shall immediately forward to the **Association** every demand, notice, summons, complaint or other legal documents received by him or his representative.

4. The **insured** shall cooperate with the **Association** and, upon the **Association's** request, assist in making settlements, in the defense of suits and in enforcing any right of contribution or right of indemnity against any person or organization who may be liable to the **insured** because of bodily injury with respect to which insurance is afforded under this policy. The **insured** shall do nothing after loss to prejudice or impair such rights, and shall attend depositions, hearings, and trials and assist in securing and giving evidence and obtaining the attendance of witnesses.

5. The **insured** shall in no way alter any medical record after a **medical incident** has occurred. An addendum to the original record by the **insured** which is signed and dated shall not be considered an alteration.

6. The **insured** shall not assume any financial obligation or pay out any money without the prior consent of the **Association**. If the **insured** does, it will be at the **insured's** own expense.

If **you** fail to comply with **your** duties outlined under this policy, **your** failure to do so may result in the denial of coverage by the **Association**.

B. **Special Verdicts or Special Interrogatories**

As a condition of coverage, **insured** agrees that **insured's** appointed or personal defense counsel, upon request made by **Association**, shall make a motion to the trial court and otherwise consent to the submission of a special verdict form or special interrogatories to the jury to determine on what causes of action or on what **claims** a jury's verdict is returned or any other reasonable factual inquiry for the jury as may be determined by the **Association.**

C. **Action Against the Association**

No action shall lie against the **Association** unless, as a condition precedent thereto, there shall have been full compliance with all of the terms of this Policy by the **insured**, nor until the amount of the **insured's** obligation to pay shall have been finally determined either by judgment against the Insured or by written agreement of the claimant and the **Association**. Any person or organization or the legal representative thereof who has secured such judgment or written agreement shall thereafter be entitled to recover under this Policy to the extent of the insurance afforded by this Policy. No person or organization shall have any right under this Policy to join the Association as a party in any action against the **insured** to determine the **insured's** liability, nor shall the **Association** be impleaded by the **Insured** or his legal representative. Bankruptcy or insolvency of the **insured** or of the **insured's** estate shall not relieve the **Association** of any of its obligations hereunder.

D. **Other Insurance**

A **medical incident** covered under this policy may also be covered under another policy issued to **you**, or for which **you** are an insured. This policy will apply in excess of such other coverage no matter how such other coverage is described. On an excess, contingent, or primary basis, this policy will come into effect only after such other insurance has been exhausted. This clause will not apply to coverage which is expressly stated to apply in excess of this specific policy.

When the insurance afforded by this policy and any other insurance both apply to a **medical incident** on the same basis, whether primary, excess or contingent, the **Association** shall not be liable under this policy for a greater proportion of the damages than the applicable limit of liability under this policy for such damages bears to the total applicable limits of liability of all valid and collectible insurance for the **medical incident.**

E. **Recovering Damages from a Third Party**

You may be able to recover all or part of a loss from someone other than the **Association**. You therefore must do all that is possible after a loss to preserve any such right of

recovery. If the **Association** makes a payment under this policy, that right of recovery, to the extent of any payments made by the **Association** on **your** behalf will belong to us. **You** will do whatever is necessary, including signing documents, to assist the **Association** in obtaining that recovery.

F. Policy Changes

This policy contains all the agreements between **you** and the **Association** concerning this insurance. The Named Insured in the **declarations**, or their authorized agent, is authorized to make changes in this policy with the **Association's** consent. This policy can only be changed by a written endorsement we issue and make a part of this policy.

Notice to any agent or knowledge possessed by any agent or by any other person shall not effect a waiver or a change in any part of this policy or estop the **Association** from asserting any right under the terms of this policy; nor shall the terms of this policy be waived or changed, except by endorsement issued by the **Association** to form a part of this policy.

G. Assignment

The interest under this policy of any insured is not assignable without the express written consent of the **Association** and shall not bind the **Association** until its consent is endorsed hereon; if, however, the Named Insured shall die, such insurance as is afforded by this policy shall apply to the Named Insured's legal representative, as the Named Insured, but only while acting within the scope of his duties as such.

H. Special Rights and Duties of First Named Insured

You agree that when there is more than one person or organization covered under this policy, the first Named Insured in the **declarations** shall act on behalf of all of you as to:

- giving and receiving notice of cancellation;
- payment of premiums and receipt of return premiums;
- acceptance of any endorsements to this policy.

I. Special Statutes

Any and all provisions of this policy which are in conflict with the statutes and regulations of the State of South Carolina are understood, declared and acknowledged by this **Association** to be amended to conform to such statutes and regulations.

J. Declarations

By acceptance of this policy, the Named Insured agrees that the statements in the **application, underwriting questionnaire** and **declarations** are the **insured's** agreements and representations and that this policy is issued in reliance upon the truth of such representations and that this policy and application therefore embody all agreements existing between the **insured** and the **Association**.

K. Licensure

In consideration of the premiums charged, it is a condition precedent to continued coverage that the **insured** have a proper Healthcare Providers License and qualifications.

L. **Liability for Assessment**

Pursuant to the provisions of a Joint Resolution of the South Carolina General Assembly and Regulation R5-75 of the South Carolina Department of Insurance, this policy shall be assessable during the lifetime of the **Association**, the assessment not to exceed one annual premium at the rate in effect for the policy period for which the assessment is necessary. Failure to pay any assessment made by the **Association** will result in the termination of coverage for any **claims** occurring during the policy period assessed and any **claims** reported after the date of assessment.

M. **Sole Agent**

The Named Insured in the **declarations**, or their authorized agent, shall act on behalf of all **insureds** with respect to giving and receiving notice of cancellation, accepting any endorsement issued to form a part of this policy and receiving return premium if any, and is charged with the responsibility for notifying the **Association** of any changes of members, partners, officers, directors or employees or any other change which might affect the insurance hereunder.

N. **Cancellation and Non-Renewal Provisions**

a) This policy may be cancelled by the **insured** by mailing to the **Association**, or any of its authorized representatives, written notice. The cancellation shall become effective on the date requested by the **insured** or the date the notice is received by the **Association**, whichever is later.

b) This policy may be cancelled by the Association by mailing or delivering written notice to the Insured at the **insured's** last known address:

1) at least 10 days prior to the effective date of cancellation if the **insured** has failed to pay a premium when due, whether the premium is payable directly to the **Association** or indirectly under a premium finance plan or extension of credit; or
2) at least 30 days prior to the effective date of cancellation if the **Association** cancels for any other reason.

This notice shall also be sent to the **insured's** agent and shall include the reason(s) for the cancellation.

c) If this policy has been in effect for 90 days or more, or is a renewal policy, the **Association** may cancel this policy only for one or more of the following reasons:

1) nonpayment of premium;
2) material misrepresentation of fact which, if known to the **Association**, would have caused the **Association** not to issue the policy;
3) substantial change in the risk assumed, except to the extent that the **Association** should reasonably have foreseen the change or contemplated the risk in writing the policy;
4) substantial breaches of contractual duties, conditions, or warranties.

d) If the **insured** cancels this policy, earned premium shall be computed in accordance with the standard short rate tables and procedures. If the **Association** cancels this policy, earned premium shall be computed pro rata. Premium adjustments shall be made within a reasonable period of time after cancellation, but payment or tender of such unearned premium shall not be a condition of cancellation.

e) If the **Association** elects not to renew this policy, the **Association** shall mail or deliver written notice of the nonrenewal, including the reason for the nonrenewal, to the **insured** at the **insured's** last known address and to the **insured's** agent not less than 30 days prior to the expiration date provided in the policy.

VI. ADDITIONAL BENEFITS

A. Extended Reporting Period

With respect to Coverage Part A, if this policy is canceled or non-renewed, except if for non-payment of **premium**, the **insured** may purchase an **extended reporting period**, commencing on the effective date of such cancellation or non-renewal and continuing thereafter for an unlimited duration, for reporting a **claim** against an **insured** to which Coverage Part A otherwise applies. In no event shall the **extended reporting period** apply to any **claim** made for a **medical incident** which occurs after the **policy period**.

The **extended reporting period** may be purchased by giving notice to the **association** within thirty (30) days after the effective date of the cancellation or non-renewal and by paying the applicable premium for such **extended reporting period** in accordance with the rules, rates and rating plans of the **association** then in effect.

The purchase of an **extended reporting period** does not extend the **policy period** or expand the coverage provided under this policy. The **extended reporting period** applies only to **claims** against an **insured** which are reported to the **association** during the **extended reporting period**.

B. Death or Disability Benefit

If an individual **insured** should die or become totally disabled while this policy is in effect, the **association** will issue an **extended reporting period** endorsement without requiring the payment of any additional premium. By total disability we mean total and permanent disability resulting in your complete inability to practice medicine due to sickness or injury. In order to qualify, such total disability must continue for a period of six (6) consecutive months while your policy is still in effect. In order to obtain a waiver of premium for the **extended reporting period** endorsement, acceptable proof of your death or total disability must be sent to the **association** in writing

C. Retirement Benefit

If an individual **insured** should retire while this policy is in effect, the **association** will issue an **extended reporting period** endorsement without requiring the payment of any additional premium provided the following conditions are met:

1) fully and permanently retired from the practice of medicine; and
2) been continuously insured with the association for at least five years immediately preceding your retirement; and
3) attained the age of 55; and
4) met your premium payment(s) obligation;
5) for those meeting requirements (1), (3) and (4) above, but not (2), a 20% credit will be applied to the **extended reporting period** endorsement premium for each full year you have been continuously insured with us immediately preceding your retirement.

In order to this retirement benefit for the **extended reporting period** endorsement, acceptable proof of your retirement must be sent to the **association** in writing promptly following your retirement.

VII. DEFINITIONS

Unless otherwise stated in a respective coverage part or endorsement, where any of the following terms are found in **bold** print within this policy, they will have only the meaning shown below:

A. **Automobile** means a land vehicle, self-propelled or not, a trailer, or a semi-trailer. This includes any machinery or apparatus attached, whether or not subject to motor vehicles registration or designed for use principally on public roads.

B. **Bodily injury** means bodily harm, sickness, or disease, including death resulting therefrom.

C. **Claim(s)** means a demand for money damages. Administrative proceedings (including, but not limited to, disciplinary matters) and criminal proceedings are not claims.

D. **Declarations** means the Declarations Page issued by the **Association** to the **insured**, which lists the applicable coverages and coverage amounts.

E. **Medical Incident** means any act, error, or omission in your providing or failure to provide professional medical services.

Any such act, error or omission, together with all related or concurrent acts, errors or omissions in the furnishing of such services to any one person shall be considered one medical incident, regardless of the length of time or number of contacts such person may have with the insured.

F. **Personal or advertising injury** means injury arising out of one or more of the following offenses:

- false arrest, detention or imprisonment;
- malicious prosecution;
- the wrongful eviction from, wrongful entry into, or invasion of the right of private occupancy of a room, dwelling or premises that a person occupies, by or on behalf of its owner, landlord or lessor;
- oral or written publication of material that slanders or libels a person or organization or disparages a person's or organization's goods, products or services; or
- oral or written publication of material that violates a person's right of privacy.

- The use of another's advertising idea in your "advertisement"; or
- Infringing upon another's copyright, trade dress or slogan in your "advertisement"

G. **Policy period** means the period commencing on the effective date shown in the **declarations**. This period ends on the earlier of either the expiration date or the effective date of cancellation of this policy. If any person becomes an **insured** under this policy after the effective date, the **policy period** with respect to that person begins on the date they became an **insured**.

H. **Pollutants** means any solid, liquid, gaseous, or thermal irritant or contaminant, including: smoke, vapor, soot, fumes, acids, alkalis, chemicals and waste. "Waste" includes material to be recycled, reconditioned or reclaimed.

I. **Professional services** means those services for which **you** are licensed, trained and qualified to perform in **your** capacity as a healthcare provider. **Professional services** also mean **your** services as a member of a formal accreditation, standards review, or similar professional board or committee, including the directives of such board or committee.

J. **Property damage** means (1) physical injury to, or destruction of, tangible property including the loss of use of it; or (2) loss of use of tangible property, which has not been physically injured or destroyed.

K. **Suit** means a civil proceeding in a court of law or an arbitration proceeding to which the **insured** is required to submit or to which the **insured** has submitted with the consent of the **Association**.

IN WITNESS WHEREOF, we have caused this policy to be signed by our Chairman and countersigned where required by law on the Declarations Page by our duly authorized representative.

Chairman of the Board

South Carolina Medical Malpractice Liability Insurance
Joint Underwriting Association
550 South Main Street, Ste. #600- Greenville, SC 29601
Tel# 864-240-5400; Fax# 864-240-2750

12/15/2009

IMPORTANT INFORMATION ABOUT YOUR JUA PROFESSIONAL LIABILITY INSURANCE

Byron A Brown
700 Plaza Circle Suite N
Clinton, SC 29325

CC: Joe H. Kirby
Attn: Broker
918 West Main Street
Laurens, SC 29360-2645

RE: Policy # JBC00041 - Claims Made Coverage
Extended Reporting Endorsement (Tail Coverage)

This is to remind you that your policy was cancelled or non-renewed effective 7/9/2009 12:00:00AM. Accordingly, an Extended Reporting Period Endorsement must be purchased to provider coverage for any medical incident which occurred on or after the retroactive date set forth in the policy and prior to the effective date of the cancellation or non renewal, but which is first reported after the effective date of the cancellation or non renewal. The cost of the Extended Reporting Period Endorsement effective 7/9/2009 12:00:00AM is $28,023.00. The Extended Reporting Period Endorsement may be purchased by giving written notice to the JUA and by paying the applicable premium shown below within the next thirty (30)

It may not be necessary to purchase an Extended Reporting Period Endorsement if your current insurance carrier will provide Prior Acts Coverage.

Extended Reporting Period Endorsement Premium Notice Slip must be returned for proper processing. Please detach on the dotted line and return with your payment within 30 days.

Extended Reporting Period Endorsement Notice Slip

Date: 12/15/2009 **System ID#: 71281** **Premium: $28,023.00**

Policy #: JBC00041

Insured's Name: Byron A Brown

I wish to purchase the Extended Reporting Period Endorsement ("Tail Coverage").
My premium payment is enclosed.

EXHIBIT 37 ALL-STATE LEGAL®

_____ _____
Signature *Date*

My mailing address should be changed to: _____

Please return to: SC JUA - 550 South Main Street, Ste.# 600- Greenville, SC 29601

ATTACHMENT 17

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State of South Carolina)
)
County of Laurens)

Chris Katina McCord, Christopher McCord, Janice Sherfield, and Jerry Sherfield,

Plaintiffs,

v.

Laurens County Health Care System and Greenville Healthcare System,

Defendants.

14-CP-30-250

Deposition of

30(b)(6) Joint Underwriters Association of South Carolina

(Burns Davison)

Date: March 1, 2016

Time: 10:05 a.m.

Location: Haynsworth Sinkler & Boyd, PA, One North Main, 2nd Floor, Greenville, South Carolina

Reported by
Sandra J. Ayers

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APPEARANCES

For the Plaintiffs: Joseph "Joey" G. Wright, III, Esq.
Jay F. Wright, Esq.
McGowan, Hood & Felder, LLC
Anderson, South Carolina

For the Defendants: Kenneth N. Shaw, Esq.
Haynsworth Sinkler & Boyd, PA
Greenville, South Carolina

Also Present: Sandra Thompson
Amy Simons

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EXHIBITS

Plaintiffs' Exhibit Number 30, "Notice to Policyholders." 8

Plaintiffs' Exhibit Number 31, "Notice to Brokers." 13

Plaintiff's Exhibit Number 32, Letter from Byron A. Brown. 20

Plaintiff's Exhibit Number 33, Fax in reference to "Byron Brown - July 9, 2008, Renewal - changing to Claims Made." 22

Plaintiff's Exhibit Number 34, "Policy Declarations Assessable Claims Made"; 15 pages. 27

Plaintiff's Exhibit Number 35, Account list, including copy of Check Number 19-109960 and 5177 and "Notice of Financed Premium." 27

Plaintiff's Exhibit Number 36, Fax and supporting documents in reference to "Extended Reporting Endorsement (Tail Coverage)." 29

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Plaintiff's Exhibit Number 37, Letter to Byron A. Brown in reference to "Policy #JBC00041 - Claims-Made Coverage Extended Reporting Endorsement (Tail Coverage)." 31

Plaintiff's Exhibit Number 38, Letters in reference to "Notification of Claim." 41

Plaintiff's Exhibit Number 39, "Certification of Insurance." 43

Plaintiff's Exhibit Number 40, "Policy Declarations Assessable Claims Made"; 2 pages. 49

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STIPULATIONS

It is stipulated by and between counsel for the respective parties that all objections are reserved until the time of trial, except as to the form of the questions.

This deposition is being taken pursuant to the South Carolina Rules of Civil Procedure.

- - - -

The reading and signing of this deposition is reserved by the deponent and counsel for the respective parties.

Whereupon,

Burns Davison, being duly sworn and cautioned to speak the truth, the whole truth, and nothing but the truth, testified as follows:

EXAMINATION

BY MR. JOEY WRIGHT:

Q Okay. Would you state your name and address for the record?

A Burns Harris Davison III, and my work address 550 South Main, Suite 525, Greenville, South Carolina 29601.

Q All right. Now, we have previously received a number of documents from Tom McCall several years ago. I sent you a copy of those, didn't I?

ATTACHMENT 18

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available for Dr. Brown, specifically, and physicians, generally, to finance the premiums; is that correct?

A Yes.

Q And these are some of the documents regarding the financing?

A Correct.

Plaintiffs' Exhibit Number 36, Fax and supporting documents in reference to "Extended Reporting Endorsement (Tail Coverage)."

Q Okay. Show you Document Number 36. These are a series of letters which I'll go over. They're the same letter, but there're notations that are different in each one. Maybe the last letter is a little bit different. The first page, JUA-10, is a letter from Amy Bryant to Dr. Brown, stating that, "JUA is required to offer you the opportunity to purchase an extended reporting endorsement" if he is not going to renew the policy. And this is what you talked about a while ago, right?

A Correct.

Q Okay.

A And this would be the same "tail," in quotes, that Mr. Kirby's statement, that was done at the

Page 30

beginning of this policy period, referred to.

Q All right. Now, when it says "JUA is required to offer you," required by whom?

A By the policy.

Q By the policy. Okay.

And, so, the date that she wrote that letter was September the 9th, correct?

A That's what it says, yes.

Q Okay. And then there is a notation on 11/2, a "2nd request"? See that?

A Yes.

Q I take it that's the second request to Dr. Brown?

A Yes.

Q And then there is another notation, 12/2/09, which is a third request -- noted as a "3rd request"?

A Yes.

Q And I take it that's a third -- in any case, a third attempt to contact Dr. Brown and talk with him about the extended reporting endorsement?

A Yes.

Q Okay. The second page, JUA-045, is -- is the same document with just the "2nd request" on it, correct?

A Yes.

Q And the third page looks like the same as the first

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page?

A Correct.

Q And then the last page, JUA-048, is from Ms. Bryant again, and she is sending an extended reporting endorsement invoice. And, so, she's sending him another letter, right?

A The fourth page, JUA-48?

Q Yeah, uh-huh.

A My reading is that -- that Ms. Bryant finally connected with somebody, either Dr. Brown or Cindy, who I presume is in his office, and they acknowledged wanting to see whatever the extended reporting period quote would be.

Q All right. Okay. Oh, and -- and -- and -- and the next page, 053, the notation that AB has basically says that, "Dr. Brown called me back and said did not know if MagMutual picked up his retro date. I advised him we would send him the offer to purchase the 'tail'"?

A Correct.

Plaintiffs' Exhibit Number 37, Letter to Byron A. Brown in reference to "Policy #JBC00041 - Claims Made Coverage Extended Reporting Endorsement (Tail Coverage)."

Q Okay. All right. And then let me show you Exhibit

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Number 37, which is a -- an invoice -- appears to be an invoice, from JUA to Dr. Brown, dated 12/15/09. And it appears to be the invoice for the extended reporting period; is -- is that what it looks like to you?

A I don't know that I would call it an "invoice." I would -- it -- it -- it's titled a "notice."

Q Okay.

A I would more -- more -- more -- more call it a "proposal" or an "offer."

Q Offer. Okay. All right, sir. And the offer was that the extended reporting period endorsement would be extended from 7/9/2009 if Dr. Brown paid $28,023 within the next 30 days; is that correct?

A Yes.

Q And -- and, so, pay the $28,023. The extended reporting period endorsement would last from the date of the policy ending 7/8/08 -- 7/9/08, for how long? How long does that extended reporting period last?

A Into perpetuity.

Q Perpetuity.

A Essentially, it -- it converts it to something similar to what would be -- what we talked about being the occurrence form.

STATE OF SOUTH CAROLINA	)	IN THE COURT OF COMMON PLEAS
	)	
COUNTY OF LAURENS	)	C.A. FILE NO. 14-CP-30-250
Chris Katina McCord, Christopher McCord, Janice Sherfield, and Jerry Sherfield,	)	
Plaintiffs,	)	AFFIDAVIT
vs.	)	
Laurens County Health Care System and Greenville Healthcare System,	)	
Defendants.	)	

The undersigned, Brent S. Reece, being duly sworn, deposes and says as follows:

1. My name is Brent S. Reece and I am Vice President of Underwriting for MAG Mutual Insurance Company ("MAG Mutual") and have served in that role since March of 2011.

2. I am authorized to give this affidavit on behalf of MAG Mutual as its representative pursuant to the South Carolina Rules of Civil Procedure Rule 30(b)(6) and have personal knowledge of the facts contained herein.

3. On or about July 17, 2009, MAG Mutual issued a physicians and surgeons professional liability claims made insurance policy to Laurens County Obstetrics and Gynecology, LLC ("LCOG"), which protected Dr. Byron A. Brown, M.D. ("Dr. Brown") policy number PSL 1800678 00 with a policy period of 07/09/2009 to 07/09/2010 with a retroactive date of 07/09/2009, and with limit layers of $1,000,000 (each loss)/$3,000,000 (aggregate) (the "Policy") as summarized in the Declarations Page to the policy attached as Exhibit 1 hereto.

4. The Policy was not issued with Prior Acts Coverage; however, Prior Acts Coverage was available, but it was declined by Dr. Brown on June 11, 2009 (in the application for coverage) and again on June 30, 2009 (in the premium estimate acceptance). Had it been selected, the Prior Acts coverage would have cost approximately ($11,861) in additional premium for the first year of coverage.



ATTACHMENT 20

5. The Policy was renewed on two separate occasions for the following time periods; as evidenced by the respective declarations pages attached hereto as Exhibit 2.
   * PSL 1800678 01 07/09/2010 to 07/09/2011
   * PSL 1800678 02 07/09/2011 to 07/09/2012

6. Each of these two renewal policies would have contained retroactive coverage back to July 9, 2009, the date Dr. Brown was originally insured by MAG Mutual. No earlier retroactive date would have been made available to Dr. Brown for either of these two renewals.

7. The written communications between MAG Mutual and Laurens County Health Care System (a/k/a "Laurens County Hospital") from 7/17/2009 to 4/12/2012 relating to the insurance policy issued to LCOG (and thereby covering Dr. Brown) are attached as Exhibit 3.

9. The documents listed in items #1 through #7 in the Memorandum dated September 15, 2011 from Michael Meyer to Matt Mitcham are attached as Exhibit 4.

FURTHER THE AFFIVIANT SAYETH NOT

Brent S. Reece

SWORN TO BEFORE ME THIS
29th DAY OF February, 2016

Notary Public for DeKalb County, Georgia
(SEAL)

Notary Public, DeKalb County, Georgia
My Commission Expires April 3, 2016

Rcvd. 12/15/09

Dear Dr. Weaver, Chief of Staff, Laurens County Healthcare System,

I would like to temporarily relinquish privileges to perform hysterectomies, anterior and posterior repairs, and urethral slings until the beginning of 2010.

Sincerely,

Byron Brown

Cc. Michael D. Stribling
Rich D'Alberto

EXHIBIT 27

ATTACHMENT 21

EXHIBIT 16

Peer/Quality 133

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State of South Carolina)
)
County of Laurens)

) 14-CP-30-250
Chris Katina McCord,)
Christopher McCord, Janice) 30(b)(6) Deposition
Sherfield, and Jerry)
Sherfield,) of
)
Plaintiffs,) Laurens County Health
) Care System
vs.)
) (Lynn Reaves
) and
Laurens County Health Care) Sandra Thompson)
System and Greenville)
Healthcare System,)
)
Defendants.)
)

Date: January 6, 2016

Time: 10:12 a.m. - 12:39 p.m.

Location: Laurens County Health Care System
22725 Highway 76 East
Clinton, South Carolina

Reported by
Vickie M. Hester, CVR

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APPEARANCES

For the Plaintiffs: Joseph G. Wright, III, Esq.
Jay F. Wright, Esq.
McGowan, Hood & Felder, LLC
Post Office Drawer 1778
Anderson, South Carolina 29622

For the Defendants: Kenneth N. Shaw, Esq.
Haynsworth Sinkler Boyd, PA
Post Office Box 2048
Greenville, South Carolina 29602

Also present: None

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Examination of Ms. Thompson by Mr. Wright: 44

EXHIBITS

(All exhibits were marked by Mr. Wright prior to the deposition, with the exception of Exhibit No. 25 which was later removed and replaced by Exhibit No. 23. All other exhibits were initialed and dated by the Court Reporter at the time they were introduced)

Exhibit No. 16, Deposition Subpoena. 3
Exhibit No. 4B, Medical Staff Bylaws. 8
Exhibit No. 23, Insurance Certificates Face Sheets. 11
Exhibit No. 8, McCord Conditions of Admission. 48
Exhibit No. 9, Sherfield Conditions of Admission. 48
Exhibit No. 24, Letter to Mr. McCord from GHS. 52
Exhibit No. 12, Memo from MAG Mutual. 54
Exhibit No. 17, Affidavit of Sandra Thompson. 58
Exhibit No. 18, Report from Dr. Madis. 59
Exhibit No. 19, List of Charts Pulled. 60

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STIPULATIONS

It is stipulated by and between counsel for the respective parties that all objections are reserved until the time of trial, except as to the form of the questions.

This deposition is being taken pursuant to the South Carolina Rules of Civil Procedure.

- - - -

The reading and signing of this deposition is not waived by the deponents and counsel for the respective parties.

Whereupon,

Lynn Reaves and Sandra Thompson, being duly sworn and cautioned to speak the truth, the whole truth, and nothing but the truth, testified as follows:

MR. WRIGHT: Let me start by noting that we have marked as Exhibit 16 the deposition subpoena in this case.

(Exhibit Number 16 Introduced)

MR. WRIGHT: And the first topic would be regarding professional liability insurance coverage of Byron Brown. And as I understand it, Ms. Reaves is the designee for that. Is that correct?

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MR. SHAW: Are you asking me, or are you asking her?

MR. WRIGHT: You.

MR. SHAW: Me?

MR. WRIGHT: Yeah.

MR. SHAW: Yes, that is correct.

MR. WRIGHT: Okay.

EXAMINATION OF LYNN REAVES

BY MR. WRIGHT:

Q. Ms. Reaves, a little bit of background. Would you give us who your employer is and what your position is?

A. Greenville Health System, and I'm the manager of Medical Staff Services.

Q. The manager of what now?

A. Medical Staff Services.

Q. And what are your primary duties?

A. The credentialing and privileging of physicians.

Q. All right. And how long have you been employed by Laurens Hospital and/or Greenville Hospital System?

A. Twenty-five years.

Q. And when did you become employed by Greenville Hospital System?

A. Two years ago this past July.

Q. Now, in the last 25 years have you held any other

ATTACHMENT 22

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A. The Credentials Committee, MEC and our board approve -- approve all credentialing files.
Q. I'm talking about maintaining the insurance.
A. Maintaining the insurance is the responsibility of the physician.
Q. My question to you, was there anyone else that was responsible on behalf of the hospital for requiring that the physicians maintain the proper insurance according to the medical staff bylaws other than yourself who collected the face sheets?
A. Ultimately our board was responsible for making sure physicians adhered to our bylaws.
Q. The board. Okay. And in the period from 2008 to say 2010 did any members of the board meet with you to discuss the insurance coverages of the physicians?
A. No, sir.
Q. And do you recall who was president of the board in --
A. No, sir.
Q. -- 2008 to 2010?
A. No, sir.
Q. Do you recall any members of the board?
A. No, sir.
Q. Okay. All right. Now, how did you receive -- and

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we're talking about the first -- first cover sheet. How did you receive the form?
A. Generally the physicians turn this in. It's dependent upon the insurance company.
Q. All right. Well, with JUA and PCF how was it handled?
A. Generally the physician turns those in.
Q. So a physician would bring by that policy every time there was a renewal?
A. Yes, sir.
Q. And you would not receive the policy -- the information directly from JUA and PCF?
A. Sometimes we would if the physician put us down as a -- as the one to receive the copy. There's some insurance companies where we receive the copy, and there's some where it goes directly to that physician.
Q. Can you tell from looking at the face sheets whether this was a policy that you received directly, or whether it was brought by?
A. No, sir.
Q. Do you have any logs about when you received it?
A. No, sir.
Q. Can you tell from the face sheet whether it was sent directly to you or it went to the physician?

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A. No, sir, I can't tell.
Q. And so for the next year you have a face sheet for the period beginning July of 2003, correct?
A. Yes.
Q. And the next sheet, you have the face sheet for July of 2004, correct?
A. Yes, sir.
Q. And I believe July of 2004 the claim amount was changed to a million dollars per claim or three million dollars aggregate, correct?
A. Yes.
Q. Is that correct?
A. Yes, sir, that's what it says here.
Q. And again, same question on all of these. Do you know whether any of these so far were sent to you directly by the insurance company or by the doctor bringing it by?
A. No, sir. I -- I do not know. Only the doctor's address is on here, so I don't think I would have received it directly from the insurance company.
Q. Now, what action would be taken by you if the doctor did not bring by the insurance certificate for the required amount according to the bylaws?
A. That's one of the qualifications to be reappointed and to stay in good standing is to have current

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insurance. So we would have continued to request that information right up until the day this current policy expires. I would continue to request that information. I've not run into a situation where they didn't provide me with a new face sheet.
Q. And did you have any policy or procedure or direction that, if that were not done, what you were supposed to do?
A. Our bylaws I'm sure specify what we are supposed to do. But I've not run into that situation myself.
Q. How long before the policy expired would you have the policy?
A. It varies. I start requesting it about 60 days out. And some I get a month or so before. Some of them I get the day before.
Q. All right. And if you would, skip on over to the face sheet dated 7/9/2007 to 7/9/2008.
A. Okay.
Q. All right. Now, do you see the word under "assessable" -- excuse me for pointing -- "occurrence"?
A. Yes.
Q. Do you know what that means?
A. At that point it changed to an occurrence based.

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Q. I'm asking you do you know what that means?
A. I would just say that at that point it changed to an occurrence based policy.
Q. What was it before?
A. It does not specify in there.
Q. Do you know what type of policies then preceded this one?
A. No, sir.
Q. And we're talking about 7/9/2007, correct?
A. Yes, sir.
Q. And I think we've gone over this, but do you know what an occurrence policy is?
A. No, sir.
Q. All right. Now, if you reviewed a policy certificate and it did not comply with the medical staff bylaws such as with the limit requirements, what would you do?
A. Take it to my credentials chair.
Q. And?
A. Let him review it. And he would -- he would deal with the physician.
Q. And when you say deal with the physician, what do you mean?
A. He would take that up with the physician.
Q. Okay. And?

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A. I'm not sure what their process would be at that point.
Q. All right. So who would make the decision whether or not the insurance certificate or policy or limits would comply with the bylaws?
A. The credentials chair would review it. If it didn't meet, then I feel certain he would take it on to our chief of staff and they would make that decision.
Q. Well, did you have occasion to present it to the credentialing -- any certificates to the Credentials Committee?
A. Credentials Committee reviews them every two years when they do reappointments.
Q. I mean, did you personally have -- ever take any --
A. No, sir.
Q. You did not. Do you recall who the credentialing chair was in 2008 and 2009?
A. No, sir, I don't.
Q. But you had no meetings with him regarding insurance coverage of the LIPs, correct?
A. Just during normal routine credential reviews.
Q. And what involvement would you have especially as it related to Dr. Brown?
A. Just having that file available for them to review.

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Q. Just having the file?
A. Uh-huh.
Q. That would be your responsibility?
A. Yes, sir.
Q. All right. Then the next certificate, if you'd look at that, that would be dated 7/9/2008?
A. Yes, JUA 2008. Yes, sir.
Q. And I'll show you here where it says, "Claims Made."
A. Uh-huh.
Q. Do you know what that means?
A. No, sir. Again, I don't know the difference between the two.
Q. Okay. Now, the next one, move on over, this is a MAG Mutual certificate 7/9/2009. Do you see that?
A. Yes, sir.
Q. And it has an effective date 7/9/2009?
A. Yes, sir.
Q. What's your understanding as far as when the insurance coverage with MAG Mutual for professional liability insurance took effect?
A. On 7/9/2009.
Q. And so what's your understanding as far as medical negligence claims that occurred prior to 7/9/2009?
A. I'm not sure.

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Q. You don't have any -- you're not sure of that?
A. We have face sheets here for JUA/PCF up to that date.
Q. So it's your understanding that JUA and PCF would cover claims prior to then?
A. It's my understanding that is the insurance he had prior to this.
Q. It also states, "Please inquire directly with the insured for individual restrictive endorsements that may apply." Did you ever inquire about any individual restrictive endorsements?
A. No, sir.
Q. Did you have any conversations -- or have you had any conversations since you were serving in your present position with either representatives of JUA, PCF Insurance Company or MAG Mutual Insurance Company?
A. No, sir.
Q. And then the final policy that we've been provided with -- or certificate of insurance from MAG Mutual for the policy period beginning July the 9th, 2010, that one was issued directly to Laurens County Hospital, correct? Or at least that's what the paper says?
A. Yes, sir.

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Q. It was just pointed out to me that in answer to Interrogatory Number 1 by your legal counsel that Dr. Christopher Nelson was chair of the Medical Staff Credentialing Committee. Are you familiar with Dr. Nelson?
A. Yes, sir.
Q. And was Dr. Nelson the chair during the period of 2008-2009?
A. I'm not a hundred percent certain.
Q. Do you know what period Dr. Nelson has served?
A. He is our current credentials chair.
Q. Current. Okay. Do you know how long he's served in that position?
A. I don't.
Q. I mean, do you know if it's been like six months or --
A. No.
Q. -- a couple of years?
A. It's -- it's been a couple of years.
Q. All right. And do you have an understanding of what the change from JUA/PCF insurance to MAG Mutual in 2009 caused regarding the professional liability coverage for claims submitted by Ms. McCord and Mrs. Sherfield?
A. No, sir.

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Q. You don't have any idea how it affected them?
A. No, sir.
Q. Are you aware that Dr. Brown performed three separate surgeries on Mrs. McCord, being July the -- I mean, December 18th, 2008, February 19th, 2009 and April 17th, 2009?
MR. SHAW: Objection.
A. No, sir. It's my understanding that I'm not here today on behalf of what I personally know, but what the hospital knows. And I can't speak to that subject.
Q. Well, what you know at the time you were handling this file is what the hospital knows, correct?
MR. SHAW: Objection.
A. And I did -- I did not know anything about any file, any -- none of that information comes through my office.
Q. All right. What about the information of the operation complications from Mrs. Sherfield May 29th, 2009; did that come through your office?
A. No, sir.
Q. Did the fact that Dr. Brown was found to be professionally negligent by the circuit judge from his professional negligence to Mrs. McCord, did that come through your office?

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MR. SHAW: Objection.
A. I can't speak on behalf of what the hospital knew or did not know on behalf of that subject. I haven't been called today to --
Q. I'm asking about as far as the insurance.
A. -- speak on behalf of the hospital.
Q. I think that affects the insurance. Yes, ma'am.
A. No, sir, I don't know anything about that as far as the insurance.
Q. All right. I have to ask you these questions. If you know, fine, tell me. If you don't, you don't. Were you aware that a money judgment was awarded against Dr. Brown in favor of Mr. and Mrs. McCord in the amount of over $1,800,000?
A. No, sir.
Q. Were you aware that a money judgment was awarded in favor of Mr. and Mrs. Sherfield for professional negligence of Dr. Brown in an amount exceeding 1.5 million dollars?
MR. SHAW: Objection.
A. Again, I can't say what the hospital does or does not know. I've not been called as a witness pertaining to those particular subjects.
Q. I'm asking you about what -- what you would know in your position as -- let's see, what's it called --

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Manager of Medical Staff Services.
A. No, sir.
Q. Were you aware in your position as Manager of Medical Staff Services that -- that the insurance company, JUA/PCF denied coverage because a claim was not submitted by Mr. and Ms. McCord prior to July the 8th, 2009?
MR. SHAW: Objection.
A. Again, my understanding of these proceedings today is that I was not brought in to speak besides whether or not insurance was -- on any subject other than the insurance.
Q. Did you understand my question?
A. I did. I believe I did.
Q. All right. And your answer is?
A. I do not know.
Q. Okay. And the same question. Were you aware that JUA/PCF denied coverage because a claim was not submitted by Mr. and Mrs. Sherfield prior to July the 8th, 2009?
A. No, sir.
Q. In your position as Medical Staff -- as Manager of Medical Staff Services were you aware that patients who were injured through medical negligence of Dr. Brown needed to file claims by July the 8th, 2009

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A. At the hospital it would be me to know that he changed from JUA to MAG Mutual.
Q. Yeah. And other than you, would it be anyone else's responsibility?
A. No, sir.
Q. Were you familiar with tail insurance and extended coverage which provides insurance coverage in claims made policies for acts occurring prior to the effective date of the policy?
A. No, sir.
Q. Today are you familiar with tail insurance and extended coverage in claims made policies? Do you understand what that concept is?
A. I have a very limited knowledge of that.
Q. Tell me what you know.
A. If they carry tail insurance, then that insurance covers them for any claims that come in after that policy was canceled.
Q. Actually before the policy was canceled, right?
A. And if they switch to another insurance company.
Q. Right. Okay. And when did you learn this?
A. Actually when our emergency physicians switched over from being independent to GHS employees.
Q. Really?
A. Yes, sir.

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Q. And when was that?
A. January of this -- of 2015.
Q. Did you have a working relationship with Sandra Thompson during 2008 and 2009?
A. Yes, sir.
Q. In your capacity as position -- who is management of -- Manager of Medical Staff Services, did Mrs. Thompson inform you of any patients injured by Dr. Brown during 2008 and 2009?
MR. SHAW: Objection.
A. No, sir. No, sir.
Q. In your position did Mrs. Thompson inform you that a $600,000 medical malpractice settlement was paid on behalf of Dr. Brown in January 2009?
MR. SHAW: Same objection.
A. No, sir. I can't speak of what the hospital did or didn't know about that. I personally didn't.
Q. Did Mrs. Thompson ever inform you of medical malpractice cases being made against Dr. Brown?
MR. SHAW: Objection.
A. I'm sure the hospital knew about these. But in my particular role I did not.
Q. If you had been told about the $600,000 medical malpractice settlement in January of 2009 and about other instances of malpractice committed by Dr.

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Brown, would you have monitored the insurance policies -- certificates more closely to make sure injured patients were presented with their rights to collect insurance for damages?
MR. SHAW: Objection.
A. I -- I'm not --
Q. Do you want me to repeat that?
A. Yes, sir. It was a lot.
Q. Okay. If you had been told in your position that Dr. Brown had paid a -- that there had been paid a $600,000 malpractice settlement on behalf of Dr. Brown in January of 2009, and if you had been told about other instances of malpractice committed by Dr. Brown, would you in your position have monitored the insurance policy more closely to make sure those injured patients retained their rights to collect insurance for damages caused by Dr. Brown?
MR. SHAW: Objection.
A. In my position that would not have been one of my job duties, no, sir.
Q. Would you have notified the injured patients or taken steps to inform the appropriate personnel at the hospital that the patients needed to be informed so that they could maintain their rights?

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MR. SHAW: Same objection.
A. That would not have been part of my job duties for the hospital.
Q. Had you known this, would you have done anything differently?
A. No, sir.
Q. All right. Now, I showed you earlier the insurance requirements on the subsidy contract.
A. Yes, sir.
Q. Do you remember that? Was this contract in Dr. Brown's file?
A. No, sir, it would not have been in his credentialing file.
Q. It would not have been. Were you aware of the contract?
A. At my office, no, sir. I was not aware of the specifics of the contract.
Q. So were you aware -- you were not aware then of the requirement for professional liability insurance under the provisions of that specific contract?
A. Under the provisions of that specific contract I was not in my current job.
Q. Okay. Were you ever -- was the hospital -- strike that. Did the hospital implement a policy allowing the change of insurance from occurrence to claims

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made?
MR. SHAW: Objection.
A. I don't know what the hospital may or may not know on that. But my knowledge of that is we've never had that specified that it had to be claims or occurrence based.
Q. And did anyone at the hospital ever inform you and sit down and explain to you the difference between an occurrence policy and a claims made policy?
A. No, sir.
Q. We're just about finished. One of the questions we had, and this may be better directed to Nurse Thompson, is there -- there's a notation of the Laurens County Medical Staff Rules and Regulations and the Medical Staff Bylaws. Is that a different document, rules and regulations?
A. Yes, sir.
Q. Okay. And do you use the rules and regulations in your position as the manager?
A. Yes, sir.
Q. Do the rules and regulations relate to anything regarding insurance -- professional liability insurance?
A. I would have to look -- I would have to review them -- look at them to see.

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Q. Okay. While we're taking Ms. Thompson's deposition -- are they available? I mean, can you get them?
(Off the record from 11:34 a.m. until 11:35 a.m.)
THE EXAMINATION OF LYNN REAVES BY MR. WRIGHT CONTINUES:
Q. What is the purpose of requiring physicians to carry medical malpractice insurance?
A. It's to protect the -- that's to protect the physicians and their assets. And it's to protect the hospital as well.
Q. How would it protect the hospital?
A. Well, the physicians would have their insurance. If something did happen, they're covered by their own insurance. And it would keep the hospital hopefully out of any kind of legal or -- matters. But it's the physician's insurance.
Q. Are you saying the professional liability insurance is paid to the hospital?
A. No, sir. It's paid by the physician. It's the physician's insurance. It's to protect that physician.
Q. Well, I know. I heard that. But how would it -- how would it protect the hospital?
A. We would not want to assume any liability on behalf

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of the hospital for a physician that was not insured.
Q. Okay. That's all I have, except for any questions that may be in the rules and regulations, which I doubt there are any. But regarding the insurance.
(Off the record from 11:37 a.m. until 11:43 a.m.)
MR. WRIGHT: WE have no further questions.
EXAMINATION OF LYNN REAVES
BY MR. SHAW:
Q. Earlier in your deposition you stated that you would send out notices to the doctors 60 days or so prior to the expiration of their -- of their current policy, correct?
A. Yes, sir.
Q. All right. And I believe you stated that normally you would get, you know, current versions of the policy before the other ones expired; is that right?
A. Yes, sir.
Q. Let me ask you, if you'll look at -- we'll just pick one of them, one that's relevant to this case here, the policy that was in effect from JUA from July 2008 -- or July 9th, 2008 to July 9th, 2009. According to the document itself, this -- the

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counter signature on this document is August 18th, 2008. Date issued would be 8/4/2008. So is it -- is it most likely that you did not receive this document until after July 9th of 2008?
A. It is most likely. Can I elaborate on that?
Q. Sure.
A. And sometimes, especially with some of the insurance brokers, they will call and say -- because I just bother physicians so much trying to get this information, they will call and say, "We have this. We're writing it. You know, it's current.". They'll give me like a verbal until they can get me a face sheet, especially if they change brokers during -- like if they go from one broker to another, it may take time. And the broker will then call me and tell me sometimes that information.
Q. Okay. That's all I've got.
MR. WRIGHT: No questions.
EXAMINATION OF SANDRA THOMPSON
BY MR. WRIGHT:
Q. Are you a nurse?
A. No. No.
Q. Ms. Thompson, if you would, tell us your employer and position.

STATE OF SOUTH CAROLINA	)	IN THE COURT OF COMMON PLEAS
	)	
COUNTY OF LAURENS	)	C.A. No. 2010-CP-30 -1139
Dixie Mitchell,	)	
	)	**AFFIDAVIT OF SANDRA THOMPSON**
Plaintiff,	)	
	)	
vs.	)	
	)	
Byron A. Brown, MD, Laurens County Obstetrics and Gynecology, LLC, a South Carolina Limited Liability Corporation, and Laurens County Health Care System d/b/a Laurens County Hospital,	)	
	)	
Defendants.	)	
	)	

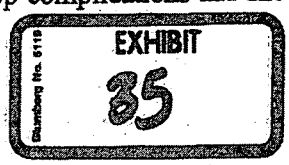
PERSONALLY appeared before me, the undersigned Sandra Thompson, who being first duly sworn, deposes and says:

1. That I am an adult over the age of 18 years and am competent to make this affidavit.

2. That the matters set forth in this affidavit are matters on which I have direct personal knowledge.

3. That I have worked at Laurens County Health Care System since 1993. I was first employed as Assistant to the CEO and then as Risk Manager and Accreditation Coordinator. I have served as Administrator for Quality and Compliance since 2006. In that capacity, I was directly involved in the quality and peer review matters involving Dr. Byron Brown which began in late 2009 and which continued for months thereafter.

4. That the patient Dixie Mitchell had GYN surgery performed by Dr. Brown at Laurens County Hospital on October 27, 2006. She was re-admitted to LCH several days later with apparent post-op complications and she underwent surgical repair of a perforated bowel by



ATTACHMENT 23

Dr. Rufus Watkins on November 3, 2009, and remained in the hospital for a number of days thereafter, including time in the intensive care unit (ICU). Her chart was reviewed due to the re-admission and post-op complications. Concerns were raised by Dr. Watkins and Dr. Brown himself (who served on the Peer Review Committee at that time) actually requested that the Dixie Mitchell chart be pulled and sent for peer review. That process began in early November 2009. As a result of this situation, additional charts were pulled for review regarding surgical complications on patients of Dr. Brown. Ultimately, eleven (11) charts were first sent for outside peer review. This was done in early December 2009. The charts were sent to a peer review service called Medical Peer Review Services, LLC in Florida, who then had the charts reviewed by Mark Madis, M.D., an OB/GYN physician in New Jersey. Dr. Madis submitted reports on the peer review he conducted on eleven (11) charts, including the chart of Dixie Mitchell. This quality and peer review process was underway when Dr. Stribling (urologist) raised his own concerns about a surgical complication on a patient of Dr. Brown's that occurred on December 11, 2009. Thereafter, Dr. Stribling (who also served as Chief of Surgery) raised those concerns to Dr. Brian Weaver (Chief of Staff) on December 14, 2009. As a result of contact with Dr. Brown about those concerns, Dr. Brown voluntarily relinquished certain privileges on a temporary basis on December 15, 2009. Thereafter, Dr. Brown raised some concerns about the monopolar hook devices. His concerns were investigated as part of and during the quality and peer review process. Dr. Madis issued written reports about his chart reviews and made recommendations. The Medical Executive Committee and an Ad-Hoc Peer Review Committee appointed specifically for the Dr. Brown investigation had ongoing meetings and reviews. More charts were sent to Dr. Madis for review with written reports received back from him. The investigation of Dr. Brown was extended to obstetrical cases. Dr. Brown was summarily

suspended by the MEC in January 2010. Dr. Brown retained legal counsel and requested a Fair Hearing under the Medical Staff Bylaws. The hospital also had legal counsel from the Nexsen Pruet law firm in Columbia. Ultimately, an Agreement was reached in February 2010 between the MEC and Dr. Brown whereby the summary suspension would be lifted, but Dr. Brown voluntarily agreed to limit certain of his privileges. The peer review process continued and charts were sent for a second outside peer review to Dr. John Moore, an OB/GYN physician in Columbia. Like Dr. Madis, Dr. Moore also issued a written report about his review. Ultimately, in May 2010, an Addendum to the Agreement between Dr. Brown and the MEC was reached whereby Dr. Brown relinquished a detailed list of privileges set forth in Attachment 1 to the Addendum and he agreed to limit his privileges to a specified list of procedures contained in Attachment 2 to the Addendum. Later, Dr. Brown voluntarily resigned all privileges in May 2011.

5. The entire quality and peer review investigation of Dr. Brown's surgical complications arose from and as a result of the Dixie Mitchell re-admission for the bowel perforation as a result of Dr. Brown's GYN surgery on October 27, 2009.

6. The entire Dixie Mitchell "investigation" (as characterized in Plaintiff's discovery requests) was conducted pursuant to the quality and peer review process set forth above.

7. That the quality and peer review investigation of Dr. Brown was conducted pursuant to the understanding that the investigation would be shielded from discovery and would be confidential under the peer review process.

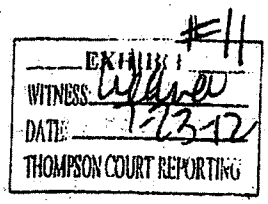
8. That the documents provided to our legal counsel in the Brown v. LCHCS case regarding the hospital investigation of Dr. Brown (including those related to Dixie Mitchell)

have been from either the quality and peer review investigation of Dr. Brown or from Dr. Brown's credentials file, with the exception of patient medical records.

FURTHER AFFIANT SAYETH NOT.

Sandra E. Thompson
Sandra Thompson

Sworn to before me this 11th day
Of February, 2013
Notary Public for South Carolina
Lindsay Black Dyer
My Commission Expires: 4/21/14



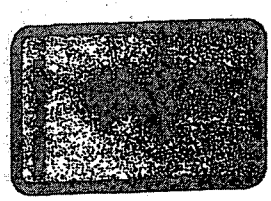
January 15, 2010

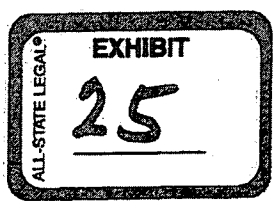
Rufus W. Watkins, MD

Chart review conducted on GYN charts with complications. Practitioner of record: Dr. Byron Brown

In my professional opinion:

1. There s a clear pattern of inadequate hand written, sometimes illegible H&Ps, not accompanied by office notes.
2. There is a pattern of not recording or documenting pap smears pre-operatively.
3. There is a pattern of not getting or documenting pertinent medical history as to events and timing of events, medications taken, etc.
4. There is a pattern of operating with inadequate exposure, often continuing laparoscopic approach even though documenting very difficult exposure.
5. Several cases had large fibroids (to navel) but were done with pfannenstiel incision. Inadequate exposure.
6. Pattern of persisting without requesting assistance or noting whether or not assistance was unavailable.
7. Repairs major urologic problems without consultation or mentioning attempt at consultation.
8. Charts with no discharge summary even if major complication.
9. Method of nursing notes make evaluation difficult and uncertain; Weights often not recorded, etc.
10. Need follow up from physician's involved regarding eventual outcome and patient status.





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LCHCS
0219

ATTACHMENT 24

R. W. Watkins, MD

January 22, 2010

At the request of the Medical Executive Committee I interviewed all Scrub Techs at LCHCS in the presence of Sue Thomason, Nurse Manager, Surgery Department.

I started the interview process by stating that the MEC had become aware of the need to improve the peer review process and that it was realized that the Scrub Techs probably knew more about how the individual surgeons performed in surgery than the other doctors did not often actually scrub with or assist each other. The Techs were told their individual comments would be considered anonymous but that collectively a report expressing their concerns would be made to the MEC. I was very careful not to mention any doctor by name or specialty, but asked them to comment whether or not there had been any pattern of problems with any specific doctor. They were told that MEC would investigate specific events if they wished but that what we were concerned about was whether or not there were patterns of technique or behavior that were detrimental to patient outcomes or to the hospital's reputation in the community. Finally they were asked to comment upon whether or not they would refer themselves, their family or friends to the doctors that they had mentioned earlier in the review process.

The results of these were:

All eleven Scrub Techs mentioned problems with two doctors- the same two doctors. Since one of the doctors was not involved in this particular peer review process this doctor will not be named in this report, but a separate report will be made to the MEC concerning the evaluation of this doctor.

Concerning the doctor who is the subject of this peer review process, all eleven Scrub Techs spontaneously mentioned- often very strongly- his name and performance. There was a general concern that there were an inordinate number of inadvertent injuries to the bladder, bowel and ureters, especially with the sling procedure. There was concerns that when performed by this MD the procedure was dangerous and it was stated that there are injures in "almost every case" and that the procedures "caused more harm than good". Several techs quested whether or not the MD was adequately trained to do this procedure.

In other procedures such as LAVH, there was concern for inadequate concern for ureters, excessive burning around ureters and bladder, and for placing trocar without adequate exposure.

Unanimously, the techs felt this doctor was being talked about in our community in a negative fashion and "giving the hospital a bad name".

Unanimously, they stated they would not refer friends or family to this MD. Three techs specifically stated they used to go to this MD but no longer do so. Two techs stated that they needed gynecologic surgery at present but would not allow this MD to operate on them; that they would have to go elsewhere (that is, to another hospital) for this surgery.

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LCHCS
0224

In conclusion, it I painfully obvious that the Scrub Techs have no confidence in this doctor, that they have grave concerns about his surgical technique, that they know of many severe patient injuries, and that they consider him- at least in his present performances- a detriment to the reputation at LCHSC.

It was clear from the interviews that they would strongly urge the MEC to correct this doctor's techniques and performances, as one stated "before other women are injured". It was also clear that they would like to be relieved of their personal liability risks incurred by operating with this MD.

Additionally, it became obvious to me that they all wanted an alternative safe, acceptable source of gynecologic care and surgery within this medical community.

Respectfully Submitted,

R.W. Watkins, MD

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LCHCS
0225

COPY

Dear Dr. Weaver, Chief of Staff, Laurens County Healthcare System,

As Chief of Surgery, I need to make you aware of a situation that is of great concern to me.

I worry greatly about what appears to be a continuing pattern of surgical misadventure by Dr. Byron Brown.

To my knowledge, within the last year Dr. Brown has damaged a ureter on 3 separate occasions. He also perforated a colon (twice in the same patient) which lead to tremendous complications.

The first damaged ureter I recall presented with an obstruction of the ureter and I was able to coax a ureteral stent past the damaged area. It is unusual to be able to pass a stent in that manner, but with luck it did go up.

The second case was not so lucky. With great difficulty I passed a stent up what appeared to be the ureter, but the patient kept leaking urine from the vagina. I therefore recommended that she go to MUSC because of the reconstruction that would be needed.

The last case was this past Friday. This was another cut ureter that required a ureteral reimplant into the bladder.

The case with the perforated colon can be better described by Dr. Watkins who repaired that.

The reason this is such a worrisome pattern is that a cut ureter is a fearsome complication. It rarely heals well; often requiring revisions and can result in reflux, scarring, kidney infection/damage, and stone formation. Needless to say this is a terrible injury and has huge implications to the urologist who has to repair the damage.

In nearly 20 years of practice in NC, among multiple gynecologists and numerous general surgeons I had to repair exactly ZERO damaged ureters. This is not an insignificant statement; it is a telling revelation of how careful surgeons and gynecologists are operating in the vicinity of the ureter. They realize what a fearsome injury it is.

Because of what appears to me to me a worrisome pattern of complications, I will, as Chief of Surgery, respectfully ask Dr. Brown to temporarily relinquish his privileges to doing all pelvic surgery until the cases can be reviewed by an outside reviewer. If Dr. Brown chooses not to do this I will request an emergency meeting of the MEC to decide whether official action should be considered regarding his operating privileges.

I am making this letter available to Dr. Brown, and a copy will also be sent to Mr. D'Alberto.

Sincerely,

Michael D. Stribling, Chief of Surgery

12/14/09

EXHIBIT #1
WITNESS:
DATE:
THOMPSON COURT REPORTING

6412/1600
PLF 00018

EXHIBIT 36

EXHIBIT 26

ATTACHMENT 25

STATE OF SOUTH CAROLINA)
)
COUNTY OF LAURENS)

AGREEMENT

This Agreement is made and entered into this 17th day of February, 20 10 (the "Effective Date") by and between the Medical Executive Committee ("MEC") of Laurens County Health Care System ("LCHCS"), and Byron A. Brown, M.D. ("Dr. Brown"). The MEC and Dr. Brown are from time to time in this Agreement referred to collectively as the "Parties."

This Agreement is made in consideration of the following facts:

On January 22, 2010, the MEC summarily suspended Dr. Brown's clinical privileges relating to all surgical procedures with the exception of C-Sections, Post-Partum Tubal Ligations, Endometrial Ablations and Dilation & Curettages ("Summary Suspension"). On February 5, 2010, Dr. Brown, through his attorney, requested a Fair Hearing under the LCHCS Medical Staff Bylaws regarding the Summary Suspension. Thereafter, and prior to the scheduling of a Fair Hearing, Dr. Brown requested that the MEC reconsider its action and rescind the Summary Suspension, thereby restoring his clinical privileges in full. Dr. Brown represented to the MEC that even if the Summary Suspension is rescinded, he will not, without first obtaining written permission from the MEC, schedule any surgical procedures at LCHCS, except for C-Sections, Post-Partum Endometrial Ablations and Dilation & Curettages.

NOW, THEREFORE, in consideration of the promises and agreements contained herein, the MEC and Dr. Brown agree and covenant as follows:

1. THE MEC RESCINDS THE SUMMARY SUSPENSION

As of the Effective Date, the MEC rescinds the Summary Suspension. Further, as a result of this rescission, Dr. Brown is reinstated as Chair of the Peer Review Committee and the Chair of the Department of Obstetrics/Pediatrics.

2. DR. BROWN'S VOLUNTARY LIMITATION OF HIS CLINICAL PRIVILEGES AND PARTICIPATION IN MEDICAL STAFF LEADERSHIP

Notwithstanding the MEC's rescission of the Summary Suspension described in paragraph 1, Dr. Brown represents that he will not, without first obtaining written permission from the MEC, schedule any surgical procedures at LCHCS except for C-Sections, Post-Partum Tubal Ligations, Endometrial Ablations and Dilation & Curettages. The MEC may withhold consent in its sole discretion. Further Dr. Brown has notified the MEC that he will be taking a leave of absence from his positions as Chair of the Peer Review Committee and Chair of the Department of Obstetrics/Pediatrics until such time as the MEC provides written consent to his return to these positions. This consent may also be withheld in the MEC's sole discretion.

Brian W. Weaver
MEC of Laurens County Health Care System Initials

Dr. Brown Initials

EXHIBIT 28 (ALL-STATE LEGAL)

LCHCS 0102

EXHIBIT 17

EXHIBIT A

3. STATUS OF PROFESSIONAL REVIEW ACTIVITY

Dr. Brown acknowledges and agrees that the professional review activity that resulted in the Summary Suspension is ongoing, and, in fact, has now been extended to include a review of obstetrical services. Dr. Brown acknowledges and agrees that the MEC's rescission of the Summary Suspension is not a determination by the MEC regarding the merits of the matters that gave rise to the Summary Suspension, and, in fact, Dr. Brown acknowledges and agrees that the MEC may, at any time, impose a summary suspension or take other action with respect to his clinical privileges as provided for under the Medical Staff Bylaws. Dr. Brown acknowledges and agrees that the MEC's rescission of the Summary Suspension in no way limits the MEC's rights under the Medical Staff Bylaws to take such similar action or other action on or after the date of this Agreement.

4. RESTRICTION ON DR. BROWN'S USE OF MEC'S RESCISSION OF SUMMARY SUSPENSION

Under no circumstances, whether in any proceeding provided for in the Medical Staff Bylaws or in any civil action/legal proceeding, will Dr. Brown assert, or in any way attempt to offer, the MEC's rescission of the Summary Suspension as evidence that the MEC acted improperly or violated Dr. Brown's rights in imposing the Summary Suspension.

5. PARTICIPATION OF CERTAIN PHYSICIANS IN PROFESSIONAL REVIEW ACTIVITY

As part of the MEC's ongoing professional review activity, Dr. Brown has offered to meet in person with other members of the LCHCS medical staff in order to respond/discuss any areas of concern regarding his clinical proficiency. Dr. Brown acknowledges that members of the LCHCS Medical Staff that provide obstetrical/gynecological services ("Staff OB/GYNs") have participated in this professional review activity. Dr. Brown consents to the ongoing participation of Staff OB/GYNs, including participation in meetings with Dr. Brown to discuss/review this matter.

Dr. Brown releases and holds harmless LCHCS, Staff OB/GYNs, and the MEC from (a) any and all claims based on the Summary Suspension, and (b) any and all claims based on the ongoing participation in the professional review activity by the Staff OB/GYNs. Dr. Brown agrees that he will not later assert allegations of conflict of interest or other claims relating to the participation of the Staff OB/GYNs or other physicians who may be in economic competition with Dr. Brown.

The MEC acknowledges that nothing under this Section 5 will be construed as Dr. Brown's consent to physicians in economic competition with him to serve as an arbitrator, hearing officer or on a panel in any Fair Hearing that may subsequently arise from this professional review activity.

MEC of Laurens County Health Care System Initials

Dr. Brown Initials

LCHCS 0103

ATTACHMENT 2

6. MISCELLANEOUS

This Agreement is to be governed by, and interpreted in accordance with, the laws of South Carolina. In the event of the invalidity of any term of this Agreement, all terms shall be considered severable and the balance of this Agreement shall remain in effect. No amendment or waiver respecting this Agreement shall be effective unless contained in a signed writing. This Agreement constitutes the entire agreement of the Parties respecting the subject matter hereof. The Parties shall be entitled to enforce rights under this Agreement at law or in equity (including specific performance and injunctive relief). Further, Dr. Brown acknowledges and agrees that his breach of this Agreement may result in a professional review action. This Agreement may be executed in one or more counterparts, each of which shall be deemed an original and all of which shall constitute but one and the same instrument. This Agreement is binding upon the Parties hereto and their respective successors, heirs, estates, personal representatives, administrators, and assigns, and inures to the benefit of the Parties hereto and their respective successors, heirs, estates, personal representatives, administrators, and permitted assigns.

ANY DISPUTE ARISING OUT OF OR RELATING TO THE SUBJECT MATTER OF THIS AGREEMENT, SHALL BE TRIED NON-JURY, AND THE PARTIES EXPRESSLY WAIVE ANY AND ALL RIGHTS TO HAVE SUCH DISPUTES TRIED BEFORE A JURY.

7. CONFIDENTIAL AGREEMENT

Except as set forth in this Agreement or as required by law, by state and regulatory authorities, or as required by a court, the Parties agree that each will not divulge, disclose or communicate to any person, firm, organization or corporation, any information about the existence of and the terms of this Agreement. However, LCHCS may disclose the terms of this Agreement to any member of the Medical Executive Committee, LCHCS Administration or the Board.

The Parties hereby enter into the Agreement on the date first set forth above.

Byron A. Brown, M.D.

MEDICAL EXECUTIVE COMMITTEE OF
LAURENS COUNTY HEALTH CARE SYSTEM

By: _____
Its: Chief of Staff

LCHCS
0104

ATTACHMENT 2

MEMORANDUM

TO: Matt Mitcham

CC: Sam McEwen

FROM: Michael Meyer

DATE: September 15, 2011

RE: Byron A. Brown, MD - Coverage

Question: Should MAG Mutual provide liability coverage and/or a defense for claims recently reported with a date of loss prior to Dr. Brown's inception date of his first policy and retroactive date?

Documentation:

1. 6/11/09: Dr. Brown's application specifically states that he does not want prior acts coverage quoted.

2. 7/6/09: Dr. Brown signed and faxed to the South Carolina office the acceptance letter stating he understands the effective date of the policy is 7/9/09 with no prior acts coverage.

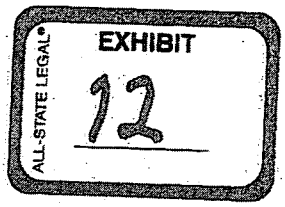
3. 7/9/09: New Business Declaration page outlines the Policy Period is From 7/9/09 To 7/9/10 with a Retroactive Date of 7/9/09.

4. 7/9/09: Endorsement PS-RES06 labeled "No Prior Acts Coverage Endorsement" was also sent to Dr. Brown as part of the initial policy.

5. 7/9/09: The Certificate of Insurance sent to Laurens County Hospital (the only hospital listed on the application) states the effective date of 7/9/09 and retroactive date of 7/9/09.

6. In the MAG Mutual Underwriting file we do have a copy of the Joint Underwriting Association Policy Declarations page that specifically shows Dr. Brown had a "Claims Made" policy.

7. 12/7/09: Computer printout note from Courtney Tighe which outlines that "Dr. Brown called re JUA calling him pushing him to buy tail cvg. Verified in file that he was on a CM (Claims Made) form w/JUA and we did not pick up his retro date. Explained how



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the gap in coverage worked... He felt okay about it since he is an LLC..."

8. Just to note that on Dr. Brown's application completed on 6/11/09, Dr. Brown stated he did not have any settlements/judgments or pending claims. UW found out that Dr. Brown had a $600,000 settlement in 1/09.

9. Sam has talked to Dr. Brown recently and Dr. Brown informed Sam that he has filed for bankruptcy and is moving out of the country. Dr. Brown asked Sam if he could slow down the cases going into suit, so that when he relocates he will purchase prior acts coverage for the claims. Sam explained these cases were reported and NOIs.

Dr. Brown has reported the following cases to MAG Mutual:

File No.	Plaintiff	DOL	Reported	File Type	Position
33328	Dennie	9/22/09	3/3/10	NOI	Covered
33329	Mitchell	10/22/09	3/3/10	Suspense	Covered
33347	Neighbors	11/24/09	3/3/10	NOI	Covered
35024	Gibbs	11/10/09	9/3/10	Suspense	Covered
35026	Leopard	7/20/09	9/3/10	Suspense	Covered
38560	Ward	9/9/09	8/30/11	NOI	Covered
	Mitchell	10/27/09	8/29/11	Claim	Covered
	Williams	12/11/09	8/29/11	Claim	Covered
	McCord	12/18/08	8/29/11	NOI	No Coverage
	Sherfield	5/29/09	8/29/11	Claim	No Coverage

Conclusion:

The first 8 claims on the above list have coverage as the medical care falls within the policy period. The last two files (McCord and Sherfield) I suggest Sam send a Reservation of Rights letter informing Dr. Brown that he has no liability coverage for any medical care prior to 7/9/09. Sam will then have to do a complete investigation as to these cases to confirm if there is any continuing medical care. If all the medical care rendered is prior to 7/9/09, we may consider entering into an agreement where MAG Mutual will agree to a courtesy defense, however, no indemnity coverage.

I look forward to discussing the coverage on the 2 claims, McCord and Sherfield. Please call so we can discuss your comments and opinions.

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State of South Carolina)
)
County of Laurens)

Chris Katina McCord, Christopher McCord, Janice Sherfield, and Jerry Sherfield,
Plaintiffs,
v.
Laurens County Health Care System and Greenville Healthcare System,
Defendants.

14-CP-30-250

Deposition
of
James W. Weiss, MHA, MBA, FACHE

Date: September 21, 2016

Time: 10:17 a.m.

Location: Haynsworth Sinkler & Boyd, PA, One North Main, 2nd Floor, Greenville, South Carolina

Reported by
Kathleen R. Tackett, CVR-M

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APPEARANCES

For the Plaintiffs: Joseph "Joey" G. Wright, III, Esq.
McGowan, Hood & Felder, LLC
Anderson, South Carolina

For the Defendants: Kenneth N. Shaw, Esq.
Haynsworth Sinkler & Boyd, PA
Greenville, South Carolina

Also Present: Amy Simons, Videographer

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Plaintiffs' Exhibit Number 5, "Order for Judgment." 54

Plaintiffs' Exhibit Number 6, "Judgment." 54

Plaintiffs' Exhibit Number 7, "Agreement," dated 02/14/02. 36

Plaintiffs' Exhibit Number 12, Memorandum in reference to "Byron A. Brown, MD - Coverage." 90

Plaintiffs' Exhibit Number 13, Article from the Institute of Medicine in reference to "To Err is Human: Building a Safer Health System." 54

Plaintiffs' Exhibit Number 14, Department of Health and Human Services Office of Inspector General guidelines in reference to "Adverse Events in Hospitals National Incidence Among Medicare Beneficiaries." 54

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Plaintiffs' Exhibit Number 17, "Affidavit of Sandra Thompson." 90

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Plaintiffs' Exhibit Number 47, "Defendants Supplemental Response to Plaintiffs' Initial Requests for Admission." 126

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STIPULATIONS

It is stipulated by and between counsel for the respective parties that all objections are reserved until the time of trial, except as to the form of the questions.

This deposition is being taken pursuant to the South Carolina Rules of Civil Procedure.

- - - -

The reading and signing of this deposition is reserved by the deponent and counsel for the respective parties.

Whereupon,

James W. Weiss, MHA, MBA, FACHE, being duly sworn and cautioned to speak the truth, the whole truth, and nothing but the truth, testified as follows:

EXAMINATION

BY MR. WRIGHT:

Q Mr. Weiss, if you would, please state your full name and your resident address.

A I'm James William Anthony Weiss, 80 Eve Creek, Beaufort, South Carolina 29906.

Q And how long have you lived at your current address?

A Since March of 2000, which would be 16 1/2 years.

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coverage in amount satisfactory to the hospital"; is that correct?
A That's what it says.
Q All right. Now, let's talk about some of the requirements of the hospital. If you would, turn to Exhibit 44.
THE COURT REPORTER: Mr. Wright, do you want me to mark 4B before we go any further?
MR. WRIGHT: Uh-huh. Yeah. 4A and 4B.
(To Mr. Shaw) Here you go, Ken.
MR. SHAW: Thanks.
Plaintiffs' Exhibit Number 4-B, "Medical Staff Bylaws," Revised June 2007.
Q Now, what I'm showing you are provisions of the South Carolina statutes and also DHEC requirements. And Section 44-7-260 requires that the hospital be operated in compliance with regulations promulgated by the department -- and "the department" being the Department -- DHEC, Department of Health -- Health -- Department of Health and Environmental Control, correct?
A Yes.
Q Okay. Now, in Section D, the hospital -- the act also requires the hospital to have "a single organized medical staff," correct?

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A Yes.
Q So a hospital cannot be legally operated in South Carolina unless it has a medical staff and unless it is operated in compliance with DHEC regulations; would you agree with that?
A Yes.
Q And, if you'll look over at 44-7-750, would you -- would you agree with me that the law requires that the hospital be operated "for the benefit of the inhabitants of such county, township, city, or town and any persons falling sick or being injured or maimed within the limits"? That's the purpose of the hospital --
A Yes.
Q -- right?
And Mrs. McCord and Mrs. Sherfield were the beneficiaries of the hospital of Laurens County Hospital because they were residents of Laurens County, correct?
A If they use it, yes.
Q Well, they used it in this -- you're -- you're aware that they -- you're aware what the case is -- that -- that Dr. Brown operated on them in Laurens County Hospital, correct?
A Yes.

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Q Okay. So would you agree with me, then, that Laurens County Hospital -- or -- or that Ms. McCord and Mrs. Sherfield were beneficiaries of the hospital since they were residents of Laurens County and -- and -- and were operated on in -- in the hospital in Laurens County?
MR. SHAW: Objection.
A If you will define "beneficiaries" for me, I'd be able to answer that.
Q Well, "Every hospital established under the provisions of this article shall be for the benefit of the inhabitants." Is that good enough for you?
A Yeah. It's -- that's good enough.
Q Okay. So they -- so they -- being "for the benefit of the inhabitants," then Laurens County Hospital for the -- was for the benefit of Ms. McCord and Ms. -- Ms. Sherfield, correct?
A From -- from what you said and what you read, yes.
Q That's the law --
A Yes.
Q -- isn't it? Okay.
All right. And, now, over under DHEC regulation -- if you flip it on over, I'll ask you a few questions about some DHEC regulations. We'll start off with Section 202, "Control."

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A Which exhibit?
Q It's same exhibit. If you just flip over a couple of pages to 202 --
A Okay.
Q -- wherein it says, in the second sentence, "A written set of bylaws for the operation of the hospital" -- do you see that?
A Yes.
Q -- "shall be formulated by the governing authority."
So the bylaws that we saw earlier are required by DHEC to be in existence if the hospital is going to be operated, correct?
A That's not what these bylaws -- they're referring to in the -- these bylaws. These are governing-body bylaws. The other bylaws that you were talking about were medical-staff bylaws.
Q I -- I think you're in error there. You see the -- where it says, the first sentence, "The governing board . . . shall be the supreme authority of the hospital responsible for management and control of the hospital and appointment of the medical staff"?
A Yes.
Q And then the last line: "The medical staff should be responsible to the governing authority for the

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are you accepting as a fact, yes or no, that Dr. Brown committed malpractice on Mrs. McCord?

MR. SHAW: Objection.

A. I don't know it to be a fact.

Q. Okay. So that's no. Are you accepting in -- in your opinions that you're rendering in this case, are you accepting, as a fact, that Dr. Brown committed malpractice on Mrs. Sherfield on May the 29th, 2009, during her surgery? Yes or no?

MR. SHAW: Objection.

A. No.

Q. Okay. Didn't find that hard.

Now, were you aware that, in 2008 and 2009 when the surgeries on Ms. McCord and Mrs. Sherfield were being done, that knowledgeable members of the health care community were aware of the Institute of Health and inspector general's reports?

A. Yes.

Q. Okay. Those are type of reports that people in the health care industry should be kept up to date with and be aware of, correct?

A. Yes.

Q. Okay. Would you agree that it was common practice, in 2008 and 2009, for hospital administrators to require physicians practicing in their hospital to

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carry and maintain medical malpractice insurance?

A. It would -- it would not be the hospital administrator, it would be the governing body.

Q. The governing body. Would it be common practice for the governing body, in 2008 and 2009, to require physicians practicing in the hospital to carry and maintain medical malpractice insurance?

A. Yes.

Q. Would you agree that medical malpractice insurance, in part, benefits and protects innocent patients who are injured in the hospital due to malpractice of a doctor by providing a means to recover damages wrongfully inflicted?

A. No. I do not.

Q. You -- you don't agree that -- that -- that the patient benefits from the malpractice insurance?

A. Restate your previous question. They may benefit but it's not done for the benefit of the patient.

Q. That's not my question.

A. That was your question.

Q. Question is: Do you agree that medical malpractice insurance, in part, benefits and protects innocent patients who are injured in the hospital due to malpractice by doctors by providing a means to the patients to recover damages -- to recover for

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damages wrongfully inflicted?

MR. SHAW: Objection.

A. I don't agree with that statement.

Q. What part do you not agree with?

A. I don't agree that it was -- that it is done for the patient for them to benefit from it. That has -- that has nothing to do with why an organization or a board mandates that there be, or requires that there be medical malpractice liability.

Q. All right. We're going to get into the question you want to answer later. But my question, simply, to you is not why it's taken out. Do you -- you understand how insurance works, don't you?

A. Yes.

Q. Medical malpractice insurance?

A. Yes.

Q. And, if we have an example where a doctor commits medical malpractice insurance in a hospital and a patient brings a lawsuit, that the insurance is there that will pay the patient for any judgement or settlement, correct?

MR. SHAW: Objection.

Q. I -- I mean, that's the effect of what happens?

A. Yes. It's the effect of what happens.

Q. And the effect of what happens is the patient

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benefits because there is a sum of money there that can pay the patient as opposed to the doctor not having the money to pay the patient, correct?

A. They may benefit, yes.

Q. Okay. That was -- that was just my question. The -- the -- is -- is -- is the medical malpractice insurance -- is there a benefit for the medical -- to -- to the patients from the medical malpractice insurance?

A. Obviously, there's a benefit.

Q. Thank you. Now, let's go to the question. Now, you were saying that the hospital requirements for medical malpractice insurance are not to benefit the patient, correct?

A. That requirement is not for -- for the patient to be -- to benefit.

Q. All right. Let's explore that a little bit. Why do you say that?

A. It's there to protect the assets of the organization --

Q. Well --

A. -- or the doctor. It's like you having -- like -- or me having liability -- professional-liability insurance -- or liability insurance. I don't buy it to protect the person who falls down my steps or

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breaks -- or gets bitten by my dog; I buy it to protect my assets and my family's assets.

So it has nothing to -- my intent is not to buy it for the person who might fall down my steps and get hurt.

Q. All right. Well, let's look at that just a little bit and -- you had mentioned earlier that the hospital's common practice to require medical malpractice insurance, correct?

A. The hospital, what? That word I didn't here.

Q. The medical-staff bylaws, the common practice is to require professional-liability insurance, correct?

A. As defined by the board of governors --

Q. Okay.

A. -- or trustees or one of the -- the authority overriding -- the fiduciary accountable overriding activity.

Q. Okay. All right. So let's -- so we can talk about it, let's say that there is a requirement that the doctor maintain $1 million --

A. Uh-huh.

Q. -- malpractice insurance per -- per occurrence, and $3 million per -- total, okay?

A. (Nods head up and down.)

Q. All right. Now, that's in the medical-staff

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bylaws?

A. Yes.

Q. Okay. Now, why is that in the bylaws? What is the reason to put that requirement on the doctors, in your opinion?

A. In my opinion and experience, it's -- it's there so that there is coverage and that it does not fall back on the organization as deep -- in deep -- as far as deep pockets are concerned --

Q. All right. Hold on a second. When you say "organization," you're talking about the hospital?

A. Yeah. Yes.

Q. Okay. Go ahead.

A. -- and to ensure that the -- the -- that the physician is accountable for covering his assets.

Q. So -- so the hospital is taking a paternal approach for the physician, that he --

MR. SHAW: Objection.

Q. -- that he is taking this insurance out to protect his assets, correct?

MR. SHAW: Objection.

A. I don't agree to the -- with the word "paternal."

Q. All right. How would you describe it?

A. It's a requirement standard in the industry that the governing body require the medical staff to

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have -- to mandate that the -- that the practitioners have medical malpractice.

If they're independent, they do it themselves; if they're employees, the hospital does it.

Q. Right. If -- if -- if they're employees of the hospital, the hospital has professional-liability insurance?

A. They may not; they may be self-insured.

Q. Or self-insured --

A. Right.

Q. -- right.

A. If they do not -- the issue being if they do not have any kind of liability insurance, for whatever -- whatever they're getting, then they have to go self-insure.

Q. Right. And would you agree with me that in -- if they are self-insured, that in the employment contract with -- with the physician, the hospital accepts responsibility for damages that may be awarded for medical malpractice?

MR. SHAW: Objection.

A. Restate that, please.

Q. Would you agree that if the -- if the physician is an employee of the hospital, that in the employment contract with the hospital, the hospital accepts

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responsibility for payment of damages if the -- if the -- if the doctor has a malpractice verdict against him?

MR. SHAW: Objection.

A. There would have to be a judgment made.

Q. All right.

A. And the insurance company would be part of that --

Q. No. No. This is self-insured.

A. Oh, self -- okay.

Q. The hospital would accept the responsibility --

A. Yes.

Q. -- as opposed to the -- to the -- to the insurance company accepting responsibility?

A. Yeah.

Q. Yeah. Okay.

A. They would be their own insurance company.

Q. Right. Okay. That's with their employees, but if they're not employees, then they have to get -- get professional-liability insurance, correct?

A. Yes. Yes.

Q. Okay. And tell me, again, because I'm still a little bit unclear why -- if the doctor is responsible -- okay. If the doctor is responsible and the hospital's not responsible, why would the hospital require the doctor to get insurance to

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protect the hospital?
MR. SHAW: Objection.
A. They would require it as part of the fiduciary requirements of the board to make -- to ensure that the hospital or organization doesn't end up responsible for any judgments.
Q. No. I mean, the hospital has its own insurance, right? Hospital has liability insurance, correct?
A. Yes.
Q. Okay. And so, if -- if the doctor is liable, and he's not an employee of the hospital, why should -- why -- I mean, why is the hospital requiring the doctor to -- to obtain insurance to protect the hospital?
MR. SHAW: Objection.
Q. I mean, the hospital doesn't need protection if they're not liable, do they?
A. And The Joint Commission doesn't require the hospital to mandate there to be medical malpractice insurance.
Q. That's not their job. That's not Joint Commission's job. You know that, correct?
A. Yes. That's why they don't require it, but if they -- if --
Q. I'm not talking about Joint Commission; I'm talking

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about -- just like you said, the hospital requires the doctor to get insurance to protect the hospital against any liability.
And my question to you, sir, if the doctor is not an employee of the hospital, and the doctor's the one that's responsible, why does the hospital need the doctor to have the insurance because it has insurance to protect itself?
A. If the physician or the -- or whomever -- the licensed independent practitioner does not have medical malpractice, then it would have -- then there would be -- the -- whoever was at -- was harmed would then go after whoever they could, and the hospital would have to -- if found by judgment, then the hospital's insurance rates would go up, and it would cost the hospital.
Q. If -- if the hospital's not liable, how could they go against the hospital?
A. You're saying that they're not liable, but they might be declared liable.
Q. But then the hospital has its own insurance if the hospital's liable.
A. And their premiums go up, and their rates -- and all kinds of other things get taken into account by providers who are -- or organizations that they

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contract with.
Q. Isn't the real reason is the hospitals are there for the protection of the people in the community, as set forth by state law, and the hospital, as a function of being a upstanding citizen in the community, knows that the medical malpractice lawsuits happen and knows that its -- that its patients need to be protected from medical malpractice by doctors that occur in their hospital? Isn't that the real reason?
MR. SHAW: Objection.
A. They need to be protected to ensure that some type of remuneration can help the patients over any harm that they get.
Q. Right. And that would be requiring insurance, professional-liability insurance, by the doctors operating in the hospital, correct?
MR. SHAW: Objection.
Q. Correct?
A. Yes.
Q. Thank you. Now, let me ask you about public policy. Since you've dealt with the hospitals in South Carolina, would you agree that the public policy of South Carolina requires hospitals to monitor patient care through oversight to ensure

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that the patient receives quality medical care and to have a high priority of safety for the patients?
A. I'm aware.
Q. Okay. And would you agree that, in order to support the public policy of South Carolina by providing quality care, the State of South Carolina does a number of things, some of which are to fund Medicaid, to pay hospitals for patient care, to fund the medical universities of South Carolina and South Carolina Medical School for physician training to deliver health care to hospitals in the -- to develop -- to deliver health care to patients in the hospitals of South Carolina and to offer tax reductions and financial grants to hospitals in South Carolina? Do you agree that those are some of the things that the State of South Carolina does to support the public policy?
A. Yes.
Q. Now, we've -- we've talked about the requirement of medical-staff bylaws and bylaws of the hospital. Would you agree that if the hospital -- this is a hypothetical question.
A. I couldn't understand that last phrase.
Q. Hypothetical question, hypothetical. If -- if the hospital failed to appropriately privilege a

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physician and allowed that physician to practice in the hospital doing surgery, that if that did occur, that would be a -- a violation of the medical-staff bylaws?

MR. SHAW: Objection.

A. No. The -- you stated that if the hospital allowed them to do that, it would be a violation of the medical-staff bylaws, hypothetically?

Q. Yeah. Hypothetically?

A. Hypothetically, I don't understand the point of the question.

Q. Okay. Let me -- let me try to do better. The medical-staff bylaws have a section in the bylaws regarding privileging of physicians, correct?

A. In '09, yes.

Q. All right. Has that changed?

A. Yes.

Q. Who privileges the physicians?

A. I'm not saying that -- who is privileging. The bylaws have evolved -- the medical-staff bylaws have evolved, and now they have rules and regulations that cover those in-the-weeds or specific things.

Q. Okay. Well --

A. So they've -- there's part of the bylaws, medical-

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staff bylaws now, and rules and regs. It's evolved since then.

Q. All right. Well -- well --

A. Because -- the issue being that rules and regs are easier to change than medical-staff bylaws. Medical-staff bylaws typically take a full vote of a hundred percent of the medical staff.

Q. All right. Well, thank you -- thank you for that but --

A. And that's evolved.

Q. Okay.

A. In '09 I would say the medical-staff bylaws were large, and they covered privileging and credentialing.

Q. All right. Well, let me -- let me amend my hypothetical then. Thank you for that information.

Would you agree that the medical staff has the obligation through bylaws and/or rules and regulations to privilege physicians before they perform surgery in hospitals?

A. Yes.

Q. Would you agree that if the medical staff failed to go through the privileging process of a doctor and he was allowed to practice surgery in the hospital, that that would be a violation of the medical-staff

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bylaws or the rules and regulations?

A. Hypothetically, if that occurred, yes, but that should not occur.

Q. Should not?

A. There should be procedures in place where staff of the hospital do not allow a physician who doesn't have privileges --

Q. Right.

A. -- to do those --

Q. Right.

A. -- to do that particular surgery.

Q. Right. So there are other provisions of the medical-staff bylaws and rules and regulations that the medical staff is required to enforce, correct?

A. Yes.

Q. And the failure of the medical staff to enforce the rules and regulations or the medical-staff bylaws, and/or, would be a violation of their duties, correct?

MR. SHAW: Objection.

A. Hypothetically, yes.

Q. Okay. All right. All right.

A. I mean, you gave a hypothetical, so hypothetically, yes.

Q. Hypothetically, yeah. Okay. And, hypothetically,

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if that breach by the medical staff caused injury to a patient, then the medical staff will have -- would have breached its duty to that patient, correct --

MR. SHAW: Objection.

A. No.

Q. -- hypothetically?

A. Hypothetically, they would've breached the organization's requirements but not to that specific patient.

Q. But not to -- even though the patient's the one that's injured?

A. If the patient gets injured, then the patient would then bring the hospital organization involved in the -- in their issues concerning liability.

Q. Well, that's what I said.

A. They'd both be liable.

Q. And the -- that's what I said. There's a breach of the duty of the medical staff to the patient by not enforcing the rules and regulations that it is required by law to enforce?

MR. SHAW: Objection.

A. Hypothetically --

Q. Hypothetically?

A. -- that -- in my experience, I have never seen that

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about a contract.
A. There -- there is no such thing as a contract.
Q. There isn't?
A. No. There's -- there's a agreement to pay, and then there's informed consent. The two of those things go together to ensure that whatever -- whatever's covered in the informed consent is done, and whatever happens as far as payment is concerned is accomplished. Where's the contract?
Q. Informed -- the informed consent is -- is -- is -- is with the -- with the doctor performing the surgery, correct?
A. The doctor executes it to -- and the -- the organization assists in that particular event.
Q. So let me just ask you just a few more questions on that issue. The services that are part of the contract between McCord and Sherfield and Laurens County Hospital, do you have any document -- have you been furnished with any document setting forth what those services are?
A. I know of no contract between the organization and the -- and the two plaintiffs.
Q. No. I'm -- the contract is -- is already admitted in -- in -- in the admissions. I'm asking you: Do you know of any -- have you been -- let me back up.

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Have you been furnished with any document that lists the services that are part of the contract with Ms. McCord and Ms. Sherfield by Laurens County Hospital?
A. No.
Q. Okay. Let me go back to a relationship between a -- a patient and a hospital, and ask you this, Doctor, as an expert in this field: Patients that are undergoing surgery and other, maybe, life-changing experiences, would you say they have a special relationship with the hospital that would be much greater than a normal contract with a provider --
MR. SHAW: Objection.
Q. -- of services?
A. I can't say that.
Q. You don't -- you can't say that?
A. No. I can't.
Q. You don't think there's a special relationship with a hospital?
MR. SHAW: Objection.
A. I think there's no more special relationship than what you stated way earlier about the -- the community and the hospital's relationship with the community and good will to the community.

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Q. Okay. And that would be a special relationship that would be different than -- than they would have with Walmart or Sears or anybody else that's a commercial establishment, right?
MR. SHAW: Objection.
A. Might be with Walmart or Sears, but there are other organizations that would have the same relationship with a community.
Q. Uh-huh. Like -- like what?
A. An ambulatory surgery center.
Q. Okay.
A. Like a doctor's office.
Q. Okay.
A. A physical therapy office.
Q. All right. So say -- give me an example outside the health care field.
A. Veterinary office.
Q. Okay. All right. They're very important.
A. Because my new -- my puppy Jack Russell -- Irish Jack Russell puppy's very important.
Q. My Shelties are --
A. I'm -- I'm --
Q. -- too.
A. I'm glad to make you smile.
Q. My -- my Shelties are, too.

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But, anyway, that -- that would be a relationship that a hospital would have with -- and they -- they like to develop the special relationship with the --
A. Oh, I think --
Q. -- with the patients.
A. -- there's -- there's -- there's an absolute --
MR. SHAW: Wait. Hold on. Objection.
THE DEPONENT: I'm sorry.
Q. Go ahead.
A. You want to ask a question?
Q. I said that would be what the hospital would want to develop with its patients is a special relationship?
MR. SHAW: Objection.
Q. Correct?
A. If that -- that's the question?
Trust of the community is of a paramount -- and ensuring that we're continuously protecting patients and their rights, you know, is paramount to the -- to our country, to our community, to our region.
Q. All right. All right. Now, let me ask you some questions about the knowledge that the hospital had about medical malpractice being committed by Dr.

STATE OF SOUTH CAROLINA COUNTY OF LAURENS Chris Katina McCord, Christopher McCord, Janice Sherfield, and Jerry Sherfield, Plaintiffs, v. Laurens County Health Care System and Greenville Health System. Defendants.	IN THE COURT OF COMMON PLEAS C.A. No.: 2014-CP-30-250 ***Defendants' Answers to Plaintiffs' Second Set of Interrogatories***

Defendants' answer Plaintiffs' Second Set of Interrogatories as follows:

GENERAL OBJECTIONS

Defendants object to each and every one of the Interrogatories to the extent that the Interrogatories request information that is protected by the attorney-client privilege, is considered attorney work-product, was prepared in anticipation of litigation, was created or generated after and/or as a result of this lawsuit being filed, or is protected by the peer review privilege. By responding to these Interrogatories, Defendants are not conceding that Plaintiffs have stated a cause of action, are not waiving any other objections to discovery, or any objections to admissibility of evidence. Subject thereto, Defendants answer the Interrogatories as follows:

21. State the amount of professional liability insurance coverage that the Board of Trustees of Laurens County Health Care System deemed necessary for Licensed Individual Practitioners ("LIP") to maintain at the following dates:

a) December 18, 2008;
b) February 19, 2009;
c) April 17, 2009;
d) May 27, 2009.

ANSWER: Pursuant to the August 2008 Governing Board Bylaws, which were the effective bylaws for all times relevant to this action, all members of the Medical Staff,

ATTACHMENT 31

including LIPs, were "required to have malpractice insurance coverage limits as defined by Joint Underwriters Association and Patient's Compensation Fund, or coverage limits of one million/three million dollars."

22. Identify and attach a copy of the documents setting forth the amount of professional liability insurance coverage that the Board of Trustees deemed necessary for LIP to maintain on the dates set forth in Interrogatory 21.

ANSWER: See Answer to Interrogatory 21. The August 2008 Governing Board Bylaws have already been produced to Plaintiffs.

23. During 2008 and 2009 was Joint Commission on Accreditation of Hospitals (a/k/a Joint Commission) the accrediting agency for Laurens County Health Care System or Laurens County Hospital?

ANSWER: Yes.

Respectfully submitted,

Kenneth N. Shaw SC Bar 077859
J. Ben Alexander S.C. Bar 15323
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Attorneys for Defendants

Dated: 4/15/16
Greenville, SC

STATE OF SOUTH CAROLINA COUNTY OF LAURENS Chris Katina McCord, Christopher McCord, Janice Sherfield, and Jerry Sherfield. Plaintiffs, v. Laurens County Health Care System and Greenville Health System, Defendants.	IN THE COURT OF COMMON PLEAS C.A. No.: 2014-CP-30-00250 *Certificate of Service*

I HEREBY CERTIFY that a copy of Defendants' First Requests for Admissions to Plaintiffs and Defendants' Answers to Plaintiffs' Second Set of Interrogatories were served upon all counsel of record on this date by depositing in the United States Mail, proper postage affixed thereto, true and accurate copies thereof.

COUNSEL SERVED:

Joseph G. Wright
McGowan, Hood & Felder, LLC
PO Drawer 1778
Anderson, SC 29622-1778

HAYNSWORTH SINKLER BOYD, PA

Amy M. Clark

Dated: 4/15/16
Greenville, SC

Page 1

State of South Carolina)
)
County of Laurens)
)
) 14-CP-30-250
Chris Katina McCord,)
Christopher McCord, Janice)
Sherfield and Jerry)
Sherfield,) Deposition
) of
Plaintiffs,) Richard D'Alberto
)
vs.)
)
Laurens County Health Care)
System and Greenville)
Healthcare System,)
)
Defendants.)
)

Date: August 7, 2015

Time: 9:07 a.m. - 10:16 a.m.

Location: Laurens County Health Care System
22725 Highway 76 East
Clinton, South Carolina

Reported by
Vickie M. Hester, CVR

Page 2

APPEARANCES

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For the Defendants: Kenneth N. Shaw, Esq.
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Greenville, South Carolina 29602

Also present: Sandra Thompson

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Stipulations: 3
Examination by Mr. Wright: 3

EXHIBITS
(All exhibits were marked by Mr. Wright prior to the deposition)

Exhibit No. 4, Medical Staff Bylaws. 26
Exhibit No. 4A, Medical Staff Bylaws. 26
Exhibit No. 7, Contract. 34
Exhibit No. 8, McCord Conditions of Admission. 39
Exhibit No. 9, Sherfield Conditions of Admission. 39
Exhibit No. 13, Article. 10
Exhibit No. 14, Office of Inspector General Report. 12

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STIPULATIONS

It is stipulated by and between counsel for the respective parties that all objections are reserved until the time of trial, except as to the form of the questions.

This deposition is being taken pursuant to the South Carolina Rules of Civil Procedure.

- - - -

The reading and signing of this deposition is not waived by the deponent and counsel for the respective parties.

Whereupon,

Richard D'Alberto, being duly sworn and cautioned to speak the truth, the whole truth, and nothing but the truth, testified as follows:

EXAMINATION

BY MR. WRIGHT:

Q. Mr. D'Alberto, you and I met off the record. And we met previously. And I'm going to be taking your deposition and asking you some questions. You've given a deposition before, haven't you?

A. Yes, I have.

Q. Okay. Ground rules you're probably familiar with, but let me just mention that the Supreme Court

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requires us to go over some of the rules with the witnesses. And that is during the course of me asking you questions, if you do not understand a question, please don't try to answer. Just ask me to rephrase the question if that's all right. You'll need to give verbal responses. So yes, no.

A. Yes.

Q. If I ask you a question that can be answered by a yes or no, if you would just answer yes or no, and then you can -- if you wish to explain, you can go ahead and explain. But I would like for you to answer the question that's presented to you. Is that okay?

A. Yes.

Q. All right. We probably won't be taking any breaks. It's not going to be a long deposition, I don't anticipate. But if we do take a break, you're aware that you cannot discuss your testimony with anyone as long as we have the deposition pending?

A. Yes.

Q. A little background information. If you would, give us how old you are and what your present employment is.

A. How old I am you said?

Q. How old. Uh-huh.

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Q. Well, let's look at that.
A. -- in a quality environment.
Q. Well, one of the functions of the medical staff bylaws is the privileging of doctors, correct?
A. That's correct, yes.
Q. And you don't consider the privileging of doctors to affect the -- the protection of the patient?
A. Privileging of doctors is to assure that the physician has all the qualifications to perform their work at the hospital.
Q. Right. And if they don't have that -- those qualifications, it affects the safety of the patient, correct?
A. If they don't have those qualifications, they're not admitted to have privileges to the hospital.
Q. Well, I mean, that's the function of the bylaws, is to make sure, right?
A. That's correct.
Q. So the function of the bylaws is to make sure that you have qualified doctors, correct?
A. That's correct.
Q. And to have qualified doctors means that the patient would be protected, correct?
A. No.
Q. If you don't have qualified doctors, the patients

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are protected?
A. We can't -- we can't profess to protect the patient. We can only do what we can to provide quality care of the patient.
Q. What's the difference between quality care and protection of the patient?
A. Quality care is meeting the acceptable standards of the practice of medicine without variation to improve the health of the patient.
Q. And that's not protecting the patient or being concerned about the safety of the patient?
A. It has nothing to do with protection as far as I'm concerned.
Q. All right. Now, one of -- one of the qualifications -- and this is over on Page 12. And if you want to look at the full bylaws, they're -- they're right here. Deals with the qualifications of appointment of the -- to the medical staff under 3.2.1. Are you with me?
A. Yes.
Q. Okay. And the bylaws require -- well, let me ask you this before we get into that. Would you agree that it is the responsibility of the hospital administration to make sure that the bylaws are properly adhered to by the medical staff?

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A. The responsibility of the administration? Is that what you said?
Q. Uh-huh.
A. It's the responsibility of the medical staff to govern themselves. Administration does not take the responsibility to assure that the medical staff follows their bylaws. They have their own self governance.
Q. Right. But -- but they are under the hospital. The hospital could not operate without a medical staff, correct?
A. Yes, that's correct.
Q. And so the medical staff is serving one of the functions required by the South Carolina Department of Health and Environmental Control, the operation of the hospital, correct?
A. Yes.
Q. Okay. So then one of the functions -- or one of the requirements of the bylaws is for the physicians in the appointment or privileging, both initially and for the continuing appointment, to maintain valid professional liability insurance coverage, correct?
A. Yes.
Q. And that the failure to maintain valid professional

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liability insurance company -- coverage is subject to withdrawal of privileges by the medical staff, correct?
A. Yes.
Q. And it is a requirement -- and this is under 7.2.9 -- that the information about the medical professional liability insurance coverage be given to the board, correct?
A. Yes.
Q. All right. Now, as far as monitoring the physicians' compliance with the medical staff bylaws, that would be not in your area of -- I mean, that would not be a function that you would do as CEO, that would be a function of the medical staff?
A. That would be a function of the medical staff leadership.
Q. Yeah. And -- and that would be -- do you have a designation for the leader or whatever it be called, medical staff director or --
A. Yeah. There's -- there's -- there is a -- medical staff leadership consists of the chief of staff, the chief of staff elect and -- and then chairs of the various departments, chair of Medicine, chair of Surgery, chair of OB, Pediatrics, those kinds of

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Q. And that settlement was in -- was it January or February of 2014?
A. It was in the '12 to '13 or '14 range. I'm not -- times flies. I can't remember.
Q. Well --
A. You're generally correct.
Q. Yeah. It was -- it was after Ms. McCord's surgery and after Ms. Sherfield's surgeries, correct?
A. Yes.
Q. And it was after July the 9th, 2009 when Dr. Brown's insurance ran out, correct?
A. I don't -- I don't know if his insurance ran out.
Q. No. No. No. I mean, it was after July the 9th, 2009 when the settlement was reached with Dr. Brown?
A. Yes.
Q. Okay. So in other words, as of July the 9th, 2009 this contract was still in effect?
MR. SHAW: Objection.
WITNESS ANSWERS:
A. After July of 2009 I think that --
THE EXAMINATION BY MR. WRIGHT CONTINUES:
Q. In other words he -- he still owed the hospital money under the contract?
A. Well, there -- there might have been a subsequent

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addendum to this contract. I don't recall. This contract was for a specific period of time and expired. But there might have been an addendum related to that piece of it. I don't recall.
Q. Well, we don't have the addendum. So if there was no addendum, then the contract required Dr. Brown to repay the amount, but he could reduce those amounts by working and so much of it being forgiven each month, correct, over on Article 4?
A. Let me take a look at that. Article 4?
Q. Yes, sir.
A. Well, this was -- this agreement was for a three-year term according to Article 4. So this agreement would have expired. And what I'm saying is that there -- if -- if -- if there -- if he did not satisfy his debt, then we would have had some other agreement to collect the remaining amount.
Q. Was it -- and you don't know whether he --
A. And I don't recall if we did or not.
Q. Okay. But in any event Dr. Brown owed $257,000 under this contract until it was forgiven in the settlement?
A. He owed that amount of money after this contract expired. And then we -- and I can't remember -- honestly can't remember if we had any agreement for

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him to pay that amount back.
Q. Okay. We'll --
A. But that -- that amount he owed us was still on the books. And I believe we were willing to forgive that as part of the settlement. But this contract was expired.
Q. Okay. Well -- okay. Let me just ask this question, and we can leave it. In any event Laurens Hospital was contending that Dr. Brown owed that amount because that was a counterclaim in the lawsuit that you had with Dr. Brown, correct?
A. Yes.
Q. Okay. And -- and the contract required that Dr. Brown maintain physician professional liability insurance, correct?
A. Yes. Correct.
Q. And the contract required in Article 6 that the minimum amount of said insurance would be one million dollars per claim or three million dollars aggregate. Is that correct?
A. Yes.
Q. Okay. Now, let me show you what I have marked as Exhibit Number 8.
(Exhibit Numbers 8 and 9 Introduced)
THE EXAMINATION BY MR. WRIGHT CONTINUES:

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Q. And these are documents of Laurens County Hospital that were signed at the time of admission by Mrs. McCord. And Exhibit Number 9 is a document that was signed on admission by Mrs. Sherfield. Are you generally familiar with these documents?
A. Not specifically. I know we have them.
Q. Okay. All right. Now, under financial agreement it says, "The undersigned agrees he signs as agent or as patient and that in consideration of the services to be rendered to the patient he hereby individually obligates himself to pay the account of the hospital in accordance with the regular rates and terms of the hospital." Do you see that?
A. Yes.
Q. Okay. What are the services to be rendered to the patient?
A. It varies depending on what the patient is here for. It could be inpatient and many services related to being an inpatient. It could be outpatient. Could be lab work. Anything that we provide by our providers here at the hospital.
Q. What services do you render?
A. The best way I can answer that is to say we're a full service community hospital. The services we render are general inpatient care for a multitude

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of diagnoses, and outpatient care for mostly testing and procedures.

Q. Let's talk about inpatient care. Somebody's in the hospital for surgery. What -- what services do you render?

A. The -- obviously if they're here for surgery, then there's -- there's the cost associated with the use of the OR, there's a cost associated with the drugs and equipment and materials used.

Q. What services are provided in the OR?

A. The services that are provided in the OR are -- are the staff to support the physician, the surgeon.

Q. Who would that be?

A. That would be OR techs, scrub techs, circulating nurse, those kinds of positions, anesthesia. Those kinds of things.

Q. What other services in the OR?

A. That the hospital provides?

Q. Uh-huh.

A. Yeah. The hospital provides basically everything except the physician service. Because the physician is an independent practitioner. The physician provides their own service.

Q. Hospital responsible for the cleaning of the --

A. Clean the room, yes.

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Q. Hospital responsible for the bed linens, making sure they're --

A. Yes.

Q. -- clean?

A. Yes. The best way to answer that in general is everything that's not the specific physician doing the service is the hospital's.

Q. Hospital services include compliance with DHEC regulations?

MR. SHAW: Objection.

WITNESS ANSWERS:

A. No, that's not specific to this admission criteria -- or this consent.

THE EXAMINATION BY MR. WRIGHT CONTINUES:

Q. So they can be -- the hospital doesn't have to provide a room that's compliant with the South Carolina Department of Health and Environmental Control regulations?

A. Oh, sure we do, yes.

Q. So that'd be one of the services?

A. Yeah. But that's not a -- I'm understanding that you're talking about services provided under this agreement by the patient.

Q. What about washing the -- the linens? I mean, that's -- would that be a service?

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A. Yes.

Q. That would be covered. But compliance with DHEC regulations would not be covered; is that correct?

A. No. That's correct.

Q. All right. What about compliance with Joint Commission requirements; would that be a service that would be provided to these patients?

A. No.

Q. That -- that wouldn't --

A. No.

Q. Why would that not be a service?

A. Those -- those are regulatory agencies that govern the -- the operation of the hospital that are either related to national standards or state or federal law.

Q. And so compliance -- compliance with state or federal law would not be a -- a service that would be rendered to the patients in your hospital; is that correct?

A. Yes.

Q. That is correct?

A. It would not -- you said not be. Yes.

Q. Okay.

MR. SHAW: Can we take a quick break?

MR. WRIGHT: Sure.

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(Off the record from 10:08 a.m. until 10:10 a.m.)

THE EXAMINATION BY MR. WRIGHT CONTINUES:

Q. Would you agree with me, Mr. D'Alberto, that the range of services to be rendered to the patient as set forth in Exhibits 8 and 9 are not listed in the contract?

A. In which contract?

Q. Eight and 9.

A. And are not listed in this?

Q. Yeah.

A. I haven't looked at these in a while, so let me take a look. This is the general consent form. It doesn't -- it doesn't list everything that we do.

Q. Right. That's my question. The conditions of admission state that services are to be rendered by the hospital to the patient?

A. Right.

Q. My question to you, quite simply, is the range of services to be rendered to the patient is not listed in this document, correct?

A. Yes.

Q. Is that correct?

A. Yes.

Q. In Mrs. McCord's case her medical bills to the --

STATE OF SOUTH CAROLINA IN THE COURT OF COMMON PLEAS

COUNTY OF LAURENS C.A. NO.: 2014-CP-30-0250

CHRIS KATINA McCORD, CHRISTOPHER McCORD, JANICE SHERFIELD, AND JERRY SHERFIELD,

PLAINTIFFS,

V.

LAURENS COUNTY HEALTH CARE SYSTEM AND GREENVILLE HEALTH SYSTEM,

DEFENDANTS.

DEPOSITION OF JOHN CHARLES HYDE, II, Ph.D.

Taken at the instance of the Defendants on Tuesday, April 5, 2016, in the offices of Edwards Reporting, Inc., 435 Katherine Drive, Suite A, Flowood, Mississippi, beginning at 12:54 p.m.

APPEARANCES:

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Q. (By Mr. Wright) All right. All right. So in this particular case, as it's been pointed out, the insurance coverage that was available to Ms. McCord and Ms. Sherfield was subsequently divested of them because the insurance coverage that Dr. Brown subsequently obtained either did not obtain extended coverage endorsement or prior claims endorsement, correct?

A. That -- that's absolutely --

MR. SHAW: Objection.

A. -- correct.

THE WITNESS: Sorry.

MR. SHAW: That's all right. I didn't understand that question, so I was objecting.

Q. (By Mr. Wright) Let me restate it. In this particular case, do you have an opinion whether or not the insurance coverage that was at one time available for Ms. McCord under her three surgeries and Ms. Sherfield under her surgery was not maintained because there was no subsequent purchase of expanded coverage endorsement or prior claims endorsement by Dr. Brown?

A. Absolutely correct. That's -- that's the reason that they did not have coverage, because he had failed to buy those --

Q. In your --

A. -- limits.

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Q. Yeah. In your professional opinion as a hospital administrator, would you consider that fact where the insurance coverage became divested as being a violation of the medical staff bylaws?

A. Absolutely. It's clear that it says have in effect at all times the minimum professional liability insurance. And it -- that is a de facto violation if it does not cover part of the -- the patient population that this individual had.

Q. All right. Let me ask you to look at Exhibit number -- I think it's 7, the subsidy contract.

A. Yes, sir. Got it.

Q. Dr. Hyde, look at -- that's the contract between Laurens County Hospital and whom?

A. And Dr. Byron Brown.

Q. And, Dr. Hyde, if you would, look at article 5, I believe.

A. I've got it. Termination.

Q. Well, let me ask you to go over to article 6.

A. Okay.

Q. Does this article require that physician to maintain professional liability insurance?

A. It does.

Q. In what amounts?

A. In the amount of 1 million per claim or 3 million aggregate.

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Q. Okay. All right. Now, if you would, look over on article 2A on page 2.

A. I've got it.

Q. Where it says, "Throughout the term of the agreement and the repayment period" -- which we'll get into a little bit later -- "the physician, Dr. Brown, must comply with all provisions of the medical staff bylaws of the hospital as well as other policies and procedures, rules, and regulations." Do you see that?

A. I do.

Q. Now, in your opinion, did Dr. Brown comply with provisions of the medical staff bylaws and this contract by maintaining the insurance and the required minimum limits?

A. No. He failed to comply. I think it's a breach of the contract.

Q. All right, sir. And under article 5, item 3 under there, if the hospital -- if the physician fails to maintain the professional liability insurance, it gets canceled, then what is the right of the hospital?

A. Well, bottom line is they can cancel the contract -- "may elect to terminate or cancel the contract."

Q. All right. And, if you note in article 4 where

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it says "Repayment," do you see that where the subsidy will be forgiven at a rate prorated out for ten years, 1 --

A. I do see ten years, 120 months.

Q. Yeah. Now, if you would, turn over to Exhibit 29. And what is the amount that the hospital was waiving of that debt of Dr. Brown each month?

A. $5,370 per month.

Q. And as of May the 31st, 2011, which is a little bit over a year and a half later, what is the amount that's owed by Dr. Brown to the hospital?

A. $257,781.

Q. In your professional opinion, did the hospital have the right that if Dr. Brown did not maintain the insurance, to require the full amount of the $257,000 to be repaid?

A. Yes. It's stipulated in the contract. They terminate the contract and then ask for whatever the outstanding balance was at that time.

Q. When you testified earlier about the hospital had right to require Dr. Brown to purchase the other insurance to be in compliance, if they had not -- if Dr. Brown had not purchased that and they had requested it, could the full amount of the indebtedness been called upon and set to repayment by Dr. Brown?

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A. Yes. That $257,000, odd cents -- or odd dollars.
Q. All right. Now, Exhibit Number 35, if you would, look at that.
A. Yes.
Q. This is a check, Premium Financing Specialists, Inc. Dr. Hyde, in your professional opinion, was that a financing mechanism that Dr. Brown could have used to pay the premiums as he had in the past?
A. Yes. It basically is somebody paying it at once and then getting paid to take periodic payments and charge interest.
Q. Okay. I'm going to skip over a lot of that because of time. Now, you were asked about the document, Conditions of Admission. And that would be either Exhibit 7 or Exhibit 8, so, if you would, turn to that.
A. Sure. It's number 8.
Q. Okay. Now, you're aware from the testimony of Ms. Reeves that this document was prepared by employees of Laurens County Hospital?
A. That was my understanding that it was, yes. And that's my recollection of her testimony.
Q. All right.
MR. SHAW: I'm sorry. Whose testimony?
MR. WRIGHT: Reeves, I think.

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MR. SHAW: I don't think she testified to that. Might have been Sandra Thompson, but I don't --
Q. (By Mr. Wright) Okay. Well, one of them testified to that. And I believe she testified it had been in existence since 1993.
A. I recall it being testified to. I didn't remember who. It was one of the two, but, yes.
Q. All right. Now, did Laurens County Hospital choose to list all of the services that it provides in that document or did it just refer to all services that may be rendered?
A. I think it -- to me, it was a blanket reference --
Q. Let me show you right there.
A. It says, "The undersigned agrees he signs as agent in consideration of services to be rendered." It doesn't say just -- it said all services, or I take that to be services, period, including everything.
Q. All right. So I'll ask you again. Did -- the hospital, when it was drawing this agreement up, did it choose to delineate all of the different services that it was going to provide to Ms. McCord or Ms. Sherfield, or did it just refer generally to all services?
A. Generally all. It didn't specify or have a laundry list of everything.

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Q. Based upon your background, training, and experience, in your opinion, when hospitals enter into contracts with their patients, do the hospitals -- are the hospitals required to comply with all state laws and regulations?
A. Absolutely.
Q. In your professional opinion, when a hospital enters into a contract with its patients, is the hospital required to comply with all federal laws and regulations?
A. Absolutely. Yes, sir. That apply to them, of course.
Q. Dr. Hyde, in your professional opinion, when a hospital enters into a contract with its patients, is it required to comply with regulations and promulgations set forth by its accreditation agency, the Joint Commission?
A. Yes.
Q. Dr. Hyde, when a hospital enters into a contract with its patient, is there a requirement that the hospital comply with the medical staff bylaws that it has drawn up, it has approved, the medical staff has approved, and that relate specifically to portions that affect the rights and safety of the patient?
MR. SHAW: Objection.
A. Again, absolutely they're required to do that.
Q. (By Mr. Wright) Dr. Hyde, in your professional

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opinion, as part of the contract, is the hospital required to comply with contracts that it enters into with physicians, surgeons that are going to perform operations on the patients, and when those provisions in the contract comply -- I mean relate to the health, safety, welfare, or legal rights of the patient? Are they required to comply with those?
A. Again, yes, sir.
Q. And, Dr. Hyde, in your professional opinion, did the hospital comply with the requirements of state law, which was the adoption of the bylaws, that the bylaws required that the physicians have and maintain professional liability insurance?
MR. SHAW: Objection.
Q. (By Mr. Wright) Did the hospital comply with that?
MR. SHAW: Objection.
A. No. They failed to comply with that section of the expecta- -- of the bylaws and also the requirement by the state that they -- that they are bound to apply -- or comply -- comply with the bylaws.
Q. (By Mr. Wright) And how about, in your professional opinion, did the hospital comply with the obligations under the contract with the physician requiring that physician to maintain insurance coverage

STATE OF SOUTH CAROLINA)	IN THE COURT OF COMMON PLEAS
)	
COUNTY OF LAURENS)	C.A. FILE NO. 14-CP-30 291
Chris Katina McCord, Christopher McCord, Janice Sherfield, and Jerry Sherfield,)	
Plaintiffs,)	AFFIDAVIT OF JOHN CHARLES HYDE, II, PhD *§§15-36-100; 15-79-129 SCCA*
vs.)	
Laurens County Health Care System and Greenville Healthcare System,)	
Defendants.)	

LAURENS COUNTY
FILED
2014 MAY 14 A 8:05

PERSONALLY APPEARED BEFORE ME THE UNDERSIGNED, FIRST BEING DULY SWORN, AND STATES AS FOLLOWS:

1. I am currently a professor at the University of Mississippi Medical Center in the Departments of Health Sciences and Family Medicine. My duties include teaching, research, and administrative responsibilities in healthcare management, health services research, clinical outcomes, and research designs. I also advise the healthcare community on management and administrative / legal issues. I also work as a Health Care Consultant providing independent expertise and advice to various healthcare delivery organizations covering a large span of administrative issues. My background, training, education and experience are set forth on the attached curriculum vitae.

2. This affidavit is made pursuant to § 15-36-100 of the South Carolina Code of Laws (1976), which requires that this affidavit must specify at least one negligent act or omission claimed to exist, and the factual basis for the negligent act or omission based upon the available evidence at the time of the filing of the affidavit.

3. The evidence made available to me for my review prior to the making of this affidavit includes:

a) Complaint entitled Chris Katina McCord, Christopher McCord, Janice Sherfield and Jerry Sherfield, Plaintiffs vs. Laurens County Health Care System and Greenville Healthcare System, Defendants; CA File No. 14-CP-30-250;

b) the documents supporting the allegations set forth in the Answer and Counterclaim entitled MAG Mutual Insurance Company , Plaintiff vs Byron A. Brown, MD; Laurens County Obstetrics and Gynecology, LLC, a South Carolina Limited Liability Corporation; Pamela Neighbors; Carroll

ATTACHMENT 34

Neighbors; Lisa Dennie; Jeffrey Dennie; Dixie Mitchell; Betty J. Ward; and Donald Ward, Defendants; C.A. File No. 6:14-cv-00353-TMC;

c) Medical Staff Bylaws of Laurens County Health Care System;

d) Subsidy contract between Laurens County Health Care System and Byron A. Brown, MD;

e) Exhibits labeled 1-89

f) Medical articles re hospital deaths referenced in Complaint;

g) South Carolina Dept. of Health and Environmental minimum standards regarding hospitals; and

h) my knowledge and experience regarding literature on hospital administration, Joint Commission Standards, and similar information.

4. Through my professional standing as set forth above, I am familiar with the applicable standard of care for hospital administration specifically applicable to the promulgation and enforcement of Medical Staff Bylaw, the enforcement of contracts with physicians who are privileged at hospitals, the requirement and enforcement of physicians professional liability insurance by hospitals, the responsibility of hospitals to protect the patients undergoing surgery in the hospital, and the public policy of states and the federal government to provide oversight of the health care industry for the protection of its citizens and specifically to ensure quality patient care in hospitals.

5. I have reviewed the evidence submitted to me, and based upon my expertise, as set forth above, it is my opinion to a reasonable degree of medical certainty that Laurens County Health Care System through its agents, servants, and employees failed to do one or more of the following which a reasonably prudent hospital would have done under the same or similar circumstance:

a) to require that physicians holding privileges to perform medical procedures at its facilities have and maintain professional liability insurance in an amount and of a type sufficient to protect patients who sustain injuries and damages from the negligent acts or omissions of the physician;

b) to require that physicians holding privileges to perform medical procedures at its facilities provide proof of professional liability insurance in an amount and type sufficient to protect patients who sustain injuries and damages from the negligent acts or omissions of the physician as a condition for continuation of the physician's privileges;

c) to use reasonable care to monitor physicians to ensure that the physician's professional liability insurance remains in effect, especially when the hospital knew or should have known that the physician's treatment injured patients;

d) to monitor the performance of physicians holding privileges, to investigate circumstances in which a physician holding privileges injures a patient, to investigate complaints made by patients, nurses, and hospital staff against a physician holding privileges, to take appropriate remedial actions against a physician who holds privileges when that physician's treatment has injured patients, and to ensure that the physician's professional liability insurance remains in effect;

e) to require all physicians privileged to perform surgery, especially including Byron A. Brown, MD, to comply with the Medical Staff Bylaws which require the physician to maintain professional liability insurance coverage on patients injured by physician malpractice as long as the physician holds privileges to treat patients at Laurens County Health Care System;

f) to require Byron A. Brown, MD to comply with the Subsidy Contract to maintain professional liability insurance coverage on patients injured by physician malpractice as long as the physician is receiving benefit under the Subsidy Contract and holding privileges at Laurens County Health Care System; and

g) to inform patients directly or by public media who were severely injured and have a potential claim for medical malpractice that notice must be given before a claims-made insurance policy is cancelled or nonrenewed to preserve insurance coverage on the claim, and to whom the notice is to be given, since the patients are not reasonably expected to have this information which was available to Laurens County Health Care System.

6. It is my opinion that it is more likely than not that the deviations from the standard of care by agents, servants, and employees of Laurens County Health Care System proximately caused or contributed to the damages incurred by Chris Katina McCord, Christopher McCord, Janice Sherfield and Jerry Sherfield as alleged in the Complaint.

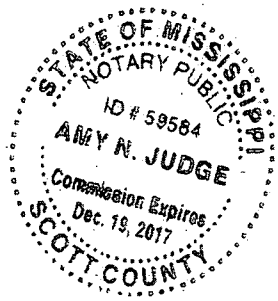
7. The factual bases for my opinions are the documents identified in paragraph 3 and my background, training, education, and experience in hospital administration for over 32 years.

8. This affidavit is given in compliance with §§ 15-30-100 and 15-79-125 of the Code of Laws of South Carolina (1976, as amended), which does not require all negligent acts or omissions known to me to be stated in the affidavit. Further, I anticipate that upon receiving additional facts from documents and deposition testimony that my opinions may be confirmed, supplemented or amended.

John Charles Hyde, II

Sworn to and subscribed before me
this 10th day of April 2014.

Notary Public for Mississippi
My Commission Expires: 12/19/17



STATE OF SOUTH CAROLINA)
: IN THE COURT OF COMMON PLEAS
COUNTY OF LAURENS)
Chris Katina McCord,)
Christopher McCord,)
Janice Sherfield, and)
Jerry Sherfield,)
)
Plaintiffs,)
)
-vs-) C.A. No.: 2014-CP-30-0250
)
Laurens County Health Care)
System and Greenville)
Health System,)
)
Defendants.)

DEPOSITION OF CHRIS KATINA McCORD
August 3, 2015

PURSUANT to Notice and/or agreement between the parties, the deposition of Chris Katina McCord, called by the Defendants, was taken commencing at the hour of 9:54 a.m. on Monday, August 3, 2015, at the Law Offices of McGowan, Hood & Felder, LLC, 1501 North Fant Street, Anderson, South Carolina.

SUE N. HAYNIE, Reporter

APPEARANCES:

McGOWAN HOOD & FELDER, LLC
1501 North Fant Street
P. O. Drawer 1778
Anderson, South Carolina 29622
BY Joseph G. Wright, Esquire
....On behalf of the Plaintiff

HAYNSWORTH SINKLER BOYD, P.A.
ONE North Main, 2nd Floor
Greenville, South Carolina 29601
BY Kenneth N. Shaw, Esquire
..... On behalf of the Defendants

ALSO PRESENT:
Christopher McCord
Sandra Thompson, Laurens County Health Care System

STIPULATIONS:

This deposition is taken pursuant to the South Carolina Circuit Court rules of Civil Procedure; reading and signing of the deposition by the witness are hereby waived.

INDEX OF EXHIBITS

Defendants' No.	Description	Entered at Page
1	Laurens County Health Care System Registration and Consent Forms	62

Plaintiffs' No.	Description	Entered at Page
1	Medical Bills, Laurens County Health Care System	104

INDEX OF EXAMINATION

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By Mr. Wright ..... Page 103

By Mr. Shaw ..... Page 107

CHRIS KATINA McCORD, having first been duly sworn to tell the truth, testified as follows:

EXAMINATION

By Mr. Shaw:

Q: Mrs. McCord, we had an opportunity to meet just a second ago, but again, my name is Ken Shaw. I'm with the Law Firm of Haynsworth Sinkler Boyd in Greenville and I represent Laurens County Memorial Hospital in this case which is now part of Greenville Health System. We're here today to take your deposition. Have you ever had your deposition taken before?

A: No.

Q: Alright. There's a few ground rules that I need to go over with you. The first and most important one is being is I ask you questions today. If you could, please respond to those questions verbally with a yes, a no, some type of verbal answer as opposed to a head shake or an uh-uh, uh-huh type kind of answer, okay?

A: Alright.

Q: And now that we've started the deposition, if you could, any questions that you may have, please direct those questions to me as opposed to Mr. Wright, okay?

A: Alright.

Q: I'm not sure how long we're going to take here today, but if at any point in time you need to take a break,

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the hospital. And the year prior to that, it was about $986, and the year prior to that I do not have a clue what it was.

Q: Are you aware that Laurens County Hospital stated in their documents that they sent to us that only $190 had been taken out?

A: Yes.

Q: Is that accurate?

A: No. I'm waiting on copies from the IRS now to get that, like a hard copy of my taxes where my money went to.

Q: Okay. Do you know how much now Laurens County Hospital is contending that you owe on your accounts?

A: According to this paper you gave me the last time we met, nothing.

Q: Alright. So the documents that Laurens County Hospital furnished us with said that you owed nothing?

A: Said that I owe nothing.

Q: Now, at the time that you signed this document, when it refers to the services to be rendered by the hospital, was it your intent that the services to be rendered by the hospital includes the hospital compliance with their Medical Staff Bylaws?

A: Yes.

MR. SHAW: Objection.

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Q: Was it your intent and understanding that those services to be rendered to you included the hospital compliance with the Medical Staff Bylaws?

A: Yes.

Q: Did it include hospital compliance, in your opinion or in your intention to be covered by the Hospital Bylaws?

A: Yes.

Q: Did the services to be rendered to you include hospital compliance with contracts with physicians who were directly or indirectly affecting your medical care?

A: That would be what I assume, yes.

Q: Was it your intent when you signed this document that the services to be rendered to the patient included the hospital compliance with the Rules and Regulations of the South Carolina Department of Health and Environmental Control?

A: Yes.

Q: Was it your intent that the services to be rendered by the hospital included the requirements of the hospital complying with the certifying agencies' rules and regulations, such as the Joint Commission?

A: Yes.

MR. WRIGHT: No further questions.

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EXAMINATION:

By: Mr. Shaw:

Q: Let me ask you a couple of follow-up questions to that. At the time that you signed this document, did you discuss — The document, your signature was witnessed by Teressa Franks. Do you see that?

A: Yes.

Q: Do you recall whether or not Teressa Franks is the person that had you sign this document?

A: I guess that's her name. I don't remember her name or face.

Q: Did you discuss this document with Teressa Franks or anyone else prior to signing it?

A: No, we did not go over it paragraph by paragraph, detail by detail.

Q: Did anyone, and since we're talking about this paragraph, the Financial Agreement, if you would, go ahead and read the first sentence for the record of what that says.

A: The very first sentence?

Q: The first sentence of where it says, "Financial Agreement," what it says after that.

A: "The undersigned agrees he signs as agent or as patient that in consideration of the services to be rendered to that patient, he hereby individually obligates himself to

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pay the account of the hospital, in accordance with the regular rates and terms of the hospital."

Q: Okay. And then the next sentence goes on to say, "Should the account be referred to an attorney for collection, the undesigned shall pay reasonable attorney's fees and collection expense." Do you see that?

A: Yes.

Q: Okay. And then there's a few more things. It goes on talking about having to try to collect should you not pay. Do you see that?

A: Yes.

Q: Alright. Anywhere in there is there any discussion that in consideration of the services to be rendered to that patient, is there anything that discusses what the services to be rendered are?

A: No, it don't say.

Q: Is there anything that says that the services rendered would be in compliance with the Medical Staff Bylaws?

A: No.

Q: Alright. Is there anything that says that the services rendered would be in compliance with the policies and procedures of the hospital?

A: No.

Q: And, again, as we discussed before, prior to

STATE OF SOUTH CAROLINA)
: IN THE COURT OF COMMON PLEAS
COUNTY OF LAURENS)

Chris Katina McCord, Christopher McCord, Janice Sherfield and Jerry Sherfield,	)	
Plaintiffs,	)	
-vs-	)	C.A. No: 2014-CP-30-0250
Laurens County Health Care System and Greenville Health System,	)	
Defendants.	)	

DEPOSITION OF JANICE SHERFIELD

PURSUANT to Notice, the deposition of Janice Sherfield, called by the Defendants, was taken commencing at the hour of 11:15 a.m. on Thursday, October 8, 2015, in the offices of McGowan, Hood & Felder, LLC, 1501 North Fant Street, Anderson, South Carolina.

IRVETA J. SHOUSE, Reporter

ATTACHMENT 36

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aunt, we talked about having a conversation with your aunt. Other than those people that I just rattled off, do you recall having any conversations with anyone else about the surgery that Dr. Brown performed and the complications of that surgery?

A. Well, the doctors. Dr. Garris. And also my disability insurance. I wasn't even thinking about that. But, yeah, my disability lawyers have all my medical records.

Q. And, again, that's who we were talking about that you saw sometime in 2011; is that right?

A. Yes.

Q. Okay. Did you speak to — well, did you speak to anyone else in regards specifically to the Conditions of Admission form other than Mr. Wright — obviously, I assume you had spoken to Mr. Wright about this particular form, and I know that you have spoken to Ms. Harris about it. Have you spoken to anyone else —and potentially your husband— have you spoken to anyone else about this form?

A. No, sir.

Q. All right. Have you spoken to anyone else about any of the other admission papers that you signed prior to surgery?

A. No, sir.

Q. Okay. Have you spoken to anyone else about what you believe the hospital's duty was to protect you, other than your attorney and anyone we have specifically mentioned today?

A. No, sir.

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MR. SHAW: Mrs. Sherfield, I think that's all the questions that I have for you.

MR. WRIGHT: A few questions. Please mark that as Exhibit 2.

(EXHIBIT NO. 2 MARKED AND ENTERED)

EXAMINATION

By Mr. Wright:

Q. Mrs. Sherfield, on Exhibit 2 —and let me point this out to you— where it says that you obligate yourself to pay the account of the hospital — you see what I'm saying?

A. Yes, sir.

Q. And then on Exhibit No. 1 it shows United Healthcare Administrators. A group named United. Was that your insurance company?

A. Yes, sir.

Q. So you gave them your insurance information so that they could make a claim for any services rendered; correct?

A. Yes, sir.

Q. Now, the services rendered...was it your intention that the hospital would comply with all state and federal laws when you signed the contract?

A. Yes, sir.

Q. Was it your intention that the hospital would require its surgeons, specifically the surgeons that operate in

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the hospital, specifically Dr. Brown, to comply with all the hospital rules and regulations?

A. Yes, sir.

Q. Was it your intention that the hospital would require its surgeons that were privileged, specifically Dr. Brown, to comply with any contracts that it may have with the hospital about patient protection?

A. Yes, sir.

Q. And do you consider the fact that the hospital requirement requiring doctors to have a million dollars minimum insurance coverage to be protection for you?

A. Yes, sir.

Q. And at the time that you made your claim, did Dr. Brown have insurance at that particular time?

A. As far as I know, he did.

Q. I mean at the time of the surgery?

A. Yes, sir.

Q. All right. Now, at the time you made your claim, you've been informed that Dr. Brown did not have insurance that was maintained when you made your claim. Or do you know?

A. I don't know.

Q. All right. Now, you testified about Dr. Brown performing the surgery and coming in and talking to you that evening of the surgery, I believe —

A. Yes, sir.

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Q. — about puncturing your bladder?

A. Yes, sir.

Q. Okay. Now, if you had been told, or informed, by the hospital that Dr. Brown's insurance to protect you, the malpractice insurance, would run out about five weeks later unless you filed a letter or notice with the insurance company, would you have filed a notice with the insurance company?

MR. SHAW: Objection.

A. Yes, sir.

Q. Subject to the objection: Would you have filed the notice with the insurance company?

A. Yes, sir.

MR. WRIGHT: No further questions.

REEXAMINATION

By Mr. Shaw:

Q. Let me ask you a couple of follow-up questions based upon what was just asked of you.

Mr. Wright asked you if you expected that the hospital would comply with all state and federal laws. Do you know what state and federal laws are applicable to the hospital?

A. To protect and make sure that my benefits are met.

Q. That your —

A. Healthwise and safetywise.

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Q. Okay. And what I'm asking you — I mean, you've kind of stated a general principle there. What I'm asking you is, are you aware of any specific state or federal law that requires the hospital to protect your rights or benefits as you said?
A. I do not know law. No, sir, not specifically.
Q. Do you know of any state or federal law that requires the hospital to tell you about a doctor's insurance coverage?
A. No, sir.
Q. The hospital rules and regulations. Do you know anything about the hospital rules and regulations?
A. No, sir.
Q. Had you seen the hospital rules and regulations prior to your surgery?
A. Not that I recall.
Q. Did you ask to see the hospital rules and regulations prior the surgery?
A. No, sir.
Q. The contracts with doctors. Prior to your surgery had you seen any contract between Dr. Brown and the hospital?
A. No, sir.
Q. All right. To your knowledge, do you know whether a contract existed between Dr. Brown and the hospital at the time of your surgery?

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A. No, sir.
Q. Did you ask anyone if there was a contract between Dr. Brown and the hospital prior to your surgery?
A. No, sir.
Q. Okay. Did you know that there was a requirement at the hospital for any doctors that were privileged to perform surgeries at the hospital to maintain medical malpractice insurance? Did you know about that requirement?
A. Yes.
Q. Okay. How did you know about that requirement?
A. Well, I just... When I've had surgeries before in the past, I know that all doctors are supposed to have malpractice insurance.
Q. And what makes you believe that all doctors are supposed to have medical malpractice insurance?
A. Well, it's a law. I mean...
Q. You believe that there is a law that requires doctors to maintain medical malpractice insurance?
A. Yes, sir.
Q. All right. Have you ever asked anyone if there was a law that requires doctors to maintain medical malpractice insurance?
A. Have I asked anyone? No.
Q. Did anyone at the hospital ever tell you that there was a law that required doctors to maintain medical malpractice

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insurance?
A. No.
Q. Where do you believe that you came up with that belief?
A. Well, when I had surgeries earlier, and when I had my hysterectomy when I was in my early 20s, my aunt —my husband's aunt— worked with Dr. Dermer who done my hysterectomy. And I knew from her that doctors had to have malpractice insurance.
Q. Your —
A. By law.
Q. Your aunt told you that?
A. Uh-huh.
Q. Is your aunt —
A. She was a nurse at Dr. Dermer's office.
Q. She was a nurse at Dr. Dermer's office.
A. Uh-huh.
Q. Where was Dr. Dermer's office?
A. In Laurens.
Q. All right.
A. And I've never asked other doctors before because I assume that they all have to because it was a law.
Q. Okay. And, again, your assumption of that is based upon what your aunt told you; is that correct?
A. Yes. And she was a nurse.

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Q. Anyone other than your aunt tell you that?
A. No.
Q. Your aunt, I'm assuming — did your aunt work for Laurens County Health System at all?
A. She worked with Dr. Dermer, who was an ob/gyn. And he delivered my babies at Laurens Hospital. So I'm not sure if she was employed with Laurens Hospital or Dr. Dermer.
Q. Where was Dr. Dermer's office?
A. In Laurens.
Q. Was it inside the hospital?
A. No. Beside it.
Q. So as we sit here today, do you know whether Dr. Dermer was employed by Laurens County Health Care System?
A. No, I don't.
Q. And you don't know whether your aunt — your aunt was employed by Dr. Dermer; is that correct?
A. Yes, sir.
Q. So you don't know whether your aunt had any — whether your aunt was employed by Laurens County Health System; is that right?
A. That's right.
Q. So, again, what I want to make sure of is, did anyone — to your recollection, has anyone at Laurens County Health Care System ever told you that there was a law that required doctors to maintain insurance?

THE STATE OF SOUTH CAROLINA
In The Court of Appeals

Appeal From Laurens County Court of Common Pleas

Eugene C. Griffith, Jr., Circuit Court Judge

Appellate Case No. 2017-001064

Chris Katina McCord, Christopher McCord,
Janice Sherfield, and Jerry Sherfield ********** Appellants

v.

Laurens County Health Care System and
Greenville Health System ********** Respondents

CERTIFICATE OF COUNSEL

The undersigned hereby certifies that the Record on Appeal contains all material proposed to be included by any of the parties and not any other material.

August 28, 2017

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