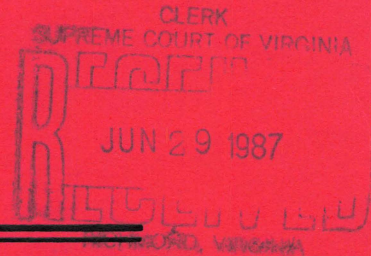


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IN THE
Supreme Court of Virginia
AT RICHMOND

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MEDICAL CENTER HOSPITALS and THE EXECUTIVE BOARD OF
DIRECTORS OF MEDICAL CENTER HOSPITALS,
Appellants.

v.

JULIA K. TERZIS, M.D., a/k/a PHYSICIAN 392,
Appellee.

JOINT APPENDIX

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Frederick Robinson
Katherine A. Taylor
FULBRIGHT & JAWORSKI
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Norfolk, Virginia 23514

Counsel for Appellee

FILING AND MAILING CERTIFICATE OF PRINTER

I hereby certify that on this 29th day of June, 1987
I filed with the Clerk's Office of this Court the required copies of this document and further certify that I mailed this same date from Richmond, Virginia the required copies to opposing counsel.

The necessary filing and mailing was performed in accordance with the instructions given me by counsel in this case.

Three copies of this Appendix have been Federal Expressed to Thomas J. Harlan, Jr., Michael F. Bergan, HARLAN, KNIGHT, DUDLEY & PINCUS, 1350 Sovran Center, P. O. Box 3188, Norfolk, Virginia 23514.

Michael F. Bergan

Appellate Printing Services, Inc.
Heritage Building
10th and Main Streets
Richmond, Virginia 23219

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VIRGINIA: IN THE CIRCUIT COURT OF THE CITY OF NORFOLK

PHYSICIAN 392,

Plaintiff,

v.

THE BOARD OF DIRECTORS OF MEDICAL
CENTER HOSPITALS, INC.,

Defendants.

NOTICE OF APPLICATION FOR
TEMPORARY INJUNCTION

TO: Frank Kollmansperger, Chairman
Board of Directors
Medical Center Hospitals, Inc.
c/o Medical Staff Office
Norfolk General Hospital
600 Gresham Drive
Norfolk, Virginia 23507

TAKE NOTICE that on the 31st day of March,
1986, at 1:30 o'clock P.M. or as soon thereafter as counsel
may be heard, at the Circuit Court of the City of Norfolk,
Virginia, I will move for a temporary injunction in accordance
with the prayers of the attached Bill of Complaint.

PHYSICIAN 392


By Thomas J. Harlan, Jr.
Of Counsel

Thomas J. Harlan, Jr., Esquire
HARLAN, KNIGHT, DUDLEY & PINCUS
1350 Sovran Center
One Commercial Place
Norfolk, VA 23510
(804) 625-7605

THOMAS J. KNIGHT,
PINCUS
NORFOLK, VIRGINIA

CERTIFICATE OF SERVICE

I hereby certify that a true copy of the foregoing Notice of Application for Temporary Injunction was hand-delivered to Frank Kollmansperger this 31st day of March, 1986.



Thomas J. Harlan, Jr.

[MFB6]

HARLAN, KNIGHT,
& PINCUS
NORFOLK, VIRGINIA

VIRGINIA: IN THE CIRCUIT COURT OF THE CITY OF NORFOLK

PHYSICIAN 392,

Plaintiff,

v.

THE BOARD OF DIRECTORS OF MEDICAL
CENTER HOSPITALS, INC.,

Defendants.

Serve: Frank Kollmansperger, Chairman
Board of Directors
Medical Center Hospitals, Inc.
c/o Medical Staff Office
Norfolk General Hospital
600 Gresham Drive
Norfolk, Virginia 23507

BILL OF COMPLAINT FOR TEMPORARY INJUNCTION

TO THE HONORABLE JUDGES OF THE CIRCUIT COURT OF THE CITY OF
NORFOLK:

Your plaintiff respectfully represents:

1. That the plaintiff is a Canadian citizen, and
physician and surgeon duly licensed to practice medicine in the
Commonwealth of Virginia, and is a resident of the City of
Norfolk, Virginia; and that the defendants are the members of
the Board of Directors of Medical Center Hospitals, Inc., a
corporation organized pursuant to the Virginia Non-Stock
Corporation Act.

2. That your plaintiff practices micro-neurosurgery,
which is a highly specialized and sophisticated branch of the
medical arts and sciences. Your plaintiff is a nationally and

ARLAN. KNIGHT,
& PINCUS
NORFOLK, VIRGINIA

internationally renowned practitioner, surgeon, scholar, author, lecturer and innovator in the field of micro-neurosurgery, and maintains a state-of-the-art, high technology diagnostic and operative facility at Norfolk General Hospital in order to provide each of her adult and pediatric patients with the full benefits of her knowledge and experience. Throughout her career, your plaintiff has succeeded in successfully treating a tremendous variety of unusual and previously incurable adult and pediatric neurological ailments and conditions and has thus actively extended the conceptual and practical parameters of modern neurology and micro-neurosurgery.

3. That your plaintiff has been fully privileged to practice medicine at Norfolk General Hospital since June of 1981, until March 30, 1986, at which time, by action of the Board of Directors of Medical Center Hospitals, Inc., her privileges were suspended for thirty days and Physician 392 was further put on "probation" for one year, the terms of which are so onerous as to make her practice difficult, if not impossible.

4. That the suspension and probation imposed on your plaintiff contrary to the Bylaws, Rules and Regulations of the Medical Staff of Medical Center Hospitals will have a profound effect and work an irreparable injury upon Physician 392 and her patients.

The plaintiff's business reputation and good name are impugned by the actions of the Board of Directors and other committees of Norfolk General Hospital, which actions are already the subject of rumor and innuendo in the medical

community. The plaintiff's opportunity and right to practice her profession in the future are further imperiled by the fact that hospitals universally ask applicants for privileges whether they have been subject to suspension and/or probation (see "Exhibit A") the action of the Board of Directors will therefore render the plaintiff unable to practice medicine in North America.

Further, your plaintiff has surgery scheduled and patients due to be admitted to Norfolk General Hospital during the period of her suspension. The suspension will deny her admitting and operating privileges. Her procedures require her highly specialized facilities at Norfolk General Hospital, which facilities she has spent five years creating. Many of these patients, both adult and pediatric, are scheduled for the second stages of multiple-stage, year-long treatments. Depriving these patients of their treatments poses threats of additional muscle atrophy and other adverse effects and will interrupt their course of treatment to their detriment.

5. That a physician, accorded privileges at Norfolk General Hospital, as was your plaintiff, is guaranteed minimal due process and procedural fairness by the Bylaws of Medical Center Hospitals.

The Manual for Accreditation of Hospitals of the Joint Committee on Accreditation of Hospitals mandates "FAIR HEARING AND APPELLATE MECHANISMS" of accredited institutions. The Bylaws of Norfolk General Hospital, embodying the contractual obligations to Physician 392 from Medical Center

CHARLAN, KNIGHT,
UDLEY & PINCUS
NORFOLK, VIRGINIA

Hospitals, further specify certain procedural guarantees which were violated in the actions taken against your plaintiff since November of 1984. Those Bylaws provide that a request for "corrective action" [such as suspension and/or probation] must be made with reference "to SPECIFIC activities or conduct which constitute the grounds." [Article IX(A)(1)] The Bylaws require the notice of a hearing before the Medical Staff or an ad hoc committee to specify "the grounds [for adverse action] and the specific or representative charts being questioned" [X(B)(e)]. None of the procedural guarantees of the Bylaws requiring specific notice and an opportunity to defend were afforded your plaintiff.

6. That your plaintiff practiced uneventfully at Norfolk General Hospital until 1984, at which time she became subject to an extraordinary inquisition into her practice, which history is set out at length in a Written Statement in Support of an Appeal appended hereto and made a part hereof as "Exhibit B."

7. That throughout the process of investigation and prosecution of various committees and Boards of Norfolk General Hospital, your plaintiff was routinely denied the rights afforded her to her by that institution's own Bylaws, to-wit:

(a) Denial of a fair hearing by the interrelationship of investigative, adjudicative and appellate bodies. One physician, Dr. Hoffman, served on all bodies which considered action against Physician 392 and served as prosecutor before the appellate body. Of the first ostensibly "appellate"

body -- the Medical Executive Committee [MEC] -- a majority of nine members had already passed judgment on Physician 392 in an adjudicative setting as members of the Departmental Authorities Committee [DAC].

(b) Failure to give adequate notice and an opportunity to defend. Physician 392 was confronted initially with 233 charges derived from 211 charts. These charges were not only multiplicitous, but were also so vaguely formulated as to be impossible to defend. Working within time constraints, Physician 392 was given an opportunity at various hearings to defend against only seven specific cases, frequently without the assistance of counsel and denied the assistance of those Fellows and/or clerical assistants who assisted her in gathering appropriate charts.

Many of the "hearings" at which your plaintiff appeared were characterized as "interviews" and in the one hearing at which your plaintiff appeared with counsel, before an Ad Hoc Hearing Committee of the DAC, your plaintiff and her counsel were denied an opportunity to rebut the multiplicitous and nebulous charges levelled against her, in violation of the Bylaws' explicit provision that the physician be afforded an opportunity to present FACTS in support of the assertion that the committee was without grounds. Your plaintiff has never been accorded a full and fair hearing on the charges against her, and never accorded an opportunity to present evidence in her defense.

LAN. KNIGHT.
& PINCUS
FOLK, VIRGINIA

(c) Failure to specify the standards by which your plaintiff would be judged. The various committees which have sat in judgment on your plaintiff have variously described the standards to be applied to her as the Rules and Regulation of Medical Center Hospitals or "medical practice as practiced at this institution." Many of the charges against your plaintiff have origins in medical record-keeping, for which no specific standard is set forth. Further, by the Bylaws and Rules and Regulations, two committees -- the Medical Records Review Committee and the Quality Evaluation Committee -- are charged with period review of hospital records and bringing lapses to the attention of the affected physician. Prior to her appearances before the DAC and MEC, your plaintiff was never apprised of any deficiencies in her record-keeping practice. Further, your plaintiff has long ago agreed to abide by the wishes of the Staff in record-keeping matters.

When faced by the deficiencies of the Rules and Regulations in setting specific standards for judgment of Physician 392's record-keeping practices, the members of the adjudicative and appellate bodies resorted to "actual practice" as the standard, at the same time they denied your plaintiff and her counsel access to random charts which would establish that standard.

(d) Denial of finality of adjudication in appearances before various committees. When first subject to a review of her practice by the Departments of Plastic Surgery and the Department Authorities Committee in November of 1984, your

plaintiff was given an "admonishment" regarding several "relatively minor" lapses in OR protocol. Following investigation by the DAC, your plaintiff was informed by Dr. William Tynes, then President of the Medical Staff, by letter of April 8, 1985, that the DAC contemplated no further action after a review of cases brought to their attention. From May of 1985 to the present, however, your plaintiff has been subject to an inquisitorial process in which she has been faced by multiplicitous and nebulous charges of alleged wrongdoing based upon 211 medical charts. Having conceded that in matters of record-keeping her hospital charts did not meet the standards brought to her attention for the first time during these proceedings, your plaintiff has been repeatedly subject to resurrection of the same charges.

WHEREFORE, in order to ensure that the interests of the plaintiff's patients and the public be protected against disruption or loss of your plaintiff's valuable and unique medical care and service, that the due process afforded your plaintiff by her contract with Medical Center Hospitals, Inc. be preserved, that your plaintiff's renown and reputation and ability to practice her livelihood not be irreparably and detrimentally affected by this denial of due process, and that the plaintiff have an opportunity to challenge the accusations of wrongdoing and present evidence in her own behalf, your plaintiff prays that a temporary injunction be immediately granted:

- (1) Restraining and enjoining the Board of Directors

and other Medical Staff of Norfolk General Hospital, and their agents, servants and employees from:

- (a) Any further investigation of your plaintiff;
- (b) Suspending or in any way modifying the hospital privileges of your plaintiff;
- (c) Preventing your plaintiff from admitting and treating surgical patients.

(2) Ordering:

(a) The Board of Directors of Medical Center Hospitals, Inc. and its agents, servants and employees to dissolve any orders that may concern your plaintiff;

(b) The Board of Directors of Medical Center Hospitals, Inc. to make its charges against your plaintiff specific and to detail each and all of the infraction of which the plaintiff is allegedly guilty, and to relate each such infraction to a particular chart or record;

(c) The Board of Directors of Medical Center Hospitals, Inc. to form an ad hoc committee of knowledgeable and totally impartial physicians from an institution other than Norfolk General Hospital, where a fair and impartial hearing can no longer be afforded to your plaintiff, to review the charges promulgated against your plaintiff;

(d) The presence of a court reporter at any proceedings against your plaintiff;

(e) That your plaintiff be afforded this Court's discovery and subpoena powers to produce medical records at any hearing, to discover the nature and motivation of the

proceedings against your plaintiff to date, and to obtain the charts and medical records of other surgeons on the Medical Staff of Norfolk General Hospital so as to adduce the actual standard of care applicable to your plaintiff as far as the plaintiff's record-keeping is concerned;

(f) That of the several hundred charts of your plaintiff on which "charges" were originally formulated, the Board of Directors of medical Center Hospitals, Inc. set forth its findings separately as to those charts in which it finds no deficiency, or for which satisfactory explanation has been provided to the DAC or MEC;

(g) That the Board of Directors afford the opportunity to Physician 392 to present evidence and to summons witnesses to rebut those charges which may remain;

(h) That the discovery and subpoena powers of this Court be further afforded to the plaintiff for the thirty (30) days during which this temporary injunction is in force, during which time the plaintiff may subpoena records of and depose, various Medical Staff in anticipation of a hearing on permanent injunction or other proceeding;

(i) Such other remedies as equity may deem meet.

PHYSICIAN 392

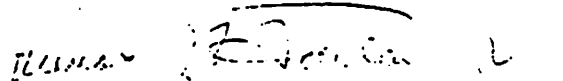
By James J. Pincus
Of Counsel

John T. Pincus

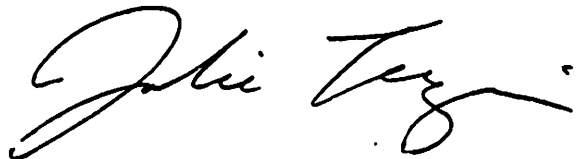
Thomas J. Harlan, Jr., Esquire
HARLAN, KNIGHT, DUDLEY & PINCUS
1350 Sovran Center
One Commercial Place
Norfolk, VA 23510
(804) 625-7605

CERTIFICATE OF SERVICE

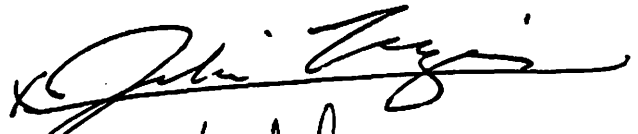
I hereby certify that a true copy of the Bill of Complaint for Temporary Injunction was hand-delivered to Frank Kollmansperger this 31st day of March, 1986.


Thomas J. Harlan, Jr.


[MFB6]



I have read the foregoing and it is true to the best of my knowledge, information and belief.



Subscribed and sworn to before me this 31st day of March 1986, at Norfolk, VA


Circuit Judge,

HARLAN, KNIGHT,
DUDLEY & PINCUS
NORFOLK, VIRGINIA

**APPLICATION FOR APPOINTMENT TO THE MEDICAL STAFF
OF MEDICAL CENTER HOSPITALS, NORFOLK, VIRGINIA**

PLEASE TYPE OR PRINT. USE ADDITIONAL PAPER WHERE NECESSARY.

1. LAST NAME	FIRST	M.I.	DATE
OFFICE ADDRESS	CITY	STATE	ZIP
HOME ADDRESS	CITY	STATE	ZIP
DATE OF BIRTH	NAME OF SPOUSE		

1. PREMEDICAL EDUCATION	COLLEGE/UNIVERSITY	DEGREE/MAJOR
	COMPLETE ADDRESS	DATE OF GRADUATION
MEDICAL EDUCATION	MEDICAL SCHOOL	DEGREE
	COMPLETE ADDRESS	DATE OF GRADUATION

INCLUDE A COPY OF YOUR MEDICAL DEGREE OR A CERTIFIED LETTER FROM DEAN OF MEDICAL SCHOOL TO VERIFY YOUR GRADUATION.

1. POST-GRADUATE TRAINING: List below the internships, residencies, fellowships, assistantships, and appointments you have served. Give name and address of institutions, and specify dates in detail. You must account for every year since medical school.

1. NAME OF INSTITUTION	DATES ATTENDED
COMPLETE ADDRESS	
2. NAME OF INSTITUTION	DATES ATTENDED
COMPLETE ADDRESS	
3. NAME OF INSTITUTION	DATES ATTENDED
COMPLETE ADDRESS	

4. Please list below all present and previous hospital affiliations and medical staff memberships, in chronological order. Include the name and address of the hospital, your status at the hospital, the department in which you had privileges, and the dates during which you practiced.

7. VIRGINIA MEDICAL LICENSE NUMBER	DATE ISSUED	EXPIRATION DATE
OTHER STATE MEDICAL LICENSES	DATE ISSUED	EXPIRATION DATE
1.		
2.		
FEDERAL NARCOTICS REGISTRATION NUMBER	EXPIRATION DATE	

Include a copy of your Virginia state license and any registrations with your application.

8. CERTIFICATION/ RECERTIFICATION	CERTIFIED BY THE AMERICAN BOARD OF _____ DATE _____ IF NOT CERTIFIED, ARE YOU BOARD ELIGIBLE? YES _____ NO _____ WHEN WILL YOU BE BOARD CERTIFIED? _____ IF NECESSARY, HAVE YOU RECERTIFIED? YES _____ NO _____ IF NOT, WHEN WILL YOU RECERTIFY? _____	
--------------------------------------	---	--

11. What is the nature of your practice? Solo: _____ Partnership (list associates): _____
 _____ Group Practice (name of group): _____
 If you have a solo practice, please list a member of the Medical Staff of Medical Center Hospitals who will answer your calls in case of emergencies or when you are out of town.

11. MEDICAL REFERENCES List at least two former chiefs of departments or residency preceptors. You are responsible for having two references letters sent to the Medical Staff Office.	NAME		ADDRESS	
	CITY		STATE	ZIP
	NAME		ADDRESS	
	CITY		STATE	ZIP
	NAME		ADDRESS	
	CITY		STATE	ZIP

IX. MEMBERSHIP/ FELLOWSHIP	AMERICAN COLLEGE OF _____	APPOINTMENT DATE _____
	AMERICAN ACADEMY OF _____	APPOINTMENT DATE _____
	MEMBERSHIP IN MEDICAL SOCIETIES _____	

X. CONTINUING MEDICAL EDUCATION	On a separate sheet, list all postgraduate activities which you have attended, or for which you have received credit in the past three years, including dates.
	List all scientific papers or essays you have written.
	List scientific meetings you have attended during the past three years.

XI. Have you had teaching experience? Yes _____ No _____ If so, please specify _____

What committee are you willing to serve on? (See attached list) _____

II. LIABILITY INSURANCE (Minimum coverage allowed: \$250,000)	INSURANCE CARRIER	AMOUNT OF COVERAGE
	ADDRESS	POLICY NUMBER

Have any claims of malpractice or claims of unprofessional conduct been asserted against you? If so, please provide the following: (1) claim filed, (2) name of claimant, (3) nature of claim, (4) current status, (5) whether the claim was disposed of by either judgment or settlement. Have you been denied liability insurance or had a policy cancelled or not renewed? If so, please explain in detail.

11. IF THE ANSWER TO ANY OF THE FOLLOWING QUESTIONS IS "YES," PLEASE GIVE DETAILS ON A SEPARATE SHEET OF PAPER.

A. Has your license to practice medicine ever been limited, suspended, or revoked?	Yes _____ No _____
B. Have you ever been refused membership on a hospital medical staff?	Yes _____ No _____
C. Has your request for any specific clinical privilege ever been denied or granted with stated limitations?	Yes _____ No _____
D. Have your privileges at any hospital ever been suspended, diminished, revoked or not renewed?	Yes _____ No _____
E. Has your narcotics registration ever been suspended or revoked?	Yes _____ No _____
F. Have you ever been denied membership or renewal thereof, or been subject to disciplinary action in any medical organization?	Yes _____ No _____

IV. To which department do you desire appointment?

- | | | | |
|---|---|---|---|
| <input type="checkbox"/> Anesthesiology | <input type="checkbox"/> Neurosurgery | <input type="checkbox"/> Pathology | <input type="checkbox"/> Radiology |
| <input type="checkbox"/> Dermatology | <input type="checkbox"/> OB-GYN | <input type="checkbox"/> Pediatrics | <input type="checkbox"/> Surgery |
| <input type="checkbox"/> Emergency Medicine | <input type="checkbox"/> Ophthalmology | <input type="checkbox"/> Plastic Surgery | <input type="checkbox"/> Urology |
| <input type="checkbox"/> Family Practice | <input type="checkbox"/> Orthopedics | <input type="checkbox"/> Psychiatry | <input type="checkbox"/> Other (Specify): |
| <input type="checkbox"/> Internal Medicine | <input type="checkbox"/> Otolaryngology/HNS | <input type="checkbox"/> Radiation Oncology | _____ |

V. SPECIAL PROCEDURES: _____

I fully understand that any misstatements in or omissions from this application constitute cause for denial of appointment or cause for summary dismissal from the medical staff. All information submitted by me in this application is true to my best knowledge and belief.

In making this application for appointment to the medical staff of Medical Center Hospitals, I acknowledge that I have received and read the Bylaws and Rules and Regulations of the Medical Staff of Medical Center Hospitals and that I am familiar with the principles and standards of the Joint Commission on Accreditation of Hospitals and the principles, standards and ethics of the national, state and local associations that apply to and govern my specialty and/or profession, and I agree to be bound by the terms thereof if I am granted membership or clinical privileges, and I further agree to be bound by the terms thereof without regard to whether or not I am granted membership or clinical privileges in all matters relating to the consideration of my application for appointment to the medical staff, and I further agree to abide by such hospital and staff rules and regulations as may be from time to time enacted.

By applying for appointment to the medical staff I hereby signify my willingness to appear for the interviews in regard to my application, authorize Medical Center Hospitals, its medical staff and their representatives to consult with administrators and members of medical staffs of other hospitals or institutions with which I have been associated and with others, including past and present insurance carriers, who may have information bearing on my professional competence, character and ethical qualifications.

I hereby further consent to the inspection by Medical Center Hospitals, its medical staff and its representatives of all records and documents, including medical records, at other hospitals, that may be material to an evaluation of my professional qualifications and competence to carry out the clinical privileges requested as well as of my moral and ethical qualifications for staff membership. I hereby release from liability all representatives of Medical Center Hospitals and its medical staff for their acts performed in connection with evaluating my application and my credentials and qualifications, and I hereby release from any liability any and all individuals and organizations who provide information to Medical Center Hospitals, or its medical staff, concerning my professional competence, ethics, character and other qualifications for staff appointment and clinical privileges, and I hereby consent to the release of such information.

I understand and agree that I, as an applicant for medical staff membership, have the burden of producing adequate information for proper evaluation of my professional competence, character, ethics and other qualifications and for resolving any doubts about such qualifications.

I will not participate in any form of fee-splitting and pledge myself to abide by the Code of Ethics of the American Medical Association.

I have not requested privileges for any procedures for which I am not certified. Furthermore, I realize that certification by a board does not necessarily qualify me to perform certain procedures. However, I believe that I am qualified to perform all procedures for which I have requested privileges.

I hereby further authorize and consent to the release of information by this hospital, or its medical staff, to other hospitals, medical associations and other interested persons on request regarding any information Medical Center Hospitals and the medical staff may have concerning me as long as such release of information is done in good faith and without malice, and I hereby release from liability Medical Center Hospitals and its staff for so doing.

DATE _____

SIGNATURE OF APPLICANT _____

DO NOT WRITE BELOW THIS LINE

MEDICAL STAFF DEPARTMENT

☐ APPOINTMENT RECOMMENDED ☐ APPOINTMENT NOT RECOMMENDED ☐ APPOINTMENT DEFERRED

COMMENTS: _____

DATE _____ CHIEF, MEDICAL STAFF DEPARTMENT _____

DEPARTMENTAL AUTHORITIES COMMITTEE

☐ APPOINTMENT RECOMMENDED ☐ APPOINTMENT NOT RECOMMENDED ☐ APPOINTMENT DEFERRED

COMMENTS: _____

DATE _____ CHAIRMAN, DEPARTMENTAL AUTHORITIES COMMITTEE _____

MEDICAL EXECUTIVE COMMITTEE

☐ APPOINTMENT RECOMMENDED ☐ APPOINTMENT NOT RECOMMENDED ☐ APPOINTMENT DEFERRED

COMMENTS: _____

DATE _____ PRESIDENT, MEDICAL STAFF _____

GOVERNING BOARD

☐ APPOINTMENT RECOMMENDED ☐ APPOINTMENT NOT RECOMMENDED ☐ APPOINTMENT DEFERRED

COMMENTS: _____

DATE _____ CHAIRMAN, GOVERNING BOARD _____

WRITTEN STATEMENT IN SUPPORT
OF THE APPEAL OF JULIA K. TERZIS, M.D.,
FROM A RECOMMENDATION OF THE
MEDICAL EXECUTIVE COMMITTEE
ON FEBRUARY 3, 1986

BEFORE THE BOARD OF DIRECTORS,
MEDICAL CENTER HOSPITALS

ORAL ARGUMENT: MARCH 24, 1986

Thomas J. Harlan, Jr., Esquire
HARLAN, KNIGHT, DUDLEY & PINCUS
1350 Sovran Center
One Commercial Place
Norfolk, VA 23510
(804) 625-7605

Dated: March 21, 1986

This proceeding purports to be an appeal of a "decision" by the Medical Executive Committee (MEC) of Norfolk General Hospital on November 20, 1985 followed by a hearing before an ad hoc committee appointed by the MEC and a reaffirmation by the MEC of its November 20 "decision" by letter of Alvin Ciccone dated February 7, 1986. It is, in fact, the first and only appearance by Dr. Terzis and counsel before the only body empowered by the Bylaws and Rules and Regulations of the Medical Staff of Medical Center Hospitals (revised as of July, 1984) to make a decision regarding this physician's staff privilege.

Dr. Ciccone stated in correspondence that the Medical Executive Committee "has decided (1) to suspend privileges . . . and (2) to place you on probation," (letter of November 22, 1985) and, following consideration of the results of an Ad Hoc Hearing Committee hearing that "it is the decision of the Medical Executive Committee that your Medical Staff privilege . . . be suspended . . ." (letter of February 7, 1986). However, by the Bylaws which govern this institution, the MEC is without power to make any such decision.

Article IX, which prescribes the "Government of the Medical Staff," in (B)(1) delineates the powers and duties of the MEC. Significantly, while given the power to "review all the information available regarding the performance and clinical competence" of Medical Staff (Bylaws, at 25), the MEC is not empowered to make any "decision" regarding privileges, but rather is limited to the power "to make recommendations to the

Board regarding . . . changes in clinical privileges." (Id.)

Thus, if we appear before you today on appeal, this "appeal" is of a recommendation only. No final decision, even absent appeal, has been made. Only this Board is empowered by the Bylaws to make a decision. Contrary to the procedure of the civil courts of law, therefore, in which the decision of a lower body is final unless appealed, we appear here today before the only decision-making body. This Board's charge cannot be to ratify, to "review," or to offer your imprimatur to a "decision" made elsewhere. This Board sits on a recommendation only -- presuming such recommendation has, in fact, been made. This Board must consider the soundness of that recommendation, the procedure by which it has been arrived at. This Board must determine whether in good conscience, with regard to the fundamental concepts of fairness as partially codified in its own Bylaws, it can possibly make that decision.

That the MEC has arrogated to itself the power to "decide" the question of Dr. Terzis' privileges in flagrant disregard of the mandate of Article IX (B) (k) is typical of the procedural irregularity and roughness which has characterized what has been over a year long ordeal for Julia Terzis.

The procedural steps of your Bylaws, to which we pray careful attention will be paid for the first time as we appear before the Board, provide Dr. Terzis and her counsel an opportunity to address you by both written statement and oral argument before you deliberate to make the only decision ever made in this case. This, of course, is our written statement.

Our guidelines are few. We are to state "facts, conclusions and procedural matters with which" we disagree, and our reasons. (Bylaws at 62). We may address "any matters raised at any step in the procedure." (Id.) Legal counsel may assist in preparation.

Our statement to this Board is that the proceedings of Norfolk General Hospital to which Julia Terzis was subject did not comport with even the minimal due process guaranteed her by this Board's own Bylaws.

The JCAH Manual for Accreditation of Hospitals (1985) demands procedural fairness. At page 76 (D)(2), The Manual provides that, if a hospital is to be accredited, it must provide "FAIR HEARING AND APPELLATE MECHANISMS." It obviously follows that such mechanisms must be implemented. The Bylaws of Medical Center Hospitals incorporate these mechanisms, the requirements ~~of~~ which were serially ignored in the "trial" of Dr. Terzis.

The Board's own Bylaws were violated by:

(1) The overlapping of members on investigatory and adjudicative boards, which failed to insulate all subsequent proceedings from any bias of the initial proceedings. Dr. Terzis could not get the FAIR HEARING mandated by the JCAH. This was compounded by the presence of the same counsel from hearing to hearing. It was further compounded by the presence of "accusers" in the investigating and adjudicative bodies.

(2) A FAIR HEARING WAS DENIED by the recurrence of vague and unspecified charges ~~lodged~~ without specific

reference to standards. It was further denied by forcing on Dr. Terzis a schedule for presenting her defense which made it impossible to present an adequate rebuttal.

(3) A FAIR HEARING WAS DENIED by the refusal of the Ad Hoc Hearing Committee to afford Dr. Terzis a point-by-point, case-by-case defense of the vague charges levelled against her, and by its refusal to specifically state those charges.

(4) A FAIR HEARING WAS DENIED by the procedure of resurrecting at meeting after meeting charges adequately addressed at prior proceedings to the satisfaction of those in the prior body.

(5) A FAIR HEARING WAS DENIED when charges inquired into ^{by} one body were addressed to the satisfaction on that body, only to be resurrected by another, without any finality to the hearing of individual charges.

PRIOR PROCEEDINGS

The statement of prior proceeding, usually a convention to acquaint an appellate body with the broad picture of the steps by which a case has arrived at their door, is of greater and particular importance in our case. The prior proceedings, carefully sketched by reference to correspondence between the various parties, reports of deliberative bodies, and the transcripts which those bodies eventually consented to have made reveal the procedural irregularities to which the investigation and prosecution of Dr. Terzis has been subject.

Prior to November of 1984, few documents establish any problems of the Medical Staff with the performance of Dr. Julia Terzis. Certainly, whatever few complaints might have existed were not brought to the attention of Dr. Terzis. A letter to Dr. Brickman, Chief of the Department of Surgery, from Dr. Windle, alleging in a very general way that there are "various" undocumented complaints, and his general observation that two "'cases'" may be scheduled during which one patient cannot be actively operated upon bears the date of January 25, 1984. This letter contextually indicates that it is in response to a request from Dr. Brickman for correspondence "concerning the physician in question." In November 1984, Donna Hauser, Administrative Director of Surgery, sent a memo to various personnel, including Dr. Brickman, regarding "OR incidents" allegedly involving Dr. Terzis and going back as long as two or three years. On November 7, 1984, Dr. Brickman requested admonition of Dr. Terzis in a letter to Dr. Tynes, then President of the Medical Staff, a letter in which he referred to "relatively minor problem" of OR incidents and five cases -- admirably specifically stated -- in which he alleged that surgery had proceeded for too long a time without significant surgical progress being made. On November 28, 1984, Dr. Terzis responded to Dr. McCraw, Chairman of the Department of Plastic Surgery, regarding the OR incidents investigated in response to Ms. Hauser's memorandum. On December 28, 1984, Dr. McCraw, Chairman of the Department in which Dr. Terzis practiced, reported the results of a Departmental Review which recommended

that "monitoring by the OR staff" was sufficient to address alleged problems regarding Dr. Terzis' pattern of practice. Departmental review by the Department in which the physician practiced, was later admitted by Dr. Ciccone in a letter to Dr. Terzis dated June 7, 1985, to be the "usual procedure," in which the physician's department reviews cases and reports to the Departmental Authorities Committee. In an unsuccessful attempt to explain why he then was departing from "usual procedure," Dr. Ciccone in that letter stated that it was "because of your specialty" that the Medical Executive Committee desired review by members of several departments.

Departure from Ciccone's and this institution's admitted "usual procedure" began on January 10, 1985, when Dr. Brickman requested at a Department of Surgery meeting that a request be tabled for the investigation of Dr. Terzis. Acting for the Department of Surgery, he requested that the DAC investigate at its next meeting. On January 16, 1985, in a letter to Dr. Tynes, Dr. McCraw reported that he had learned that the investigation by the Department of Plastic Surgery had been labeled a "white wash." On January 30, 1985, Dr. Brickman wrote to Dr. Tynes expressing the wishes of the Department of Surgery to have the question of Dr. Terzis' pattern of performance in five specific incidents reviewed by an unbiased group of members of the Medical Staff. On February 6, 1985, Dr. Tynes notified Dr. Terzis that these matters were to be considered at a DAC meeting on February 25, 1985.

Apprised of only five specific cases, and obviously

prepared to discuss those cases, Dr. Terzis attended a DAC meeting held on February 25, 1985 to discuss the materials brought to their attention by the allegations of Ms. Hauser and Dr. Brickman. At that meeting, the Department of Orthopedics brought in ten new cases which had not been previously mentioned and the Department of Neurosurgery made generalized statements regarding "the experimental nature" of Dr. Terzis' procedures. On February 28, 1985, Dr. Ciccone informed Dr. Terzis by letter that the DAC was prepared to make certain recommendations to the Executive Committee meeting on March 4. These were to include: an admonishment that Dr. Terzis abide by the Bylaws, particularly refraining from operative procedures which would result in greater than twenty minutes without surgical progress and a request for convention of an Ad Hoc Investigation Committee by the President of the Medical Staff.

Prior to that meeting, Dr. Terzis by counsel had occasion to write to Dr. Tynes on March 1, 1985, invoking the Bylaws (B) (1) & (2) and requesting that "specific activities or conduct" be made the grounds for corrective action. Counsel pointed out that the most fundamental and minimal motion of due process demanded notice of specific charges. He further pointed out that at the February 25 hearing of the DAC, Dr. Terzis had addressed those charges outlined to her by Dr. Brickman, at which time she was confronted by separate and distinct charges never brought to her attention before that date, and lodged by the Department of Orthopedics and Neurosurgery. Further, counsel pointed out that most of these very matters had come up

before to the DAC, and that it had previously forwarded the matters to Plastic Surgery where the investigation was completed and resolved. On March 20, Dr. Tynes wrote to Dr. Terzis informing her that she would be informed by April 8 of "specific information" presented by the Departments of Surgery, Neurosurgery and Orthopedics to give her ample time to prepare her response before the DAC meeting. He further committed himself to investigation only of those issues.

On April 8, 1985, in a letter to Dr. Terzis, Dr. Tynes informed her that the DAC had completed its information gathering and that no further action was contemplated. The admonishment of Dr. Terzis resolved upon in the March 4, 1985 meeting of the MEC was to remain in effect. On May 13, 1985, however, in a peculiar letter to Dr. Terzis, Dr. Ciccone in effect "revoked" the April 8 letter of his predecessor, Dr. Tynes. Although counsel and Dr. Terzis had every reason to believe that the review of the pattern of practice of Dr. Terzis was at an end, Dr. Ciccone stated that there had been "an unfortunate regrettable oversight" in that the cases submitted by the Departments of Orthopedics and General Surgery "had not been included in Dr. Tynes' letter." Dr. Ciccone indicated that these cases would be presented to the DAC on May 28, 1985. Cases "thought to merit further review" would be forwarded to Dr. Terzis, who would be given an opportunity to appear before the DAC in June.

On May 24, Dr. McCraw, Chairman of Dr. Terzis' department, wrote to Dr. Ciccone requesting at least that the

physicians bringing the charge meet "face to face" with the physician whose competence they were impugning. He further requested that the DAC take specific steps to assure that their proceedings incorporated the fundamentals of due process: precise charges and specific detail; a hearing by an unbiased group (not those who brought charges); finality to the hearing -- as there obviously had not been in prior reviews; finally, an opportunity to present evidence by experts in her own discipline. It was Dr. McCraw's understanding that the DAC meeting of May 28 would result in specific cases sent to Julia Terzis for review prior to her response. On June 7, 1985, Dr. Ciccone had occasion, however, to write an uncomfortable letter to Dr. Terzis in which he apologized for "having to communicate . . . once again recent changes that have taken place concerning the review of your case."

Dr. Ciccone's letter is fraught with awareness of the irregularities of the proceeding to date. Although his May 13 letter had indicated that only those cases presented for review by the Departments of Orthopedics and Neurosurgery would be considered at the DAC meeting, the DAC had undertaken a sweeping review of "all of your patients' medical records." Ironically, he stated that the MEC felt that a review of "only five to ten" cases would be "unfair." Apparently, having to prepare for and to respond to a review of some 270 cases which would eventually result in 211 cases on which multiple charges were brought was to be somehow "more fair." His letter further revealed his discomfort when he admitted that the usual procedure would be

for a physician's department to be given the opportunity to review cases and report to the DAC -- a procedure which had already occurred in Dr. Terzis' case. Finally, he stated that the MEC had appointed an ad hoc committee to complete this review. Dr. Ciccone stated that he had placed on the committee those individuals who were "quite vocal" regarding Dr. Terzis "in an effort to resolve these issues through this forum." How the selection of those who are "quite vocal" comports with the sense that a investigating committee should be impartial and unbiased is a mystery.

The Ad Hoc Investigation Committee was comprised of Dr. Edmondson, Adamson, Merrell, Hoffman, Neff, Gwathmey, and Richmond. It must be noted by this Board that Drs. Hoffman and Neff were likewise to serve on the Departmental Authorities Committee to which the Ad Hoc Investigating Committee would report. Drs. Hoffman and Neff were also on the MEC.

In the interim, on May 7, 1985, Dr. Terzis was reappointed without qualification to the active staff of the Department of Plastic Surgery of Norfolk General Hospital.

Dr. Ciccone next wrote to Dr. Terzis on June 20, 1985, to inform her that the Ad Hoc Committee was in the process of investigating 270 charts, which were taking "more man hours than anticipated." The report of this Committee would thus be delayed until September. On September 23, Dr. Ciccone reported to Dr. Terzis by letter that the Ad Hoc Investigating Committee had completed a three month review and presented its report on September 23. He further reported that the DAC was "considering

corrective action" at its meeting of October 7. Dr. Terzis was invited to attend and respond "with any information you consider relevant to the issues." With this letter Dr. Ciccone included the report of the Ad Hoc Investigating Committee identifying some 211 charts on which 223 separate charges had been based, ranging from allegedly "inadequate" history and physicals to extremely substantive charges questioning "appropriateness of surgery." How Dr. Terzis was to respond in two weeks with "information she considered relevant" to the enormous number of charts and to the vague and unclear charges based upon those charts defies the imagination. In addition, this letter from Dr. Ciccone resurrected the spectre of the OR incident charges addressed by Dr. Brickman and the DAC previously and also included a letter from Dr. Penix stating his concern regarding "human experimentation" and implying that this might be an area of inquisition.

On October 1, 1985, counsel for Dr. Terzis wrote to Dr. Ciccone protesting a two-week notice of the proposed DAC meeting and pointing out that the DAC, in effect, had been investigating for nine months, with three months spent on medical records by a committee of five, resulting in the culling of 211 records for review. While the review of records by the Ad Hoc Committee had consumed "many man hours," it was apparently assumed that in the case of Dr. Terzis, preparation of a defense would not take many woman hours. Counsel at this time again requested clarification of the charges and specific procedural regulations violated identified on a case by case

basis. He requested statements of the policy regarding mask removal, presence of the primary physician in the OR, the length of time in which a patient might stay in the OR without surgery, the specific statement of operation consent policy. This was the first of many requests by counsel for Dr. Terzis for a statement of the standards by which she was to be judged, all of which remain unanswered. On October 2, 1985, Dr. Ciccone wrote to Dr. Terzis denying her the presence of an attorney or other representative at the October 7 meeting of the DAC. It must be noted that this Board in its consideration of procedural fairness that review of the reports of the meetings of the DAC will reveal that counsel for the committee WAS PRESENT. The report of the DAC meeting of November 5, 1985, will indicate the presence of Mr. Greg Luce as "guest."

At the request of counsel for Dr. Terzis, the DAC extended the time for its meeting until October 28 and, upon the unavailability of Dr. Terzis on the 28th, to November 5, 1985. On October 28, 1985, counsel for Dr. Terzis wrote to Dr. Roper, Chairman of the DAC, requesting that although he understood that Dr. Terzis would not be allowed counsel at this meeting -- and because of that understanding -- a record be made by a court reporter, which Dr. Terzis would pay for. He further requested that the inquiry be specific. On October 31, 1985, Dr. McCraw further wrote to Dr. Roper, in a personal plea for fairness to be accorded to Dr. Terzis. He noted that the Department of Plastic Surgery had investigated in reply to charges against Dr. Terzis, and that these had been answered to the satisfaction

of the DAC until the ad hoc investigation. On behalf of Dr. Terzis, he requested for her an opportunity to answer all the charges with "evidentiary support of her residents and co-workers." He moved the DAC to make specific charges, within appropriate time for Dr. Terzis to answer. He pled that the DAC should result in a final settlement of all charges. He noted the peculiar procedural posture which left Dr. Terzis "presumed guilty until proven innocent." Dr. McCraw sent copies of his letter to each member of the DAC and to the Board of Directors.

At the DAC meeting of November 5, Dr. Terzis was addressed a number of questions on specific cases, approximately seven. Charges based on some 204 cases remained unaddressed. She was, however, denied by Dr. Roper the opportunity to have a court reporter present, although she had informed counsel that Dr. Roper had previously approved the presence of a court reporter. On November 8, 1985, Dr. Ciccone reported to Dr. Terzis by letter that the DAC report and recommendation had been unanimous on November 5. Prominent among the names on the DAC are those of Dr. Windle, who had provided written allegations upon which the investigation was founded; Dr. Penix, who prior to this adjudication had accused Dr. Terzis of "experimental surgery"; Drs. Neff and Hoffman, who had served on the Ad Hoc Investigating Committee. Transcription of those proceedings made available to counsel indicate that Dr. Hoffman undertook particular guidance of the DAC, in effect testifying as to his finding as a member of the investigating committee. In the course of deliberation, Dr. El Mahdi found Dr. Terzis'

records, in particular her office notes, the best he has ever seen and found that the Ad Hoc Committee had been "highly inaccurate." Throughout the course of their deliberations, Mr. Luce as counsel sat in advising the DAC.

Dr. Ciccone advised Dr. Terzis that the recommendations of the DAC would go to the MEC for action on November 11, 1985. She was to make an appearance to defend herself in three days. He stated that all material sent on to the MEC, presumably the report of the Ad Hoc Investigating Committee, and the DAC report, would be sent to Dr. Terzis on the day of the meeting. Dr. Ciccone confessed that this was "short notice!" On November 11, 1985, the date scheduled for the MEC meeting, counsel for Dr. Terzis replied that no report of the DAC had been received by Dr. Terzis or counsel. Counsel noted that the appellant had been subject to questioning on 211 charts and was now summoned to a meeting of the MEC without any consultation with Dr. Terzis or her counsel regarding the availability. Counsel complained bitterly of the refusal of the committees to date to attend to the requirements of due process.

On November 12, counsel for Dr. Terzis again wrote to Dr. Ciccone indicating that he had received the report of the special meeting of the DAC held on November 5 approximately four hours before the MEC was scheduled to meet. In his letter, counsel noted that September 23, 1985 was the first notice to Dr. Terzis that 211 records would be reviewed. She was expected to be prepared for a DAC meeting on October 7, which was continued to November 5. In the period of September 23 to

November 5, Dr. Terzis was required to obtain 211 charts from Norfolk General Hospital (if she was to copy, that was to be done at her expense) and was to compare them with her own office records. Dr. Terzis had been required to prepare a defense to vague assertions regarding 211 charts ranging from recordkeeping to substantive questions of the appropriateness of surgery without any indication as to what cases would be considered. Further, the official report of the November 5 meeting failed to summarize Dr. Terzis' answers to questions. The DAC in this report failed to identify any particular chart having been adequately responded to. Before the meeting of the MEC, counsel requested that the charges be made specific, with a listing of the applicable bylaw or regulation or other rule identified with each case, that a court reporter be present, and that Dr. Terzis be afforded the presence of her attorney.

On November 13, 1985, Dr. Ciccone wrote to Dr. Terzis granting an extension of time for the MEC meeting to November 19 "and such other later dates as necessary." A court reporter would be permitted to record Dr. Terzis responses to questions, but she was again to be denied counsel. Again, the record of the meeting of the Medical Executive Committee on November 20, 1985 (a continuation of the November 19 hearing), will indicate the presence of Michael Manfredi, an attorney and colleague of Mr. Luce. Mr. Luce and his firm have therefore been serving as counsel to the DAC, which recommends action to the MEC, which supposedly deliberates in an atmosphere of independence, while counsel breaches all appearances of fairness by advising both

committees. During this whole period, Dr. Terzis has been denied the opportunity to be represented actively by counsel before these committees.

On November 20, the MEC continued its investigation of Dr. Terzis and jealously guarded what now become its tradition of preventing Dr. Terzis from ever confronting her accuser. The record of the Medical Executive Committee meeting on November 20, 1985, reveals that the Committee went on, in the absence of Dr. Terzis, the accused, to take testimony from "three groups" of physicians, among them the Ad Hoc Committee which had done the original investigation (one member of which, Dr. Hoffman, was not only a member of the DAC, but was also a member of the MEC). Dr. Hoffman had thus managed to serve in finding probable cause on the investigating committee; to participate in ratifying his own observations on the DAC; and to reaffirm himself as a member of the MEC. The MEC likewise took evidence from Drs. Bowers, Snyder, Brickman and Stark, "physicians involved in cases" with her. Finally, they interviewed Dr. Matchett, a physician involved in a case in which Dr. Terzis had testified the previous evening.

This ex parte taking of evidence without the opportunity to refute or offer contrary evidence to a committee counseled by, in effect, the same legal adviser as the original investigating committee and staffed by one member who served on all committees which had sat in judgment on Dr. Terzis, violates every principle of fundamental due process and fairness. From the time of the first investigatory ad hoc committee appointed

by the MEC, Dr. Terzis was faced with 211 charts for the basis of multiple charges. Dr. Terzis first received the report of this committee on September 23, 1985. Although the Ad Hoc Committee had worked with five and six members at various times reviewing all of the charts for approximately three months, Dr. Terzis was required to appear before the DAC within approximately five weeks from her notice of the charges. While counsel for the various committees were present (and often the same from committee to committee), Dr. Terzis had been denied counsel. At the DAC meeting of November 5, 1985, only a few -- perhaps seven -- of the 211 cases reviewed and the subject of charges were discussed with her. Dr. Terzis was simply denied the opportunity to answer the charges against her. The DAC subsequently dropped 36 of the charges made by the investigatory ad hoc committee, sustained 150 of those charges, amended 18 and added 2 additional charges.

Thus, on November 11, Dr. Terzis was first informed of the 170 charges which remained to be addressed, or were to be addressed for the first time, before the MEC. She was to appear within eight days to prepare responses to these charges. Although the original investigative committee had approximately nine months to accumulate its charges, Dr. Terzis was required to send her residents and her secretary to gather those portions of the hospital charts for copying which they divined might be applicable to the nebulous charges lodged against Dr. Terzis. What chart or document does one gather to refute the charge, for example, that a surgical procedure was "inappropriate"? The

Norfolk General Hospital records were available to Dr. Terzis only on the premises of the hospital. Once these charts were obtained by her assistants, the same assistant was required to pull the relevant office charts of Dr. Terzis to refute charges. At the hearing on November 19, 1985, before the Medical Executive Committee, Dr. Terzis desperately needed the assistance of her secretary and her residents who had attempted to organize the hospital and office charts to allow her to responsibly reply to the Committee. Further, at least one of these assistants was a resident fellow involved in treatment and familiar with Dr. Terzis' methods. Unconscionably, the Committee excluded her assistants from the hearing room and picked and chose from among 170 charges derived from 211 charts, without any capacity for Dr. Terzis to anticipate which chart or case would be the subject of discussion. Given the nebulous and vague nature of the charges, this Board will appreciate how ludicrous is the direction for her to bring with her "those materials which she believes relevant to answer the charges." Which member of this Board charged with an "inappropriate" business transaction or piece of legal advice or medical procedure -- much less thirty -- could isolate the document or documents to refute the charge? At the meeting, Dr. Terzis was forced to make heroic efforts in recollection, after which and out of her presence several witnesses were subjected to ex parte examination.

The MEC discussed no more than six or seven cases on November 19. Dr. Terzis simply did not have the opportunity to

explain or otherwise defend the vast number of charges made against her, despite the admonition of Article IX of the Bylaws that the request for any corrective action MUST be based upon "specific activities or conduct." Bylaws, IX(A)(1). Although counsel for the various committees have argued, and the Bylaws, on their face, suggest that the rules of procedure do not apply before the level of appellate review (Article X) implicit in the appellate review procedure is the standard by which lower bodies shall proceed. Article X, (E), provides that the MEC is to present "FACTS supporting its adverse recommendation" and "the affected practitioner shall thereafter be responsible for supporting his challenge of the adverse recommendation or decision by an appropriate showing that the charges or grounds involved lack any FACTUAL basis or that such basis or any action based thereon is either arbitrary, unreasonable or capricious." It is absurd to believe that the obligation on a committee to resort to fact to support a charge is triggered only in appellate review. Appellate review is merely to review the FACTS, supposedly gathered at prior proceedings. Likewise, the affected practitioner is to be afforded the privilege to counter accusation with FACTS before the appellate review. The MEC discussed very few specific charges with Dr. Terzis. Dr. Terzis was not given the opportunity to explain the vast bulk of charges. The MEC dropped 69 charges, sustained 108, amended 28 and added a total of 6 new charges, for a total of 142 charges. On December 26, 1985, Dr. Terzis was hand-delivered the MEC decision regarding these charges and subsequently noticed her

appeal pursuant to Article X.

The MEC appointed a seven member special ad hoc committee, chaired by Dr. Cross, to give what her counsel hoped would be an impartial hearing on these charges. Between December 26 and January 27, the date scheduled for the hearing, some of Dr. Terzis' residents and members of her secretarial staff were on vacation which allowed her far less than thirty days to prepare for the ad hoc committee hearing.

Dr. Terzis was required to review the records from four and a half years of practice at Norfolk General Hospital. She was further being charged with violations of rules and bylaws regarding recordkeeping, for which she had already been admonished, and to which she had conceded that her records, as contained in the Norfolk General Medical Records Department were not as complete as they might be, although she denied that her office records did not adequately supplement these. During these four a half years, one particular rule and regulation, No. 24, of the Medical Center Bylaws, Rules and Regulations had been observed in a bi-weekly breach:

The physician will be notified by mail that, if the record has not been completed within an additional fifteen (15) days he will automatically lose all his admitting privileges. This notification made by the Medical Records Department of the hospital will be by registered letter, return receipt requested. In addition, a phone call will be placed to a physician's office by the Medical Records Department to ascertain that they are aware that the physician is being placed on final notice . . .

. . . The Quality Evaluation Committee shall be responsible for making the recommendation to the President of the Medical Staff that all privileges be automatically written pursuant to Article X, Section 10 of the Bylaws.

Thus, although regulations clearly mandate that the Medical Records Library personnel and Quality Evaluation Committee are charged with monitoring records periodically and promptly bringing this to the notice of the affected physician, Dr. Terzis was simultaneously charged with four and a half years of violation of rules and regulations.

Dr. Brickman (former Chief of Surgery and Chairman of the DAC in January 1985) testified before the MEC that no regulation in the hospital Bylaws, Rules and Regulations required Dr. Terzis to wear her operating room mask above her nose. It was his testimony that those employing certain optical instruments in the management of their patients employ the same procedure. Dr. Brickman also testified that no one disseminated "operating room procedures" to the surgeons until recently, when it was given to all new surgeons. The effect of Dr. Brickman's testimony was that the operative consent form was a "ticket to the operating room" and that operating room personnel were required to adhere to their own policy. This policy was not the policy of the Department of Plastic Surgery, but rather only that of the Department of General Surgery. It was the observation of others on this committee that Dr. Terzis' personal consent form was "excellent."

Most of this should have been behind Dr. Terzis by

January 27, 1986. However, there remained to Dr. Terzis' great concern what might be called "substantive" charges. It is a position of counsel for Dr. Terzis, and Dr. Terzis' understanding herself, that the issues of recordkeeping had been previously addressed by, inter alia, the Department of Plastic Surgery and the DAC with an admonition issuing. The remaining substantive charges were to be addressed at the hearing of January 27. Counsel for Dr. Terzis attempted in consultation with Mr. Luce and in a pre-trial meeting to obtain some information regarding the rules by which the body would proceed. He suggested a procedure by which the Ad Hoc Hearing Committee would address "recordkeeping" charges as a group and the far more serious and substantive "appropriateness of surgery" charges as a second group to be approached on a case by case, charge by charge basis. This would allow for point by point specific refutation of the charges in accordance with the right accorded the physician in Article X to present "an appropriate showing of the charges or grounds involving lack of any factual basis." Counsel was denied the request for this procedural ruling.

The "hearing" of the ad hoc committee was comprised of Dr. Hoffman's reading into the record the report of the MEC. Although recordkeeping questions had largely, and one would think finally, been addressed at previous committees, records were the focus of the hearing. Counsel for Dr. Terzis attempted to have the Ad Hoc Hearing Committee focus on a case by case basis. Dr. Hoffman presented ad hoc case No. 40, No. 54,

No. 88, No. 50, medical record No. 136345310 and similarly reported what the MEC report had stated. How counsel for Dr. Terzis was to divine that the committee would hear these particular cases is a mystery. How counsel could schedule rebuttal witnesses to these specific cases is a mystery. Given the original 211 charts reviewed, how could counsel isolate those cases to which the Ad Hoc Hearing Committee would choose to address themselves, or be directed by Dr. Hoffman, to prepare his witness to be present for the presentation of contrary facts? The mindset of this committee was more than eloquently revealed when counsel for Dr. Terzis objected to the method by which the committee was proceeding and the inability of any attorney to defend when the procedure would be trial by ambush. Counsel explained that the logical conclusion of the principle that the MEC would put on its case first would mean that it would undertake a review of those cases supporting its charges, after which Dr. Terzis and counsel would put on their case. Such were the ground rules. However, who could anticipate that review of 211 charts would be completed in approximately eight hours? Witnesses were prepared to refute various testimony. These included an assistant and a former resident who participated in certain of the cases and had information which would specifically refute, for example, the testimony of Dr. Snyder. He was not available to counsel for the defendant, because he could not be told when to appear. Dr. Levine, who had specific information regarding the angiogram contrary to that presented by Dr. Snyder, was in Canada and had been alerted

to appear on the weekend. Dr. Lieberman, likewise a practitioner with Dr. Terzis, with specific information regarding these cases, was called away to attend to his wife who was seriously ill in Florida. When counsel for Dr. Terzis objected to the method of procedure, by which Dr. Hoffman merely restated the generalization of the MEC report and discussed some five specific cases, and protested that he was unable to effectively refute testimony when he had no knowledge which specific cases would be discussed, the mind set of the Ad Hoc Hearing Committee became very clear:

DR. KAPLAN: You must understand that when a committee appears and goes through several hundred charts and comes up with the overwhelming representation that they're incomplete, you are going to have to believe that . . .

That's what we believe.

(Transcript of Ad Hoc Committee, line 10, ff).

And again, when counsel for Dr. Terzis attempts to view each chart, chart by chart, to finally give factual hearing which the Bylaws mandate, Dr. Kruger states that every chart has been examined by at least two physicians, and he does not understand why this committee should go over them again. (Transcript of Ad Hoc Committee, p.75). This Committee charged with giving a FAIR HEARING thus revealed that its decision was a foregone conclusion.

While the Committee contended that "Dr. Terzis has the burden to respond," (Transcript at 82), counsel was defeated in

his attempt to respond with a factual defense to the various and cumulative charges as they were transmuted from the Ad Hoc Investigating Committee appointed by the MEC through the DAC and MEC. The MEC is charged at the ad hoc committee hearing to offer "facts supporting its adverse recommendation" (X)(E)(7). The resident is charged with notifying the affected practitioner of "grounds upon which the adverse action is based, the specific or representative charts being questioned . . ." This physician faced charges on several hundred charts and it was therefore reasonable to assume FACTUAL REVIEW AND REBUTTAL of each of those charts. This opportunity was denied to counsel. When counsel for Dr. Terzis objected that the presentation by Dr. Hoffman on behalf of the MEC rested on all the cases noticed to Dr. Terzis, and that he should therefore have the opportunity to cross examine or present contrary evidence on each of those cases, he was denied that opportunity. Counsel for the ad hoc committee -- and formerly for the DAC and MEC -- was acutely aware of the problem. Mr. Luce refused to instruct the committee to address only those cases which Dr. Hoffman had specifically addressed in his presentation unless it was willing to make its conclusion only on those. Thus, although only five specific cases were addressed, and those cases were not made known in advance to counsel for Dr. Terzis, the ad hoc committee chose to address all of those MEC reports. The vast majority of these cases were therefore never the subject of specific adjudication before the DAC, before the MEC, or before the ad hoc committee. You will understand how dumbfounded counsel for

Dr. Terzis was when instructed to pick the ones that he considered "unfounded" and then put them on. (Transcript of Ad Hoc Committee Hearing, p.94). In other words, because Dr. Terzis faced charges numbering 142 involving 127 charts on 118 patients, it was her obligation and her counsel's to somehow determine what evidence would refute certain nebulous charges, and to proceed on a case by case basis to show each of these to be "unfounded." Counsel attempted to perform this herculean task. He was informed in the course of the third day of hearing, January 29, 1986, that although the ad hoc committee had listened to partial evidence in only about five or six cases, the committee chaired by Dr. Cross had determined to entertain no further evidence.

Counsel for Dr. Terzis that day informed Mr. Luce by letter that Dr. Terzis stood ready to appear before the committee and discuss every single charge brought by the MEC. Dr. Terzis wished to bring Dr. Levine from Canada to refute any charges regarding the primary care of patients and Dr. Lieberman, who had done the nerve conduction study and other studies relevant to the appropriateness of treatment.

Dr. Terzis was not accorded a "hearing", but a recitation of the 142 charges which survived the MEC. Although this was an administrative proceeding, with relaxed rules of evidence and procedure, relaxation lapsed into rigor mortis. The committee abrogated its duty to HEAR EVIDENCE in support of [the MEC's] adverse recommendation or decision." (X) (E) (7). The Ad Hoc Hearing Committee did not take evidence in more than

Dr. Hoffman's random selection of several cases to be presented to the Committee. While counsel and Dr. Terzis reasonably expected to refute 142 charges, they ended up in a judicial shooting gallery in which they were expected to refute Case 1, Case 14 . . . Case X, willy-nilly as it pleased the prosecutor. Even their attempt and offer to undertake a case by case review was denied. Dr. Terzis contends that the procedural charade outlined above has denied her fundamental due process as afforded her by the Bylaws which govern this institution, and which you are charged with enforcing. It violates rights afforded by the common law notions of fundamental fair play. It requires that this Board reverse the "finding" of the MEC as so tainted by the roughshod denial of due process as not to merit this Board's serious consideration. We ask this Board to deny the recommendation of the MEC for the sanctions proposed for imposition upon Dr. Terzis. While we realize that this document has been time consuming in its presentation of the procedural background, we feel this background is necessary to bring to the attention of this Board the sense of what Dr. Terzis has borne. Further, our argument regarding the denial of due process to Dr. Terzis is founded upon his procedural picture. We appreciate your careful attention to this point and ask you now to consider the framework of relevant law which gives rise to our objections to the proceedings below which have denied Dr. Terzis her fundamental due process right.

ARGUMENT

Hospitals do not operate in a legal vacuum, and, public or private, are not free to exclude a practitioner from practice by whim or caprice. An annotation at 37 ALR.3d 637, collects approximately fifty cases which indicate that courts have undertaken review of the action of private hospital committees and boards in depriving a physician of what is generally acknowledged to be a compelling personal right -- the right to earn a living. It is no secret that the decision made here today, and the recommendations afforded to you from below, will have a profound affect on Dr. Terzis. This Board is invited to look at its own application for privileges bound into the Bylaws. Where can a physician apply where he or she will not be asked whether he has ever been refused membership on a staff, whether his clinical privileges have ever been limited, whether his privileges have been suspended, whether he has ever been subject to disciplinary action?

Whether it is derived from the Fifth and Fourteenth Amendment guarantees of due process, from a common law concept of "fair play," or from a Court's awareness that the Bylaws of a private institute a binding contract between the institution and its physician in that the due process guarantees embodied therein represent a contractual guarantee to the physician, the courts have found numerous grounds on which to review the actions of hospital governing bodies which deprive a physician of privileges. The question as to whether these privileges are

constitutionally derived through the Fifth Amendment in its application to the states in the Fourteenth and its application to this institution is a legal question. If it need be addressed, it will be addressed to a court of law. What is clear, to Dr. Terzis' counsel and to counsel for this institution and its many committees, Mr. Luce, is that the due process guarantees provided by the Bylaws of this institution will be upheld by a court of law. That is, a court will hold this institution contractually obliged to provide Dr. Terzis the guarantees which the Bylaws enumerate. McElhinny v. William Booth Memorial Hospital, 544 S.W.2d 216 (Ky.); Christhill v. Annapolis Emergency Hospital Association, 496 F.2d 170 (4th Cir.); Pole v. Charlotte Memorial Hospital, Inc., 374 F. Supp. 1302 (D.C. N.C.); Klinge v. Lutheran Charities Association, 523 F.2d 56 (8th Cir. Mo.).

The PROCEDURAL and SUBSTANTIVE LAW which governs this case is, at a minimum, that stated in your Bylaws. This law has been violated in the proceedings against Dr. Terzis.

I.

A FAIR HEARING WAS DENIED DR. TERZIS
BY THE INCESTUOUS INTERRELATIONS OF THE
COMMITTEES WHICH JUDGED HER.

One of the standards of your Bylaws and mandated by JCAH is fairness in a hearing. This right was requested independently by Dr. McCraw in his letter to Dr. Tynes asking for a unbiased hearing. It is recognized in the articles of the Bylaws which provide for fair notice to the physician of the

charges against him. It is further recognized in Article IX(A)(5) which provides that when a request for corrective action was initiated by a member of the DAC or the MEC, then that member should not participate in the committee's decision. This is a fundamental recognition of the fact that the accusatory and investigatory roles are kept separate to guarantee actual and substantive fairness. Again, in Article X(D), the Bylaws provide that the hearing committee in the initial appellate review may have no member who had "actively participated in consideration of the adverse recommendation." There is implicit in these rules the principle that for a fair hearing, the body conducting the hearing should not be tainted by the proceedings which went before it.

The most superficial review of the composition of the various committees which have sat to investigate, prosecute, and try Dr. Terzis reveals the most glaring breach of this promise that hearings shall be fairly conducted by unbiased parties. Among those initiating the investigation of Dr. Terzis recommended to the DAC by Dr. Brickman are Drs. Windle and Penix, two physicians who had occasion to write regarding complaints against Dr. Terzis. Undertaking the "investigatory" phase of the DAC proceeding are, inter alia, Drs. Hoffman and Neff, who will eventually sit on the DAC and judge the report of their own committee. Before the MEC, Dr. Terzis appears before Drs. Roper, Lilly, Hoffman, Eng, Waldrop, Solhaug, Crockford, Windle and Bodner who had sat on the DAC. Of the fifteen members of the MEC, Dr. Terzis had been heard previously by

nine, whose "recommendation" to the MEC one would reasonably expect them to ratify. Finally, Dr. Hoffman served as member of the investigating committee, as member of the DAC, and as member of the MEC. In addition, counsel for the DAC and the MEC in that adjudicative function are Mr. Luce and his associate, Mr. Manfredi, one or the other of whom will have participated in all proceedings to which Dr. Terzis is subjected.

Counsel for Dr. Terzis repeatedly requested the appointment of unbiased committees, which had not previously heard charges against the affected practitioner and explicitly pointed out to counsel for the Medical Center Hospitals the incestuous nature of the relationship between these bodies. The relationship of one body to the other is in this case so glaring that one would expect it to be sui generis. In fact, at least one court has heard in the past on a case with such significant similarity to Dr. Terzis' experience before the committees of this hospital that we believe this case must be brought to your attention in discussion and have further appended a copy to this statement.

In Applebaum v. Board of Directors of Barton Memorial Hospital, 163 Cal.Rptr. 831 (1980), the Court appears to have decided the case now before this Board. Applebaum, a Board-certified family practitioner, had obstetrical privileges at the defendant hospital. He was the subject of complaints about his delivery techniques made by a head nurse and night supervisor to a Dr. Furman, one of the obstetrical practitioners with privileges at the hospital. Furman requested an

investigation by the hospital's chief of staff. The executive committee of the hospital met, with Furman present, although abstaining, and determined to order the formation of an ad hoc committee comprised of the members of the obstetrics department to investigate. Dr. Furman who declined to serve as chair, discussed eight patient records before the ad hoc committee. Although the Dr. Applebaum had objected to the charges in Furman's letter as vague, he claimed that the presence of Dr. Furman's committee destroyed its impartiality. The case makes clear that Dr. Furman conducted most of the questioning at the ad hoc committee meeting. In an interesting analogy to the case before you, the question appeared to be the plaintiff's following of detailed obstetrical guidelines, which he agreed to follow rigorously for a trial period. The ad hoc committee, however, by a majority vote recommended suspension of privileges.

The executive committee considered the ad hoc committee report. Five of the members of the ad hoc committee attended the executive committee meeting. The executive committee interviewed Dr. Applebaum and recommended a limitation of privileges requiring him to perform all deliveries with another member of the obstetric staff. However, when the administrator of the hospital informed him of the executive committee's recommendation he included the "findings" that the plaintiff had failed to obtain consultation in 37 cases and demonstrated "incompetent techniques" in delivery.

Dr. Applebaum requested review of the committee

decision by a medical staff appeal committee. The appeal committee was comprised of three physicians who had not previously been involved. It heard testimony from the administrator, Dr. Applebaum, Dr. Furman, and two general practitioner members of the obstetric staff. At the appeal committee meeting, "counsel indicated the question of overlapping membership had been raised by the plaintiff in an unsuccessful attempt to obtain a writ of mandate from the superior court the day before the second appeal committee meeting." 163 Cal.Rptr. at 834. He further apprised the committee of his "concern that the members on the appeal committee may have been influenced by discussions about the plaintiff at the meeting of the executive committee." Although Dr. Applebaum had attempted to obtain a tape recording of the meeting, he was not able to do so. Id. Dr. Applebaum eventually became Plaintiff Applebaum, contending that the hospital proceedings violated due process because the ad hoc committee and the appeal committee were prejudiced. The ad hoc committee was prejudiced by the presence of a complaining physician, and the appeal committee prejudiced by remarks made at the executive committee meeting in the presence of two of the three appeal committee members. A lower court decided that independent review of the record revealed "professional differences," that very broad guidelines regarding the requirement of consultations made actual determination difficult, that due process was initially violated by the present of a complaining physician on the ad hoc committee and

further due process violation occurred when the appeal committee member heard disparaging comment about Dr. Appelbaum. In effect, it found violations of due process and the insufficient evidence to support the hospital's act.

In an instructive analysis for this Board, upon the hospital's unsuccessful appeal, the Court considered whether the presence of an accuser in the adjudicatory process "impermissibly tainted" the proceeding. Recognizing that it was dealing with a private institution which was governed not by constitutional due process but by "fair procedure," the Court stated that "biased decision-makers are constitutionally impermissible and even the probability of unfairness is to be avoided." 163 Cal.Rptr. at 836, citing Withrow v. Larkin (1975), 421 U.S. 35 (47). The Court went to find this likewise administratively impermissible as well:

Due process questions are raised when the administrative agency's initial view of the facts based on evidence derived from non-adversarial processes as a practical or legal matter forecloses fair and effective consideration of the merits at an adversary hearing leading to the ultimate decision. (Withrow v. Larkin, supra, at p.58) (emphasis added).

The Court noted that the plaintiff contended that the ad hoc committee proceeding constituted an impermissible combination of investigatory, prosecutorial and adjudicatory functions in one body.

The Court analyzed the procedure to which the doctor had been subjected:

. . . It was done by a group which included the instigator of the charges, had overlapping membership in the body (executive committee) which reviewed both the initial and final decisions and to which the majority of the former adjudicators later belonged. The question before us is whether this situation, completely apart from any question of actual bias on the part of any the physicians involved and from the merits of the charges, presents a violation of fair procedure rights . . . We hold that it does.

As a practical matter and without in any way impugning their good faith, the general practitioner and pediatric specialist members of the ad hoc committee were in an extremely difficult position. The charges were brought by one of the two specialists on whom they were accustomed, and, indeed, required to rely for obstetrical expertise and with whom they were in frequent and intimate professional contact . . . To presume impartiality the ad hoc committee in such circumstances goes beyond what could reasonably be expected of human beings in this professional setting. In this situation a realistic appraisal of psychological tendencies and human weakness compels the conclusion that the risk of prejudgment or bias was too high to maintain the guarantee of fair procedure . . .

We recognize that the ad hoc committee's function under the hospital Bylaws was nominally investigatory, not adjudicative. Nevertheless, the chances of a contradictory conclusion by another body within the hospital were virtually nil. The Bylaws mandated review of the ad hoc committee's decision by the executive committee, and apparently a twelve member body upon which five members of the ad hoc committee sat. Having made an adverse decision, the five could hardly be expected not support it before the executive committee. The appeal committee, later also connected to the executive committee, was composed of doctors from other departments within the hospital. Although the appeal committee did hear testimony from the obstetrical specialists in plaintiff's defense, half of the

hospital's obstetrics department and another specialist testified adversely. To some extent, the same psychological factors which impugn the impartiality of the ad hoc committee were at work on the appeal committee members. (Emphasis added).

Finally, paraphrasing Justice Taft in a Supreme Court decision, the Applebaum Court stated:

Every procedure which would offer a possible temptation to the average man as a judge which might lead him not to hold the balance nice, clear and true between the accused and accuser, denies the former due process of law. The procedure at issue here, given the circumstances in which it was accomplished, violated this standard of fairness. The fatal flaw in the proceedings before us was the law of impartiality in the fact finding process.

This case has been offered at length to this committee to illustrate that the "impermissible combination of investigatory, prosecutorial and adjudicatory function" is onerous to the most fundamental notion of fair play. The presence of Drs. Hoffman and Neff on the investigative committee of the DAC -- an investigative body -- and later service on the DAC -- an adjudicative body -- impermissibly tainted these proceedings, and denied Dr. Terzis a fair adjudication. The presence of "accusers" Drs. Windle and Penix on DAC as fact-finding body further tainted the apparent and actual impartiality to which Julia Terzis should have been afforded. The presence of Dr. Hoffman as investigator on the DAC, as prosecutor before the DAC, as fact finder on the DAC, as prosecutor and fact finder on the MEC, is a further incestuous convolution which compromised the "balance, nice, clear and true

between the accused and the accuser, which would guarantee Dr. Terzis due process of law."

This intertwining of membership -- the "overlapping membership" in the terms of the Applebaum case -- continued when Drs. Roper, Lilly, Hoffman, Eng, Waldrop, Solhaug, Crockford, Windle and Bodner sat on the MEC considering the recommendation of the DAC. Here, a fact-finding body, the Medical Executive Committee, was tainted by the presence of nine members of the DAC (a MAJORITY of both those present and the total membership). In particular, the presence of Dr. Windle, whose initial accusation among others led to the original formation of the Ad Hoc Investigating Committee, and Dr. Hoffman, who had served on all committees is a compromise of the JHAC principle of FAIR HEARING. Echoing the Court in Applebaum, Dr. Terzis can only ask: Having made an adverse decision, could the nine members of the DAC be expected not to support it before the Medical Executive Committee?

The breach of due process and the failure to isolate the administrative agency's initial view of the facts from fair and effective consideration of the merits at an adversary hearing is further compounded by the presence of counsel for the hospital at the deliberative meetings of the DAC and the MEC. In the former, Mr. Luce advised and in the latter his alter ego, Mr. Manfredi, advised. The nature of the advice, if we are to judge from the transcript of the DAC meeting privately prepared for one of its members and from the participation of Mr. Luce in the proceeding of the Ad Hoc Hearing Committee, was to advise on

the nature absolute minimum of due process to be afforded Dr. Terzis, and the steps each committee was required to take to pass judicial muster. Its counsel has done this hospital a terrible disservice in attending to the superficial charade of a fair hearing and its abysmal ignorance of the reality of impartiality as mandated by standards of fair play and due process which they participated in compromising.

II.

A FAIR HEARING WAS DENIED DR. TERZIS
BY THE FAILURE TO STATE SPECIFIC FACTUAL
CHARGES AGAINST HER AND TO AFFORD
HER AN OPPORTUNITY TO DEFEND AGAINST
THOSE CHARGES ON A CASE-BY-CASE BASIS.

The concept of fundamental fairness and fair play embodied in the concept of due process is also reflected in the primary principle of Anglo-American jurisprudence that the accused is afforded notice of the specific charges against him and an adequate opportunity to defend against those charges. The Court in Poe v. Charlotte Memorial Hospital, Inc., 374 F. Supp. 1302 (1974), noted that as early as the trial of the apostle Paul, due process, which was not an American advention, was recognized as the essential of a fair hearing. In the New Testament, Acts of the Apostles, Chapter 25, Verse 16, the Roman governor refused to proceed against Paul without a hearing, reporting to King Agrippa that "It was not the custom of the Romans to give up anyone before the accused met the accusers face to face and had opportunity to make his defense concerning the charge laid against him."

This principle of fairness is reflected in this Board's own Bylaws. The request for a corrective action, according to Article IX(A)(1), must be made with reference "to SPECIFIC activities or conduct which constitute the grounds." Article X(B)(e) requires the notice of hearing before an ad hoc committee of the Medical Staff from the President to notice the "grounds upon which the adverse action is based, specific or representative charts, and any other reasons or subject matter that were considered." In (E)(5) of the same Article, the Chairman of the ad hoc committee is charged to present to both sides "a reasonable opportunity to present relevant oral and documentary EVIDENCE." (E)(7) directs MEC to appoint a member or attorney to "present FACTS supporting its recommendation." In the same subsection, the affected physician is permitted to "support [his] challenge by showing the lack of FACTUAL basis or that the action is arbitrary, capricious and/or unreasonable."

The procedural safeguard of presenting the accused with specific and factual charges to which he may respond with specific evidence was routinely ignored by the various bodies which have so far sat to determine Dr. Terzis' guilt of the broad array of nebulous charges filed against her.

Dr. Terzis was first informed of the result of the investigation of the ad hoc committee on September 23, 1985, based upon its review of 217 charts over three months by a five and six man committee. She was invited to attend to respond with "any information she considered relevant" to the charges based upon 211 of those charts. Implicit in the vague

formulation of the Bylaws regarding specificity of charges is the principle that any charge must be specific enough to enable a medical staff member to defend himself. Likewise, the rules clearly indicate that the staff member has the opportunity to present to any committee facts concerning a chart. The original scheduling of the "interview" with Dr. Terzis on October 7, less than two weeks from the date she received all of the charges was patently absurd when one considered that it required the ad hoc committee three months to formulate those charges. The medical records librarian did not let the charts out of the Medical Records Library at Norfolk General Hospital. In a period of two weeks, Dr. Terzis was expected to go to the library and find all the pertinent pages in which she was supposed to find evidence or facts to rebut the charges which were no more than nebulous allegations formulated by the ad hoc committee. She required the assistance of a secretary and a fellow to do this. Then, she was required to correlate all of her personal office charts with the documents gathered from the Norfolk General Hospital charts. This was in response to allegations that certain performances were "inadequate" or "inappropriate" without any objective standard as to what constitutes adequacy or appropriateness. It is true that Dr. Terzis was afforded continuance of 29 days upon request of counsel. However, in effect, Dr. Terzis was asked in 29 days to prepare to try 211 malpractice cases with the apparent concern of the committee ranging from "adequacy" of recordkeeping to "appropriateness" of surgical procedures -- in other words, to confront questions of

both form and substance, without an inkling of what the hearing before the DAC would focus upon.

At the Ad Hoc Investigative committee meeting, Dr. Terzis requested and was initially promised by Dr. Roper that a transcript of the hearing would be prepared; she was specifically denied the assistance of counsel and assistants who would appear in the room with her to correlate charts, although she had been forced to rely on these assistants throughout her preparation of the case. In this "interview" Dr. Terzis forthrightly fielded questions from the members of the DAC on cases as they were randomly thrown at her, valiantly attempting to reconstruct and recall the details of 211 cases without the assistance of those who helped her in preparing for the hearing. The DAC, in fact, provided to Dr. Terzis an opportunity to address only a few of the cases upon which their charges were based, but that committee allowed to survive charges based upon far more than the cases the physician had been allowed to address. As a result of its deliberations, the DAC dropped 36 of the ad hoc committee's charges, sustained 150, amended 18 others, and added 2 extra charges not heretofore presented to Dr. Terzis. The results of these deliberations were delivered to her on November 11, 1985 and she was to be heard before the MEC on November 19, 1985.

Dr. Terzis was now required to go through 170 charges, obtain additional documents from the medical charts, go back to her own records, and mount a defense to these charges, with the probability that she would be expected to be responsive to cases

thrown at her by random by the Medical Executive Committee. Appearing before the Medical Executive Committee, she was denied the assistance of Dr. Maragh, who had done the basic ground work in collating the Norfolk General Hospital charts with her own personal charts, which would address the question of substantive "appropriateness" of surgery. Dr. Terzis conceded that the history and physical in the hospital charts might be less extensive than desirable, but staunchly maintained that her personal charts were complete and accurate, an evaluation which shared by Dr. El Mahdi. The Medical Executive Committee focused its attention on general matters of recordkeeping, conceded as stated above by Dr. Terzis, OR "incidents" thought long ago put to bed by the proceeding before Dr. McCraw the the Plastic Surgery Department and its recommendation to the DAC. Other matters concerned the question of consent, in which Dr. Terzis provided consents for certain cases in which they been "missing" in the charts of specific cases. No discussion began until page 93 of a 151 page transcript of the 32 charts regarding "appropriateness" of surgery on Table IV of the DAC report. At the request of Dr. Baker (p.93, transcript of MEC meeting), the members of the committee were invited to "select out cases, instead of her going through all 32 of them." Substantively, Dr. Terzis had an opportunity to discuss chart No. 149, 88, 54, an additional chart identified as medical record 136345310 and No. 85. Forced to rely upon her own wits, and deprived of her assistant who had assisted in preparation of her response to the charges forwarded to the MEC, Dr. Terzis was forced to sort

through four and a half years of sophisticated medical treatment, comprised of largely 12 hour days, and to reconstruct events on particular cases at the whim of the MEC. Unbeknownst to Dr. Terzis, the MEC continued this meeting on November 20, after its "interview" with her, and interviewed physicians in an ex parte setting, where they were not subject to cross examination or contrary testimony which would address particular cases chosen by that committee.

The Medical Executive Committee dropped 69 charges, sustained 108, amended 28 and added 6 new charges for a total of 142 charges. This Board will observe that to this point, Dr. Terzis has been unrepresented by counsel before any deliberative body although the bodies are represented. She has been presented with an array of nebulous charges ranging from OR rule infractions and recordkeeping matters -- largely conceded and resolved -- to charges of a substantive nature impugning her judgment as a physician, but nebulously phrased in terms of "appropriateness" of surgery or consult, without the slightest indication of what the committee considered as an objective standard of "appropriateness."

Dr. Terzis was not given the results of the MEC hearing until December 23, 1985. She noticed an appeal from this decision to the ad hoc committee scheduled for Monday, January 27, at the request of her counsel who sought more time for preparation. This is the first time that she was allowed to have counsel before any body, although each body before which she appeared was represented by counsel each step of the way.

Despite the fact that Dr. Terzis' counsel requested that charges be broken down into alleged insufficient documentation of the chart and substantive allegations concerning patient care, and requested that the substantive allegations be discussed case by case, this fundamental right of fair procedure to address FACTUALLY the charges presented by the MEC was denied. The decision of the MEC at the advice of its counsel was that the MEC would put on "all of its charges" and Dr. Terzis and counsel would put on its defense at the conclusion of this presentation. Dr. Hoffman, detective for the Ad Hoc Investigating Committee, Judge for the DAC and MEC, served as prosecutor for the Ad Hoc Hearing Committee. Dr. Hoffman read into the record verbatim the charges of the Medical Executive Committee with reference to chart No. 40, although it was in litigation and heard over the objection of counsel for Dr. Terzis, chart No. 50, medical record No. 136345310. Anticipating the opportunity afforded to him by the Bylaws of this institution, counsel for the physician reasonably assumed that he would hear 142 separate charges specifically addressed, to which he would have the opportunity to cross examine and make specific response. Quite reasonably, it was assumed that this would take longer than six and a half hours on one evening of testimony. Essential witnesses on behalf of Dr. Terzis were located in Canada and in Florida, and were not available on January 28 to speak on behalf of Dr. Terzis.

Reasonably relying upon the Bylaws, counsel assumed that the MEC would put on the FACTUAL EVIDENCE which would

support its adverse decision [Article X(E)(7)]. Relying on the same section, he reasonably believed that he would be provided an opportunity to put on like FACTUAL EVIDENCE contrary to that adverse decision. Counsel attempted to proceed through the charges of the MEC on a case by case basis but was rebuked by the ad hoc committee and was told by the chair that a review of each chart was "unreasonable." (p.73 of Transcript of Ad Hoc Committee).

It was clear that not only those cases discussed by Dr. Hoffman for which an opportunity to present specific contradictory testimony might have been afforded or for which the opportunity for cross examination might have been present was before this committee. It was clearly stated that it was of no consequence whether Dr. Hoffman had or had not discussed a case, the charge remained against Dr. Terzis for the consideration of the ad hoc committee. (p.72)

The attitude of the physicians comprising the ad hoc committee was clearly revealed in Dr. Kruger's statement that because every chart had been examined by at least two physicians, there was no need to go over them again. (p.74) Dr. Terzis was simply not afforded the right to put on evidence afforded by Article X(E)(7). She was denied the right to support her position by showing a lack of factual basis, to which her counsel regularly and repeatedly objected. (p.75)

Counsel made it clear that this was a question of fundamental due process. (p.78) Dr. Kaplan likewise confessed for the Ad Hoc Hearing Committee that their deliberations were a

foregone conclusion when he stated that Mr. Harlan "must understand that when a committee appears and goes through several hundred charts and comes up with . . . [an] overwhelming representation" the later review board would have to believe that. (p.78, L.10 and following). Mr. Luce refused to instruct the committee to address only those cases Dr. Hoffman addressed unless it would make its conclusion only on those. (p.94) The burden thus ended up on counsel for Dr. Terzis to pick those cases which Dr. Terzis felt "unfounded" and put them on. Id. Dr. Terzis, of course, regarded all of the substantive cases questioned by the nebulous assertion of "inappropriateness" or "inadequacy" as "unfounded," and was denied an opportunity to put on evidence in a logical and meaningful manner to rebut the report of the MEC presented to the Ad Hoc Hearing Committee for its imprimatur.

Dr. Terzis was DENIED HER RIGHT to establish that the 142 charges surviving the DAC and MEC were without FACTUAL BASIS afforded her by the Bylaws in Article X(B)(7). The record before this Board is replete with the objections of counsel for Dr. Terzis before, during and after the hearing of the MEC regarding the inability of Dr. Terzis to mount a defense to literally hundreds of vague charges based upon four and a half years of practice. In cutting off a case by case review, the ad hoc committee totally abrogated its responsibility to provide the only potentially fair hearing Dr. Terzis had been entitled to in Norfolk General Hospital.

were consent forms not promulgated by her department, but by the Department of Surgery. It is likewise important to note that Dr. Terzis' testimony and the testimony of Dr. Brickman established that while certain procedures are now brought to the attention of incoming physicians, this was not always the practice of this hospital. Furthermore, the record is without explanation as to why the Medical Records Committee and the Quality Evaluation Committee, charged to the specific responsibility of assuring compliance with certain recordkeeping procedures failed to ever bring to the attention of Dr. Terzis prior to the inquisition into her practice her failure to comply with what they considered to be good practice.

However, the incident reports emanating from OR and reported in Ms. Hauser's memo have been tried, and tried, and tried, and tried. At each meeting, these reports are the subject of discussion. They are appended to the report of the DAC; they are discussed before the MEC. Dr. Terzis has explained the peculiar requirements of her practice with the Zeiss microscope which requires delicate adjustments by mouth during her surgery and thus make the conventional mask an anomaly. Dr. Terzis has further agreed to comply with the procedures of OR. Dr. Terzis has agreed to comply with the recordkeeping requirements, now fully brought home to her in the course of her hearing. These matters were decided before the DAC and were the subject of an admonishment. The notes of finality throughout Dr. Terzis' experiences have all been false notes. On April 8, 1985, she was informed of the apparently

final decision of the DAC, which would be revoked by a later letter. If Dr. Terzis has explained to the DAC to its satisfaction in her "interview" any questions that they have, the next "interview" will add several cases not considered before and return to the menu of vaguely phrased charges related to 211 or 142 or whatever number of charts are before the body at that time.

When, with counsel present, Dr. Terzis faced what was potentially the one potentially fair hearing (and has been described by Mr. Luce as the only hearing up to that date), her counsel attempted to address on a case by case basis the charts then the source of charges against her. Rebuffed in his attempt, the result was predictable in that the Ad Hoc Hearing Committee was free to rely upon charges in cases whether addressed or not. There was simply no finality to any proceeding ever had against Dr. Terzis.

V.

CONCLUSION

It is Dr. Terzis' hope that FINALITY and FAIRNESS resides with this Board. Dr. Terzis appeals to you as fair men, men not embroiled in daily hospital politics, and men of common sense, to accord her fair play and finality. Dr. Terzis requests that you dismiss, once and for all, the numerous charges against her as unsupported by convincing factual evidence presented at any stage of these proceedings. In judging Dr. Terzis, this Board sits as the final governing body

of a medical facility which seeks to be recognized as the finest and most progressive medical facility in this area. In judging Dr. Terzis, this Board judges a microneurosurgeon of national and international renown whose plight has attracted the attention of national and international medical bodies. Do not idly approve the prior proceedings with the easy justification that the decision is, after all, that of the DAC and the MEC. The decision is this Board's. Nor can this appeal be dismissed on the principle that the physicians involved in the prior proceeding were more knowledgeable or better equipped to make a judgment in this regard. This, you will recall, was the rationale of the Ad Hoc Hearing Committee, the first "appellate" body which felt that where two physicians had trod before, there could be no error to be examined by a third. The principles here are less medical and less legal than they appear. The question before you today is to examine the record, to the extent such a record has been permitted to exist, of the charges against Dr. Terzis, their origin and resolution. To that record, we ask only that you bring common sense and a sense of fairness. We ask you to measure that record against the mandate of the JCAH the the proecural requirements of your own Bylaws. We ask that you find that where there is such an incestuous overlapping of relationships between committees, initial bias may taint every subsequent proceeding. We ask you to find that were any member of this Board confronted by 142 charges based upon 211 transactions over the past four and one-half years he would want to be accorded the right to address each and every

one of those charges specifically, with relevant, factual and documentary evidence, and that he would wish to be accorded the time to do it in an effective manner. We ask that this Board find the proceeding against Julia Terzis so fundamentally and systematically unfair, so unfounded by evidence in the record, and so tainted by bias and animosity that all charges must be dismissed and Julia Terzis allowed to return in peace to the practice of medicine which is her livelihood and her life.

JULIA K. TERZIS, M.D.

By Michael J. Beigan
Of Counsel
for Thomas J. Harlan

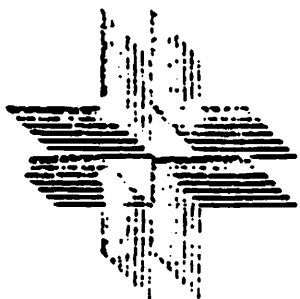
Thomas J. Harlan, Jr., Esquire
HARLAN, KNIGHT, DUDLEY & PINCUS
1350 Sovran Center
One Commercial Place
Norfolk, VA 23510
(804) 625-7605

CERTIFICATE OF SERVICE

I hereby certify that a true copy of the foregoing Written Statement in Support of the Appeal was hand-delivered this 21st day of March, 1986, to: Frank Kollmansperger, Chairman of the Board of Directors, Medical Center Hospitals.

Michael J. Beigan
for Thomas J. Harlan Jr.

[MFB6]



Medical Center Hospitals

600 Gresham Drive
Norfolk, Virginia 23507

March 25, 1986

Dr. Julia K. Terzis
Plastic Surgery Specialists, Inc.
400 W. Brambleton Avenue
Suite 300
Norfolk, Virginia 23510

RE: Final Decision of the Board of Directors
of Medical Center Hospitals

Dear Dr. Terzis:

In accordance with the Bylaws and Rules and Regulations of Medical Center Hospitals (Bylaws), you requested and were provided an appellate review from the recommended Decision of the Medical Executive Committee regarding your medical staff privileges. At its meeting on March 24, 1986, the Board considered the following information:

1. A written statement submitted on your behalf by your legal counsel
2. The written statement submitted by Alvin J. Ciccone, M. D., on behalf of the Medical Executive Committee
3. Oral argument presented on your behalf by Dr. Charles Horton, by your legal counsel and by you
4. Oral argument by Dr. Ciccone on behalf of the Medical Executive Committee
5. Responses by you, your legal counsel and Dr. Ciccone to questions by the Board

After a thorough and complete review of the record of these proceedings, including the transcript of the hearing held by the ad hoc hearing committee, the Board has reached the following Final Decision.

FINAL DECISION

Please be advised that by unanimous vote of the Board of Directors of Medical Center Hospitals, the Board has affirmed the recommended Decision of the Medical Executive Committee with the following modifications; to wit:

During the period of suspension described in the corrective action section of the Medical Executive Committee Decision,

the hospital records of Physician 392 are to be completed with appropriate information available from her office files to the extent possible and to the satisfaction of the Medical Executive Committee.


This requirement is in substitution of the requirement that Physician 392 append her office files to the appropriate hospital records.

A true copy of the recommended Decision of the Medical Executive Committee, which the Board of Directors adopts as its own with the foregoing modification, is attached hereto. Notwithstanding the typographical error contained in Article X, G, this Decision constitutes the final decision by the Board of Directors and is not subject to further hearing or review.

A duplicate original of this letter and of the Decision of the Medical Executive Committee, which the Board has adopted as its own, as modified, will be sent to you by Certified Mail, Return Receipt Requested, in accordance with the Bylaws. The suspension of your privileges in accordance with the terms of the decision shall commence upon your receipt of a copy of this Decision by Certified Mail or within five (5) calendar days from the date hereof, whichever shall first occur. The effective date of this order is thus set in order to allow time for you to arrange the rescheduling of surgery and for the orderly transition of care and treatment for patients previously admitted and for the appropriate discharge of patients who may now be admitted to Medical Center Hospitals.

Any questions regarding the terms and conditions of this Final Decision of this Board should be addressed in writing to Alvin J. Ciccone, M. D., President of the Medical Staff, Medical Center Hospitals, 600 Gresham Drive, Norfolk, Virginia 23507.

Sincerely yours,



Frank Kollmansperger
Chairman
Board of Directors
Medical Center Hospitals

FK:alm

cc: Alvin J. Ciccone, M. D.
President of the Medical Staff

David L. Bernd, President
Medical Center Hospitals

Thomas J. Harlan, Esquire
Gregory M. Luce, Esquire

BEFORE THE MEDICAL EXECUTIVE COMMITTEE
OF MEDICAL CENTER HOSPITALS

Decision of the
Medical Executive Committee
Regarding Physician 392

At its regularly scheduled meeting of February 3, 1986, the Medical Executive Committee considered the Report and Recommendation of the Ad Hoc Hearing Committee ["Hearing Committee"] regarding Physician 392. A copy of that Report is attached hereto and incorporated by reference herein.

The Hearing Committee was appointed to consider this matter at the request of Physician 392 following an initial decision of the Medical Executive Committee dated November 22, 1985. In accordance with the Bylaws, Rules and Regulations of the Medical Staff of Medical Center Hospitals [the "Bylaws"], the Medical Executive Committee has considered the Hearing Committee's Report and Recommendation, and the record of the proceedings, including all exhibits introduced at the hearing.

Based upon its review of the foregoing, the Medical Executive Committee, by unanimous vote, accepts the Findings and Conclusions of the Report and Recommendation of the Hearing Committees for the reasons set forth therein. The Medical Executive Committee, by unanimous vote, modifies the Corrective Action recommended by the Hearing Committee.

The final Findings, Conclusions and Corrective Action of the Medical Executive, Committee are set forth below.

FINDINGS OF THE MEDICAL EXECUTIVE COMMITTEE

A. Inadequate histories and physicals were noted in a significant number of charts (see Table I). Specific deficient components were:

1. Absence of pertinent medical history and physical examination for neurological deficit;
2. Absence of history of previous procedures, results, and/or complications;
3. Absence of notation regarding significant pre-existing medical problem;
4. Lack of detailed history of any pre-existing studies or evaluations which might have been significantly pertinent to that particular surgery; and
5. Lack of indications for surgery and anticipated results.

B. Informed consent for surgical procedures was found to be inadequate in a significant number of charts (see Table II) as manifested by:

1. Discrepancies between the procedure performed and the procedure listed on the operative consent;
2. The absence of a consent form in the medical record;
3. Absence of physician's signature; and
4. Absence of witness's signature.

C. There was a paucity of notes and/or countersignatures by the attending physician regarding the patient's medical status, both preoperatively and postoperatively. Many of the cases reviewed were of difficult, complicated problems, requiring sophisticated specialty care. In only 15 cases was there documentation in the progress notes that Physician 392 had indeed seen the patient outside of the immediate operative environment (See Table III.) The Committee notes that Regulation 13 of the Bylaws, however, does not expressly require the attending physician to personally sign or countersign the medical record.

- D. In a number of charts, operative notes were either absent, inadequate, or incomplete (See Table IV).
- E. Concerns were raised as to the appropriateness of surgery in Ad Hoc Study Nos. 40, 54, and 88. The Committee considered only the evidence regarding Ad Hoc Study Nos. 40, 54 and 88. With respect to Study No. 40, the Committee considered there to be sufficient facts to conclude that proceeding with surgery and surgery itself were appropriate. With respect to Study No. 54, the Committee concluded that the cancellation of surgery by Physician 392 was appropriate, but noted that a timely consultation would have averted unnecessary anesthesia in this instance. With respect to Study No. 88, the Committee concluded that the surgery in this instance was inappropriate, that a timely and proper consultation was necessary, and further notes that Physician 392 made the decision to proceed with surgery even after being advised of medical contraindications to surgery.
- F. Concerns were raised regarding the quality of patient care in the three charts. There were sufficient facts available regarding the charts designated below to support the conclusion that the care provided was less than the standard of practice in this hospital. Moreover, these charts contained information showing the need for cross-specialty consultation or alternative responses to preoperative laboratory

and radiologic findings. The Committee finds that in each of the following cases it was inappropriate to proceed with surgery:

1. Ad Hoc Study Number 50,
2. Ad Hoc Study Number 88,
3. Ad Hoc Study Number 233.

G. In the following cases, the explanations offered by Physician 392 were not supported and, in some cases, were directly contradicted by other physicians or records involved in the cases or by the statements of other responsible members of the Medical Staff:

- 1 Ad Hoc Study Number 54,
2. Ad Hoc Study Number 88,
3. Ad Hoc Study Number 233.

Conclusion of the Medical Executive Committee

,,

The foregoing Findings support the following conclusions:

1. That the practice of Physician 392 fails to meet the Rules and Regulations of the Medical Staff set forth in Rules No. 13, 14, 16, and 17;
- 2.a) That in the medical recordkeeping practices of Physician 392, that physician has failed to meet the standard of practice of this medical staff.
- 2.b) That in Study Nos. 50, 88 and 233, the practice of Physician 392 was demonstrated to be below standard of practice of the Medical Staff by the evidence in the record of errors in clinical judgment.
3. That in the appearance and statements by Physician 392 in prior proceedings, and in proceedings of the Hearing Committee, serious questions have been raised as to the veracity of Physician 392.

The foregoing Conclusions support corrective action under the Bylaws. The Committee determines that these Conclusions

support corrective action under the Bylaws Section IX.A. because the conduct of Physician 392 has been determined to be:

- a) detrimental to the patient's safety or to the delivery of quality patient care;
- b) disruptive to hospital operations; and,
- c) below the standards of the Medical Staff in maintaining adequate medical records and in the clinical judgment exercised in Study Nos. 50, 88 and 233.

Corrective Action

Based on the foregoing Findings and Conclusions of the Committee, the following Corrective Action is imposed:

- 1) That for a period of 30 days from the effective date of a final decision, the Medical Staff privileges of Physician 392 be suspended, during which time unaltered patient records from Physician 392's personal files shall be appended to the appropriate hospital charts with the dates of attachment noted by medical records personnel, and that the charts be otherwise attended so that the hospital records are complete and conform to the rules and regulations; and, that Physician 392 shall demonstrate to

the satisfaction of the Medical Executive Committee compliance with the requirements of this paragraph within the time allotted.

2) That following satisfactory completion of the foregoing period of suspension, Physician 392 be placed on probation for a period of one year, during which time there shall be concurrent review of all medical records and practice patterns of Physician 392 to ascertain inclusion by Physician 392 of the following items in each patient's hospital records:

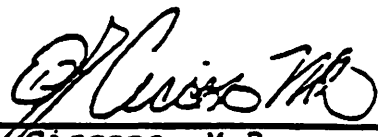
- a) pertinent history and physical examination;
- b) plan of care and expected outcome;
- c) indications for surgery;
- d) complete operative permit;
- e) complete operative record;
- f) progress notes signed by Physician 392;
- g) discharge summary signed by Physician 392;
- h) evidence of continuing involvement of Physician 392 in patient care by notes and signature or countersignature of Physician 392 in the hospital record; and
- i) inclusion of any other pertinent documentation required and necessary for the care and treatment of patient.

- 3) That Physician 392 obtain appropriate and timely consultations from a member of the Medical Staff when indicated.
- 4) That within 30 days of the effective date of a final decision, Physician 392 be given two hours of instruction by the medical record librarian in hospital record keeping, and two hours of pertinent basic operating room protocol instruction by the Operating Room Management committee; and, that records of such completed instruction be forwarded to the Medical Executive Committee.
- 5) That in consideration of the Findings and Conclusions set forth above, upon a determination by the Medical Executive Committee that any of the terms of suspension or probation set forth herein have not been met by Physician 392, such determination shall be grounds for suspension of the Medical Staff privileges of Physician 392. Suspension of Medical Staff privileges shall be imposed for such breach of any one or more of the terms of suspension or probation without further recourse to the procedures of Article X of the Bylaws, upon acceptance by the Board of Directors of a recommendation for suspension by the Medical Executive Committee.

The effective date of a final decision shall be as determined by reference to Article X.F.2 and Article X.G.

In accordance with the Bylaws a copy of this Decision shall be delivered to Physician 392, to her counsel, and to the President of Medical Center Hospitals.

Medical Executive Committee
of Medical Center Hospitals

By 
Alvin J. Ciccone, M.D.
President of the Medical Staff

Date: 7 Feb 1986

0206b/gml14

TABLE I

INADEQUATE/ABSENT HISTORY AND PHYSICAL OR DOCUMENTATION OF PRIOR STUDIES (55 CHARTS)

<u>Ad Hoc Study Number</u>	<u>Medical Record Number</u>	<u>Comments</u>
6.	230178710	(probably inadequate history and physical for 4 1/2 hour procedure - no attending signature on history and physical) (10-10-84, no eye exam)
7.	442505644	(inadequate documentation of status of prior nerve grafts, aims of surgery; "EENT exam normal," 10 hour surgery)
8.	460925788	(3rd admission--no neurologic documentation - inadequate history and physical for 14 hour procedure; 4th admission--no documented history and physical) (EMG not documented)
9.	270262986	(no neurological exam - inadequate physical, no EMG, which hand? Surgery cancelled by pulmonary consultant)
10.	101501210	(history does not adequately document 1st procedure-inadequate)
15.	112046818	(inadequate neurological exam)
25.	094544105	(inadequate history and physical on both admissions)
27.	227080174	(4 admissions - 2/4 inadequate history and physicals)
28.	261759838	(inadequate history and physical)
29.	274744361	(inadequate history and physical)
30.	711006692	(inadequate history and physical)
31.	800142499	(inadequate history and physical)
32.	119381066	(inadequate history and physical)
33.	100125424	(history and physical poor and inadequate)
35.	230665237	(substandard - bad - history and physical)
36.	281767651	(history and physical inadequate)
37.	223561003	(history and physical inadequate)
38.	230807133	(history and physical inadequate)
39.	101584391	(history and physical inadequate)
40.	228204672	(history and physical inadequate)
41.	229124283	(no documentation of injury) (no outpatient studies on chart)
42.	229883234	(history and physical inadequate)
43.	242585461	(history and physical inadequate)
45.	338244393	(eventually done by infectious disease consultant)
51.	227505540	(inadequate physical)
54.	229825509	(Adm. #1: no pulses recorded; Adm. #2: no history and physical)
56.	151425469	(inadequate history and physical)
57.	265594537	(physical exam marginal) (EMGs and nerve conduction studies not in chart)

68. 800145558 (no history and physical)
70. 142709349 (inadequate)
89. 110540994 (no neurologic exam on chart)
92. 214713356 (no neurovascular hand exam documented pre-op)
94. 261835132 (bilateral brachial plexus injuries not documented by EMG)
97. 250536760 (physical exam of arms and hand not adequate, inadequate neurological exam)
99. 243108102 (neurologic exam not adequate - no documentation lower CN function)
132. 236947121 (inadequate history and physical for surgery performed)
145. 223769831 (inadequate; transfer note: not a complete H&P)
146. 261835132 (inadequate)
147. 227786333 (history poor - what were previous operations?)
149. 010832134 (inadequate physical; checklist H&P for major reconstruction) (EMG and myelogram "done" but not in chart)
158. 224980142 (inadequate physical; checklist H&P)
164. 235645850 (no physical exam-describes injury, but no other physical)
167. 622890853 (physical exam inadequate; checklist H&P)
180. 225066176 (poor physical - no pulses recorded)
184. 201484292 (inadequate physical - no neurovascular exam for brachial plexus case; poor description of deficits)
187. 223767238 (poor physical - no pulses recorded)
198. 237903360 (no documentation of neurologic function in brachial plexus)
199. 388308960 (physical exam does not document post curran n. status)
204. 227849864 (physical exam marginal for an inpatient procedure - no M.D. signature)
211. 229382277 (etiology of original problem not documented; diagnosis of reflex sympathetic dystrophy not considered; PE does not document status of ulnar nerve function) (no EMG or clinical data)
213. 296287075 (PE does not adequately document nature and extent of injury - 1st admission--no documentation of right arm neurovascular function)
216. 213528879 (inadequate exam of affected arm in brachial plexus - injury; no neurological exam or consult)
220. C41500682 (no detailed neurological exam for brachial plexus case) (no patient PTT for myelogram)
225. 711006692 (no EMG in chart; 12 hour operation; no record of post-op. visits by Physician 392)
228. 153344694 (inadequate history and physical on patient with history of reticulum cell sarcoma - expected result?)

TABLE II

CONCERNS REGARDING CONSENT (42 CITES)

Procedure performed different from that for which consent given
(2 charts)

<u>Ad Hoc</u> <u>Study</u> <u>Number</u>	<u>Medical</u> <u>Record</u> <u>Number</u>	<u>Comments</u>
35.	230665237	(carpal tunnel release - but cubital tunnel also done - why not documented need for this and no consent)
96.	223444525	(permit for Guyon release; carpal tunnel release also performed)

Not in chart (2 charts)

<u>Ad Hoc</u> <u>Study</u> <u>Number</u>	<u>Medical</u> <u>Record</u> <u>Number</u>	<u>Comments</u>
93.	117013348	(incomplete chart? Where was surgery done?)
200.	230888761	

No M.D. signature (18 charts)

<u>Ad Hoc</u> <u>Study</u> <u>Number</u>	<u>Medical</u> <u>Record</u> <u>Number</u>	<u>Comments</u>
1.	229668735	signed 10-20-85 (1984 case)
8.	460925788	(orthopedics consent not signed by surgeon - Adm. #2) signed 10-20-85 (surgery May 84)
10.	101501210	signed 10-20-85 (August 1984 case)
17.	229826175	signed 10-20-85; insertion of CVP and A-line and neurovascular free flap left toe to third finger
21.	307429345	(7-18-84 admission) signed 10-20-85
27.	227080174	(Adm. #3: not signed by M.D.)
31.	800142499	(inadequately signed) copy of op note signed 10-20-85)
34.	229227805	June 1984 case; signed 10-20-85
39.	101584391	
41.	229124283	(also inadequate) October 1984 case; signed 10-20-85
72.	286446269	(No M.D. signature)
86.	149180439	August 1984 case; signed 10-20-85
91.	190422887	(signed 10-20-85)
96.	223444525	(Adm. #1: no M.D. signature)
98.	227126885	(incomplete) August 1984 case; signed 10-20-85
100.	526387701	(phone consent 6/11/82; No M.D. signature)

180. 225066176
205. 136502365

Does not specify procedure/body part or names wrong/body part or more procedures done than named on consent (6 charts)

<u>Ad Hoc Study Number</u>	<u>Medical Record Number</u>	<u>Comments</u>
41.	229124283	(inadequate consent - which side?)
57.	265594537	(which side)
74.	230769722	(inadequate - does not say which side)
81.	262027059	(inadequate - does not designate which arm injured)
89.	110540994	(exact procedure not specified; no M.D. signature) signature now; not on copy
158.	224980142	(vague)

No witness/M.D. signed as witness (9 charts)

<u>Ad Hoc Study Number</u>	<u>Medical Record Number</u>	<u>Comments</u>
7.	442505644	(no independent witness)
20.	262300832	(M.D. signed as witness)
57.	265594537	(M.D. signed as witness)
87.	245023800	(incomplete - no witness) (M.D. was witness)
88.	167409317	(same individual was witness and counselling M.D.) no M.D. on consent for CVP line
92.	214713356	(incomplete - same individual signed as counselling M.D. and witness)
96.	223444525	(Adm. #2 and Adm. #3: M.D. signed as witness)
97.	250536760	(M.D. and witness same)
211.	229382277	(M.D. signed as witness; no signature in M.D. blank)

Inadequate (4 charts)

<u>Ad Hoc Study Number</u>	<u>Medical Record Number</u>	<u>Comments</u>
24.	050508840	M.D. same as witness
29.	274744361	only Plas. Spec. consent; no M.D. signature on form
57.	265594537	(resection of median nerve with possible nerve graft)
70.	142709349	(<u>hospital</u> consent not adequate) see no M.D. signature

Inappropriately signed (1 chart)

Ad Hoc
Study
Number

Medical
Record
Number

Comments

25.	094544105'	1st Admission: Countersigned op note 10-20-85 and consent 10-20-85; no problem found on 2nd (top) admission
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TABLE III

#392 NOTES/DOCUMENTATION PRESENT (15 CHARTS)

<u>Ad Hoc</u> <u>Study</u> <u>Number</u>	<u>Medical</u> <u>Record</u> <u>Number</u>	<u>Comments</u>
6.	230178710	(countersigned operative note)
14.	525239120	(signed history and physical)
113.	231722506	(signed operative permit)
117.	229825509	(10/83 admission - note)
118.	229984610	(10/21/83 signed discharge note; 10/21/82 signed history and physical; signed op note)
119.	230178710	(3/83 - history and physical and operative permit signed)
123.	570271513	(seen on post operative day #3 by #392)
124.	167568514	(dictated and signed operative note)
125.	206525016	(signed notes)
131.	525239120	(3/83 signed operative note; seen by #392)
135.	800111424	(signed operative note)
161.	225962394	(signed discharge note and operative note; operative permit acceptable; 2 preoperative notes and 3 postoperative note)
185.	231261494	(10/83 signed discharge note; signed operative note)
195.	450048153	(3/83 operative permit acceptable; operative note signed x 3; 4/84 - signed operative note and discharge note, also attending note present)
226.	800098892	(countersigned some progress notes; none from 7-16 through 8-6 when patient transferred to CHKD. Surgery 7-28, 8-6)

TABLE IV

CONCERNS REGARDING OPERATIVE NOTES (7 CHARTS)

Absent/Inadequate Operative Note (4 charts)

<u>Ad Hoc Study Number</u>	<u>Medical Record Number</u>	<u>Comments</u>
11.	223767238	(No op note on second admission)
31.	800142499	(Inadequate)
35.	230665237	(One-half of op note not dictated - part on cubital tunnel.)
90.	227040291	(Incomplete operative note)

Operative Note Not Properly Signed (3 charts)

<u>Ad Hoc Study Number</u>	<u>Medical Record Number</u>	<u>Comments</u>
19.	122264394	(op. note dictated by Dr. Levine not co-signed)
20.	262300832	(incorrectly signed)
25.	094544105	(one operative note not signed properly.)

1 VIRGINIA: IN THE CIRCUIT COURT OF THE CITY OF NORFOLK

2

3

4 PHYSICIAN 392,

5

Plaintiff,

6

-vs-

7

THE BOARD OF DIRECTORS OF
MEDICAL CENTER HOSPITALS, INC.,

8

9

Defendant.

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11

NOTICE OF APPLICATION FOR
TEMPORARY INJUNCTION

12

13

Before: The Honorable Leonard B. Sachs,
Judge of the aforesaid court.

14

15

Date: March 31, 1986, at 2:00 p.m.

16

Place: Norfolk, Virginia.

17

18

APPEARANCES:

19

HARLAN, KNIGHT, DUDLEY & PINCUS
By: Thomas J. Harlan, Jr. and
Michael F. Bergan,
Attorneys for the Plaintiff.

20

21

TAYLOR, WALKER & ADAMS
By: John Franklin, III,
Counsel for the Hospital.

22

23

24

Reported by:

25

Doris O. Derieux, RPR, CSR.

PROCEEDINGS IN CHAMBERS

THE COURT: This comes on to be heard today in the case styled Physician 392, plaintiff, versus The Board of Directors of Medical Center Hospitals, Inc., defendant, on a notice of application for temporary injunction.

The plaintiff is represented by Mr. Thomas J. Harlan, Junior. He has advised me that this is really a petition for a temporary restraining order letter to be enlarged into a temporary injunction and thereafter into a permanent injunction after an evidentiary hearing.

MR. HARLAN: Now --

THE COURT: If you will, Mr. Harlan, give me just a moment for the purposes of the record so that in the event that there should be some judicial review of this proceeding this will be a non-dimentional outline bearing in mind that you have what amounts to a fifty or sixty-page written memorandum here of factual proceedings which went before the hospital board --

MR. HARLAN: Yes, sir.

THE COURT: -- and that are attached to these pleadings, so that will be a complete history.

If you can give us a pres se that you could aim me to so that I can know, then, what you are asking me to do in a factual basis.

3
1 MR. HARLAN: What we are asking you to do is
2 this: In today's modern hospital setting a physician applies
3 to a hospital for privileges through a questionnaire. One of
4 the questions, some of the questions they ask are: Have you
5 been suspended; have your privileges been suspended; have you
6 been placed on probation, and things of that nature. Because
7 the hospitals are so tight today, they can refuse the
8 physician's application to practice and this has a national
9 Northamerican significance to any physician. If a physician
10 in Norfolk is denied privileges at the hospital, I am talking
11 now from the applicant's point of view, no other hospital in
12 the United States will take that physician and they can base
13 their decision for refusal on the questions that they ask in
14 the questionnaire, such as have you been put on probation or
15 suspension.

16 Now, the Board of Directors as of last week has
17 affirmed a Medical Executive Committee's recommendation.

18 THE COURT: That is MEC. That is a title of a
19 board.

20 MR. HARLAN: MEC and DAC, MEC being the Medical
21 Executive Committee and DAC being the Departmental Authorities
22 Committee, and the Medical Board of Directors has in effect
23 affirmed the following:

24 Number one, Doctor Terzis is on thirty days
25 suspension of privileges to do anything in the Norfolk General

1 Hospital until she gets her, quote, charts, end quote,
2 up-to-date and from that time forward she is on probation for
3 one full year, and that she will be reviewed quarterly by the
4 medical staff, and that she is strictly admonished to adhere
5 to all the bylaws, rules and regulations of the hospital. In
6 other words, she has been placed on a tightrope by what I
7 perceive unreasonable men creating unreasonable restrictions
8 and they are going to be unreasonable judges of her, and I
9 will let the Court draw its own conclusions as this thing goes
10 through.

11 Therefore, rather than allow this to happen,
12 because not only are Doctor Terzis' privileges affected, but
13 the patients she deals with in the hospital, more importantly,
14 who are in the position now who are babies coming up for
15 surgery where appointments had been made a year in advance to
16 get this lady so that she can do the surgery. All this is
17 jeopardized.

18 She has privileges at other hospitals in this
19 city, DePaul, for example, but they don't have all of the
20 facilities and they don't have the trained personnel to assist
21 her in the surgical production which she does.

22 So that you have some idea, Your Honor, surgical
23 procedures can last fourteen, fifteen, sixteen hours, as
24 microsurgical technique is long, it is tedious, it is time
25 consuming. Residents who have been trained with her, Fellows

1 who are with her assist her in the surgery, and the results
2 are reanastomation or rejoining nerves or regrafting nerves
3 and changing nerves in the various areas of the body,
4 particularly the brachial plexus, the leg, the fact that that
5 is her specialty.

6 Now, her patients are still in the hospital. The
7 Board of Directors came out last week with their decision and
8 their decision is final after five days and this is the fifth
9 day today and she will suffer irreparable harm if this Board
10 is allowed to continue in these ways.

11 Now, one other thing before we get into this, and
12 let me just tell you, Your Honor, though we have the law to
13 support this, and, if you will, just accept this as in good
14 faith as we start. The Fourteenth Amendment constitutional
15 concept of due process only applies to state-run hospitals.
16 Norfolk General Hospital by any study of the case authorities
17 is not a state-run hospital Therefore, the full sanctions of
18 the Fourteenth Amendment of the due process concept do not
19 apply. By due process concept I mean notice of a hearing,
20 specific charges being given to you in time sufficient to
21 prepare defenses to these charges to submit at a hearing where
22 you can be represented by counsel so that you can confront
23 witnesses and have evidence placed before you to challenge it
24 so that you may be allowed to place evidence and to be able to,
25 upon an adverse basis of such a hearing, be able to appeal,

1 which includes the right of having a court reporter taking
2 down and generating a record, and all of this is under the
3 presupposition it is being done fairly and impartially. That
4 is the touchstone of the Fourteenth Amendment, and I have
5 skipped over some of the subtleties, but essentially that is
6 what is done under the Fourteenth Amendment.

7 To further illustrate that, Doctor Terzis was a
8 member of the medical staff of the Medical College of
9 Virginia, a state-run institution. Apart from any contractual
10 obligation on the one hand and the Medical College on the
11 other, she could have the Fourteenth Amendment protecting her
12 in her livelihood

13 One of the tiny differentiations I would like to
14 make is there is a difference between an applicant applying
15 for privileges at a hospital and the different sanctions that
16 apply and another situation where you already have had staff
17 privileges, and she is trying to reduce them or to do harm to
18 them in the first situation almost universally because the
19 courts have been somewhat reluctant to get involved in the
20 practice of medicine. A hospital can refuse on fairly
21 legitimate ground, even tenuous ground, to accept a member
22 physician of the staff, and that is to protect the public
23 ostensibly because the ways of medicine and the ways people
24 practice and things like that are not known by the Court and
25 the Court doesn't like to get into the practice of medicine.

1 However, in the situation where a person is already on the
2 staff, such as Doctor Terzis, if it is a state-run
3 institution, which this one is not, the Fourteenth Amendment
4 applies, but we are now down to Norfolk General Hospital. What
5 applies?

6 The case law says that the Fourteenth Amendment
7 guarantees. The Constitution does not apply, but at the very
8 minimum the hospital must comply strictly with its own bylaws,
9 rules and regulations, and therein lies why we are here before
10 you.

11 We feel that the bylaws and rules and regulations
12 are poorly drafted at this hospital. Number two is they do,
13 however, have certain basic concepts; number three, that the
14 charges have emanated from these basic concepts which are so
15 vague as to make it impossible to defend against, and,
16 secondly, the protocol which it comes under, the appellate
17 protocol from these bylaws have not been followed by this
18 Board. We have not been given a hearing and the rules and
19 regulations require a hearing be given us in the sense that a
20 lawyer be present. We have had no charges given to us that
21 are specific. We have not had evidence put in on any of this.
22 We have heard the allegations. We have had no
23 ability --

24
25 (Whereupon, Mr. Bergan entered the room.)

1

2

MR. HARLAN: This is Mike Bergan. He is with me.

3

4

5

6

We have not been able to put on evidence in defense of the charges, as I will show, and the results are that a very miscegenistic board of physicians, boards of physicians, have sat in judgment of Doctor Terzis.

7

THE COURT: Or incestuous.

8

MR. HARLAN: Incestuous and miscegenistic, both.

9

THE COURT: You mean misceginistic.

10

Miscegenistic would be inter-racial evidence, but

11

miscegenistic would have to do with women mating and so on.

12

MR. HARLAN: No, no. Miscegenistic in the sense

13

that there is intermarriage between the members of the DAC and

14

the Medical Executive Committee and the Board of Directors or

15

an Appellate Ad Hoc Committee and the Ad Hoc Committee.

16

There are members who are in partnership with one another and

17

the idem sonan is involved. Some of the board members are

18

partners that catch anything that both partners can't catch.

19

THE COURT: I am getting your drift.

20

MR. HARLAN: Let me first begin by showing you

21

what I am talking about, and it may be miscegenistic as well.

22

Here is the Departmental Authorities Committee.

23

THE COURT: They are color coded.

24

MR. HARLAN: They are rainbow-like qualities that

25

you see in a particular board. You will see it is --

1 THE COURT: What does the color code indicate?

2 MR. HARLAN: It is down at the bottom, Your
3 Honor. The key is right by your index finger.

4 THE COURT: All right.

5 MR. HARLAN: Now, --

6 THE COURT: There are cases involving this?

7 MR. HARLAN: Yes, sir. They are there as an
8 appendage in the back to help you.

9 THE COURT: Henry Merchantson is a familiar old
10 case if you have that one. Henry Merchantson is a United
11 States Supreme Court decision about 1945, '46, '47, somewhere
12 along in there.

13 MR. BERGAN: I believe that is cited in the case
14 pendens.

15 THE COURT: All right. What it says is that the
16 prosecutor came out and sat on appeal.

17 MR. HARLAN: We have a beautiful combination
18 here, not only the prosecutor sits on the appeal but the
19 witnesses that are called are members of the group and one of
20 the trial judges who sits in judgment of the veracity of
21 Doctor Terzis is listening to all of the evidence and
22 subsequently voting on it.

23 Now, if you will, look at the first Ad Hoc
24 Committee in my outline, if Your Honor please. They were
25 first impaneled by the Medical Executive Committee sometime in

1 February of 1985 and they went into the vineyards and went
2 through all 270 charts that Doctor Terzis had generated in the
3 Norfolk General Hospital for a period of about four years,
4 culminating in 211 charts being brought as charges, and out of
5 the -- which 211 charts some had multiple charges in them and
6 they made that recommendation, as you will see in my yellow
7 pad, directly to the Departmental Authorities Committee. The
8 Departmental Authorities Committee got these charges, as did
9 Doctor Terzis, on September 23, 1985. We were told -- Doctor
10 Terzis was told to appear, and keep in mind that is a hearing
11 where they can ask you to appear but no lawyer is allowed --
12 on September 23, Doctor Terzis had no way of being able to
13 prepare 211 defenses to 211 non-specific charges. There are
14 countless letters that went back and forth at that time by me
15 as her attorney to Mr. Luce who is with Miles and Stockbridge
16 relating to the Departmental Authorities Committee complaining
17 bitterly over the lack of specificity of the charges, lack of
18 any foundational basis to bring the charges.

19 Let me give you an example. The fact that the
20 bylaws and rules and regulations speak in terms of medical
21 authorization and that a patient in going into surgery shall
22 have a medical authorization, nowhere in the bylaws and rules
23 and regulations does it say that the medical authorization
24 shall be a part of the patient's chart, just as an example,
25 but nevertheless it doesn't say that.

1 Secondly, the bylaws, rules and regulations say
2 there shall be a complete history and physical but they don't
3 begin when it presents, so the erudite group that composes the
4 Departmental Authorities Committee or Medical Executive
5 Committee can say that creates a doubt in my mind which is
6 substantial, meaning that you should have gone back from the
7 day of the patient's birth and discussed every single thing
8 the child had at that time or all of the illnesses it had
9 since birth and age forty-seven and so forth. So it is not
10 defined and these are the two bases that I complained of in
11 writing, was the inability to draft specific charges because
12 there was no foundation in the bylaws and rules and
13 regulations, and, secondly, the charges that you bring have no
14 foundation. In fact, the rules and regulations mandate that
15 you shall have a medical authorization in the chart.

16 In any event, on September 23rd the charges came
17 out. They told us, told Doctor Terzis, she would have to be
18 present October 7th. We sent a letter out and they deferred
19 the hearing before the Departmental Authorities Committee on
20 November the 5th. Now, as I told you, this Ad Hoc Committee
21 was comprised of what, six or seven members?

22 MR. BERGAN: It is five members.

23 MR. HARLAN: The members are Doctor Gwathmey, Dr.
24 Richmond, Neff, Gilbert and who else?

25 MR. BERGAN: Doctor Hoffman.

1 MR. HARLAN: Doctor Hoffman. Keep in mind that
2 name, George Hoffman.

3 THE COURT: Who is he with?

4 MR. HARLAN: He is with Jock Wheeler's group. He
5 is a vascular surgeon or thoracic surgeon.

6 Now, therefore the Ad Hoc Committee, I am going to
7 call it the George Hoffman Ad Hoc Committee, came out with
8 these charges and they were finally heard on November 5th by
9 the Departmental Authorities Committee. Doctor Terzis and I
10 and one of her partners, Doctor McCraw, had written to the
11 Chairman of the Departmental Authorities Committee and asked
12 them to -- then there is a mandate in the rules for a record,
13 but it doesn't say what type of record should be kept. So
14 anything from so far as a scribe writing in longhand to a
15 court reporter. We were promised by Doctor Roper, Doctor
16 Terzis was promised by Doctor Roper that there would be a
17 court reporter present and they would be fully transcribed.

18 She arrives on the evening -- which, by the way, all of these
19 are nocturnal hearings, began at five-thirty at the end of the
20 work day. So this nocturnal hearing, number one, began
21 November 5th. Doctor Terzis appears by herself, together with
22 her residents and secretaries who have been gathering facts
23 from the medical records librarian, hired a xerox machine, had
24 their own copies. She said, example, what does this charge
25 mean? Copy the whole record. So she had this done, this

1 yeoman job of copying all 211 charts or pertinent portions of
2 the chart.

3 THE COURT: How much copying was that?

4 MR. HARLAN: An enormous amount, boxes stretching
5 from here to that wall, and I am indicating for the record
6 approximately eight feet of boxes of records, and this was all
7 at her expense and done primarily by her residents and Fellows
8 who went with her on the surgery or were working after hours
9 to get this done while she was trying to be Director of the
10 Microsurgical Research Center and doing surgery. So she
11 brings them back to her office, then compares them with her
12 own charts which are similarly lined up boxes side by side and
13 they walk into the Departmental Authorities Committee. There
14 were no more than seven charges partially aired in her
15 presence at the Departmental Authorities Committee. Brand new
16 charges were brought that she had never heard of before in
17 front of the Departmental Authorities Committee, and on
18 November the 11th -- November 5th is the date of the
19 hearing -- November 11th, the Departmental Authorities
20 Committee came out with 170 charges, which meant they had
21 reduced some of the original 211, added six new ones.

22 MR. BERGAN: Six brand new charges.

23 MR. HARLAN: And modified others. Now, on
24 November the 11th the written new charges come out and the
25 recommendations of the DAC as to what should be done with her,

1 and she is given a full eight days, six working days, six
2 days, not working days, lineal days, until November 19th --
3 excuse me, eight days, I can't subtract, to appear before the
4 Medical Executive Committee, and we are screaming again in
5 protest. We are saying we don't have enough time, and again
6 she goes before the Medical Executive Committee at five-thirty
7 in the afternoon for a session that lasted November 19th and
8 20th. She was only there on the 19th, and charges were again
9 discussed, no more than five charges were discussed before the
10 Medical Executive Committee where they further modified and
11 reported to the Board of Directors 142 charges, some of which
12 were the same, others which were modified, further of which
13 were new charges.

14 At this point in time we noticed our appeal and
15 the function is that the Medical Executive Committee then
16 appoints an Appellate Ad Hoc Committee chaired by Doctor
17 Parker Cross consisting, among others, of Doctor Jock Wheeler,
18 who happens to be the partner of Doctor George Hoffman. Now
19 the prosecutor -- acting the role of prosecutor before the
20 Departmental Authorities Committee was Doctor George Hoffman
21 who is a member of the Departmental Authorities Committee.
22 Acting in a role of prosecutor before the Medical Executive
23 Committee is Doctor George Hoffman who is also a member of the
24 Medical Executive Committee and acting as a prosecutor before
25 the Appellate Ad Hoc Committee was also Doctor George Hoffman.

1 There is an issue of veracity, for example,
2 touched upon in which Doctor Hoffman's partner was directly
3 involved. Doctor Hoffman's partner, Doctor Snyder said that
4 Doctor Terzis did not call him on a particular Wednesday. It
5 wasn't until Thursday that she called and that he did not know
6 of a certain angiogram that was done, and yet we called in
7 Doctor Brickman who is former chief of surgery before whom the
8 same Doctor Snyder had testified that, yes, indeed, she did
9 call me on Wednesday and the patient went to surgery and I was
10 the one that goofed up.

11 Now, sitting in judgment of this issue in
12 veracity we have got Doctor Hoffman who is prosecuting, Doctor
13 Snyder, his partner, who is sitting there testifying against
14 Doctor Terzis, and we have got Doctor Wheeler sitting on the
15 Board as one of the trial judges to determine the issue of
16 whether his partner or Doctor Terzis is lacking in veracity.

17 Now, nine members of the Medical Executive
18 Committee --

19 THE COURT: I don't want to cut you off, but let
20 me ask you if I can if I am being presumptuous in saying that
21 you are asking for a temporary restraining order because as of
22 tomorrow she won't be able to operate?

23 MR. HARLAN: Yes.

24 THE COURT: And you have stated and given me some
25 factual background which I presume the ~~Doctor~~ would testify to

1 if sworn --

2 MR. HARLAN: Yes.

3 THE COURT: -- about the nature of the
4 proceedings, and I suppose that is no secret because that is
5 just the way they are.

6 MR. HARLAN: Supposed to be so right, but it
7 wasn't, but nevertheless --

8 THE COURT: What I mean, this is no secret. This
9 is the way these proceedings are held without lawyers and so
10 on.

11 MR. HARLAN: That's right.

12 THE COURT: There were eight days between this
13 notice and this hearing and so on.

14 MR. HARLAN: Yes.

15 THE COURT: And that the statement is that she
16 would suffer irreparable harm.

17 MR. HARLAN: Yes, in two ways: Number one, she
18 will be plagued for all time in applying to any other
19 hospitals by virtue of this and, secondly, she will suffer
20 irreparable harm because of the enormity of the unfairness and
21 the failure of these people to adhere to their own bylaws,
22 rules and regulations.

23 THE COURT: All right.

24 MR. HARLAN: And her patients, of course.

25 DOCTOR TERZIS: I have young babies now.

1 THE COURT: Let me ask you another question. I am
2 just trying to get things through here. I don't know whether
3 it is in the Constitution, Article I, Section 10. Does that
4 have due process in it?

5 MR. HARLAN: Just as long as we keep in mind that
6 due process doesn't apply. It is a contract based on our
7 resource --

8 MR. BERGAN: The State Constitution might well.
9 The Federal Constitution might not have the provisions, but
10 the State Constitution provides it.

11 THE COURT: Article I, Section 11.

12 MR. HARLAN: I am arguing this --

13 THE COURT: I believe in the State Constitution.
14 I am a Jeffersonian.

15 MR. HARLAN: But this is a private hospital.

16 THE COURT: That is all right. Article I,
17 Section 11. Let's see. I may be wrong. I don't know. Let's
18 see. I have never thought of it before, but it appears to me
19 that it says here, Article I, Section 11, no person shall be
20 deprived of his life, liberty or property without due process
21 of law.

22 MR. HARLAN: Well, the Court may very well have
23 me amplify it because it certainly needs to be amplified.

24 THE COURT: I was asking you. I was simply
25 raising a question.

1 MR. HARLAN: I think it is a very interesting
2 question. Let me just say to you that perhaps since the thing
3 has come up fairly rapidly the Federal Constitutional due
4 process only applies in a state-run organization utilizing
5 federal funds and is therefore acting upon a private citizen.

6 It is derivative in that sense. Now, all I know is that the
7 funding that the Norfolk Medical Center Hospitals has by all
8 odds would be deemed inadequate to make Norfolk General
9 Hospital's action state action.

10 THE COURT: I don't think you have to deal with
11 state action because that is the Fourteenth Amendment concept.

12 MR. HARLAN: Okay.

13 THE COURT: That is the whole essence of the
14 Fourteenth Amendment. The Fourteenth Amendment says no state
15 shall --

16 MR. HARLAN: Yes, sir, that is correct.
17 Precisely.

18 THE COURT: I have right here somewhere -- hold
19 on. Let me see what it says.

20 Off the record.

21
22 (Whereupon, an off-the-record discussion took
23 place.)

24
25 THE COURT: Do you want to put the Doctor on or

1 do you feel that you have a sworn petition here?

2 MR. HARLAN: Yes, sir, I've got a sworn petition.
3 I don't know whether I signed it under haste or not, but let's
4 see if she signed it.

5 MR. BERGAN: It is by signature of counsel.

6 THE COURT: I will let her read that. I will
7 take a break and if she wants to swear to it and figure that
8 is a sworn petition --

9 MR. HARLAN: Yes, sir.

10 THE COURT: -- then perhaps we can bridge these
11 hearings somewhat.

12 MR. HARLAN: That is fine. We will be glad to do
13 that and I will do it right away.

14 May I make a suggestion while she's reading that,
15 sir? This is part and parcel of this book. This is the
16 application.

17 THE COURT: Yeah, but all I am interested in is
18 whether or not she will swear --

19 MR. HARLAN: All right, fine.

20 THE COURT: -- that the allegations and
21 assertions and factual statements in this petition or bill of
22 complaint are factual and accurate to the best of her
23 knowledge, information and belief, and if she will swear to
24 that it is, fine, and I will swear her in and we will just
25 amend it or append it as a sworn petition rather than as a

1 petition signed by counsel, and then I can act on it without
2 her testimony because this would be her testimony for purposes
3 of a temporary restraining order.

4 MR. HARLAN: Fine.

5 MR. BERGAN: We had anticipated testimony, which
6 is fine.

7 THE COURT: Well, I think for a temporary
8 restraining order, I am pretty cautious about them, but I feel
9 that --

10 MR. HARLAN: If the Court feels irreparable harm
11 will result --

12 THE COURT: That is what I feel and I feel that
13 the greater the balances that I will base our order on your
14 representations. If she signs this thing, I will enter the
15 temporary restraining order for ten days, give you a chance to
16 file further orders of the Court. We will enlarge it as you
17 go along.

18 MR. HARLAN: All right, sir. At least in our
19 research on this. Is this by limitation or is the Court just
20 fixing ten days or --

21 THE COURT: Normally I give temporary restraining
22 orders for ten days, fourteen days, it doesn't matter. You
23 didn't ask for a temporary injunction as such. It is just a
24 temporary restraining order, temporary injunction.

25 MR. HARLAN: I have asked for a longer time.

1 MR. BERGAN: We asked for an injunction.

2 THE COURT: The Court is ready to grant a
3 temporary injunction. You will have to fill me in on the law
4 on this thing.

5 How many days are you asking?

6 MR. BERGAN: We had anticipated thirty days
7 because we need to take depositions of doctors and records of
8 doctors. It took these doctors three months to review.

9 THE COURT: Doctor, if you would like to adjourn
10 to the outer office with your attorney, you can read it, and
11 if you have any questions you can close the door. Why don't
12 you go out there with her so you can answer any questions she
13 may have, and I will just suspend. You can close the door.

14

15 (Whereupon, a recess was taken and at this point
16 John Franklin entered the room.)

17

18 MR. FRANKLIN: I have been asked to come over
19 here on behalf of the hospital. Greg Luce, who is counsel for
20 the hospital, called me just a few minutes ago from Washington
21 and said that the hospital had received notice only as of
22 one-thirty today and would like to be here in this matter. He
23 also advised me that he could be down here by five-thirty
24 today for it to be heard.

25 THE COURT: I am going to go ahead and proceed. I

1 am going to enter a temporary injunction and then we can hear
2 it out fully. That is the nature of a temporary injunction is
3 so they can make out a prima facie case. If they allege and I
4 preceive irreparable harm, I will grant it so the matter can
5 be developed in an orderly way, but five-thirty tonight is not
6 really helpful to me and I don't see where it is necessary. I
7 appreciate his interest and his concern for his client, but I
8 just feel that it can be developed in an orderly way.

9 MR. FRANKLIN: May I just say this to the Court:
10 I think it has been done in an orderly way and it has been
11 reviewed by a number of committees at the hospital. It has
12 been reviewed by the Board. It is the hospital's decision
13 that --

14 THE COURT: Let me say this: I think it can be
15 judicially reviewed in an orderly way.

16 MR. HARLAN: Which is for the first time.

17 THE COURT: They are entitled to a right to
18 judicial review. Obviously I can't decide it today, so they
19 just came before me and I assume on a sworn petition rather
20 than live testimony because I just wanted to shorten the
21 proceedings, and I felt that if the allegations of the
22 application were sworn to that that makes a prima facie case
23 complaining of irreparable harm, and I see irreparable harm in
24 not granting this to permit an orderly development of the
25 judicial review, and I don't see any deleterious effect for

1 the hospital in maintaining the status quo pending the
2 development of the matter for the courts to decide.

3 MR. FRANKLIN: Well, Your Honor, if I might, the
4 decision of the Board and the decision of the hospital has
5 been for the protection and benefit of its patients, so there
6 is the potential, at least, of the allegations that gave rise
7 to this incident and they were reviewed by the hospital and
8 certainly there is at least potential risk to patients.

9 MR. HARLAN: If there were a potential risk for
10 patients, if Your Honor please --

11 THE COURT: Wait a minute. Is there some
12 question about the Doctor's competence?

13 MR. FRANKLIN: Your Honor, there is some question
14 about things that have been done within the hospital, yes,
15 sir, and whether you call that competence, I am not sure, but
16 there have been questions about surgery, there have been
17 questions about the medical records, there have been questions
18 about matters that relate directly to patients' care and
19 relate directly to the patients of Norfolk General Hospital.

20 THE COURT: All right. Well --

21 MR. FRANKLIN: And it was not a decision that was
22 lightly made. It has been reviewed by any number of
23 committees. All have come up with concurrent decisions, and I
24 think there is the potential deleterious effect if this Court
25 were to permit a hearing on the temporary point.

1 THE COURT: No. I would think that it -- well,
2 I -- I don't want you to think I am insensitive to concerns of
3 the hospital because I am not, but what I am concerned about
4 today is a petition for a temporary restraining order or
5 injunction, whichever, and I have read the petition or the
6 bill of complaint, whatever you want to call it, and to me it
7 makes out a proper case for temporary injunctive relief, and
8 so I will grant it for thirty days. Once this lady has been
9 sworn, since the allegations came in on signature of counsel
10 because they anticipated live testimony, they told me, and I
11 told them I would rush it if they would permit me to expedite
12 it by accepting her sworn petition, and she adopts those, and
13 that is why they are out there at the moment. I told them to
14 retire so that if she has any questions or if there were any
15 changes to be made they could make them before she is sworn
16 and file an affidavit of correctness.

17 But I think really if I had a serious concern
18 that this physician was not competent, as I have had about
19 some, I would probably want a full hearing before I made any
20 decision, but I think what I perceive here is something
21 different, and so it is a matter of style, a lot of other
22 things, maybe temperment, and I don't see real competence at
23 the bottom line here, so I don't think the hospital will be
24 prejudiced. They will be upset, I am quite sure, and I think
25 the Board will be upset, various committees will be upset, but

1 I can understand that because they have been working on this
2 stuff six months now, I guess, or more, but she is here now
3 asking for judicial review and certainly I can't decide it
4 this afternoon, and if this fellow came down from Baltimore --

5 MR. FRANKLIN: From Washington.

6 THE COURT: -- from Washington, all that could
7 happen is that we would rehash everybody's position, modify it,
8 and I would still have to make a decision as to whether or not
9 to grant a temporary injunction and permit you to develop this
10 case for a judicial review and we would be coming back at the
11 same place. In other words, under no theory could I decide
12 this case on the merits.

13 MR. FRANKLIN: I understand that, Your Honor. My
14 concern --

15 THE COURT: In the meanwhile she loses her
16 privileges. That is a decision that is there and so I find in
17 my balance that it -- weighing the equities, I think the
18 equities are with Doctor Terzis today on this matter.

19 MR. FRANKLIN: May I ask Your Honor, I understand
20 and I have not seen the final decision of the Board and
21 literally I was called just before I ran over here, but having
22 been involved in the case at the earlier stage, I understand
23 there are procedures for pre-op consults and review of files.

24 THE COURT: I think from what I understand there
25 is a thirty-day suspension entirely and thereafter one year on

1 probation with certain stringent conditions which may include
2 those which you mentioned, but the thirty days of suspension
3 of operating privileges and hospital privileges is the matter
4 that I am more concerned about today. I might be less excited
5 about the peer review or that sort of thing preoped, although
6 that could get kind of burdensome, but --

7 MR. FRANKLIN: Well, that would if the Court
8 would --

9 THE COURT: I am not even getting to that now. I
10 am talking about the suspension of privileges. That is what
11 concerns me, but --

12 MR. FRANKLIN: If she comes back to the hospital
13 and is practicing within the hospital, then would the Court
14 also decide that we can't review her files?

15 THE COURT: I am entering a temporary injunction
16 against the Board's order, period.

17 MR. FRANKLIN: In toto?

18 THE COURT: In toto.

19 MR. FRANKLIN: So that there would be no pre-op
20 consultation or review of her files during this period of
21 time?

22 THE COURT: No, the point being that the petition
23 filed by Tom Harlan alleges that she has not been treated
24 fairly. I am just putting it that way in a nutshell, and that
25 the charges were ill-defined, the specifics were ill-defined

1 or not defined, and that therefore the result is flawed, and
2 so based on that allegation, that goes to the whole decree.

3 But the matter which gives me the greatest
4 concern and which leads me to enter today's temporary
5 restraining order or injunction is really the suspension of
6 privileges. Now, if that were not there, then I would have to
7 consider whether or not the pre-op consultations and so on
8 should be enjoined here today by a temporary injunction, but I
9 am enjoining the whole package today.

10 MR. FRANKLIN: Well, might I suggest to the Court
11 that some type of review -- this is not something that has
12 been short in its final decision.

13 THE COURT: There is always the -- the chart
14 committee is always there. Am I right?

15 MR. FRANKLIN: Well, there is some question about
16 whether the chart committee is always there, but --

17 THE COURT: Well, we have a method with dealing
18 with these things and if history is a teacher, my guess is
19 that every chart of hers will be picked up every morning after
20 there is an entry and it will be reviewed very carefully, and
21 I expect Doctor Terzis will think or assume that it will be
22 done, don't you?

23 MR. FRANKLIN: I am not sure. I can't speak for
24 the hospital. Literally I have been dispatched today to pray
25 for them for time to be heard. I am not sure what the

1 hospital is doing. I was involved in a very limited aspect of
2 the case.

3 THE COURT: Yeah. The Canons enjoin us to be
4 sparing with ex parte injunctive relief and I am ever mindful
5 of it, but today I think it is a case that I would find there
6 had been a contest given the same judgment simply because I
7 pointed out if they were to sit here for three days and argue
8 about the right and wrong of a temporary injunction, at this
9 point I would still have to come to the conclusion as to
10 whether or not to grant this injunctive relief pending the
11 development of the case for judicial review which I would have
12 to grant. So it really doesn't matter how many days of
13 hearing we would have or whether or not I should give this
14 injunctive relief. I would come up with the same decision
15 whether it was with or without.

16 MR. FRANKLIN: Well, I am not prepared to argue
17 whether injunctive relief is appropriate in this situation and
18 I quite frankly don't know, I haven't reviewed the law, but I
19 think the concern of Mr. Luce is that the Court is basically
20 substituting his judgment even on a temporary basis with the
21 judgment of the Board.

22 THE COURT: We do it all the time.

23 MR. FRANKLIN: And so I am not prepared to --

24 THE COURT: Tell Mr. Luce that is what I get paid
25 for, substituting my judgment for that of others.

1 MR. FRANKLIN: I understand that and he --

2 THE COURT: That is what I am here for. That is
3 my job. As they say in Spanish, that is my yob, so that is
4 what I say to Mr. Luce.

5 Have you got a copy?

6 MR. HARLAN: I will give you a copy.

7 I would respectfully suggest that you put Doctor
8 Terzis under oath and --

9
10 (Whereupon, Doctor Terzis was sworn by the
11 Court.)

12
13 THE COURT: I will acknowledge it. If you sign
14 it right there, Doctor, then I will mark it down here. That
15 is the Court's copy.

16 MR. HARLAN: This is the order which I will
17 enter.

18 THE COURT: Have you seen this?

19 MR. FRANKLIN: No, I have not, Your Honor.

20 THE COURT: Have you got a copy?

21 MR. FRANKLIN: I have not.

22 MR. HARLAN: Let me just take a look at this.

23 THE COURT: Sit down.

24 MR. FRANKLIN: I can stand. That is all right.

25 THE COURT: I haven't seen that yet.

1 MR. FRANKLIN: I note in this order --

2 THE COURT: Wait a minute. I haven't seen it
3 yet.

4 MR. FRANKLIN: I am just wondering if I was
5 reading what happened today.

6 THE COURT: He may not get everything he asked
7 for because I haven't read it.

8 I am not going to order mandatory relief.

9 MR. HARLAN: All right, sir.

10 THE COURT: Because that really comes after you
11 have developed your case, and if you are entitled to it, then
12 you will get mandatory relief.

13 MR. HARLAN: All right, sir.

14 THE COURT: I am not going to enjoin any further
15 investigation.

16 MR. HARLAN: Let me just direct a comment on
17 that, if I can. I will tie this up with Doctor Terzis. In
18 the meantime, before this Board is --

19 THE COURT: Let me just say this: I intend to
20 enjoin the enforcement of the Board's order, period.

21 MR. HARLAN: All right.

22 THE COURT: So that she is returned to status quo
23 and she has the same privileges as before.

24 MR. HARLAN: All right, sir.

25 THE COURT: It is then a simple order and that is

1 all we need entered. I can get one of my secretaries to type
2 it.

3 MR. HARLAN: Either that or you can just scratch
4 out anything below.

5 THE COURT: Well, let me just -- we will go up
6 and get one of my secretaries to type the order which is
7 basically a one-line order which just says they are restrained
8 and enjoined for a period of thirty days or until further
9 order of the Court from the enforcement of the order of the
10 Board of Directors dated whatever.

11 MR. HARLAN: All right. My only problem is that
12 she could very well come out with another investigation while
13 this matter is pending because you have got people
14 investigating her, nurses looking at her, beating on the door.

15 THE COURT: Well, we will deny that investigation
16 because I don't think I can stop that. I think that is a
17 matter of the hospital keeping up with the charges. I think
18 they ought to defer these charges because otherwise we get
19 into the realm of what in criminal law would be called maybe
20 prosecutorial vindictiveness.

21 MR. HARLAN: The other thing I would want the
22 Court to consider, and this is just housekeeping, that I
23 intend to take a series of discovery depositions. I would ask
24 the Court the ability to utilize the subpoena duces tecum
25 power. We have to make an analysis of certain records so as

1 to show the actual standard of care by her peers in terms of
2 record keeping. We don't need to --

3 THE COURT: I am not going to prejudge any of
4 those things.

5 All right. That will come to me. It wouldn't be
6 fair to shift it around from judge to judge, so I will just
7 have my name put on the file and I will live with it.

8 MR. HARLAN: Well, if you would be kind enough to
9 tell me the language that you consider, I will have it typed
10 right away.

11 THE COURT: All right. Where is the Board's
12 order that you have? Is that an attachment here?

13 MR. HARLAN: Yes, sir.

14 MR. BERGAN: It is attached to the last document.

15 THE COURT: All right.

16 MR. HARLAN: If I may make a suggestion --

17 THE COURT: Well, I think it does exactly what
18 you are intending to do and no more.

19 MR. HARLAN: What I did, I just took this and
20 drew a line like that and took this out because the Court said
21 no and all it does is just do exactly what --

22 THE COURT: It speaks here of dissolving the
23 order that may involve the plaintiff. We are not dissolving
24 anything. We are just suspending the action or enforcement of
25 anything.

1 MR. HARLAN: Action of the Board. All right.

2 THE COURT: What this will do, I will have B, C
3 and otherwise suspend any adverse action on the part of the
4 Board or its subsidiary committees.

5 MR. HARLAN: Just so that she can practice as any
6 other physician until the Court has made the determination
7 until this injunction expires.

8 MR. FRANKLIN: Your Honor, if I might, she is not
9 just any other physician at this point. There has been
10 determined to be some concern about her practice.

11 THE COURT: Oh, I know, I know. All right.
12 Let's walk down to the secretary and type. Just for the
13 record, so it will be complete, I am going to enter an order
14 which will basically use the first paragraph, paragraph one of
15 your order, deleting subparagraph (a), and maybe add a little
16 bit. We will go down and dictate it now and we will be ready
17 to roll.

18 MR. HARLAN: All right. Thank you.

19 THE COURT: There will be a thirty-day
20 injunction.

21 MR. FRANKLIN: Let me for the record dictate my
22 objection on behalf of the hospital to the entry of the order
23 and to this proceeding and notice. We have not received
24 notice until approximately one-thirty and an hour's delay and
25 I arrived here at about twenty minutes of three.

1 THE COURT: Your objection is noted and preserved
2 for the record.

3 All right.

4

5 (Whereupon, this hearing was concluded.)

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VIRGINIA: IN THE CIRCUIT COURT OF THE CITY OF NORFOLK

PHYSICIAN 392, ,

Plaintiff,

v.

THE BOARD OF DIRECTORS OF MEDICAL
CENTER HOSPITALS, INC.,

Defendants.

ORDER OF TEMPORARY INJUNCTION

Upon the prayer of the plaintiff in the Bill of
Complaint herein, an injunction is immediately granted:

1. Restraining and Enjoining the Board of Directors
of Medical Center Hospitals, Inc. (MCH) and its agents,
servants and employees or subsidiary committees, from:

(a) Suspending or in any way modifying the hospital
privileges of Physician 392;

(b) Preventing Physician 392 from admitting and
treating surgical patients.

This injunction shall be effective from March 31,
1986 to May 1, 1986 or until further order of this Court.

ENTER:



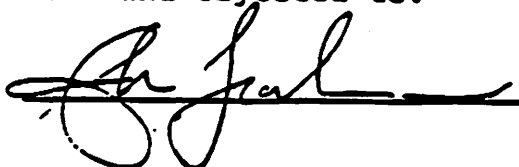
Leonard B. Sachs, Judge

I ask for this:


_____, p.q.

3/31/86
A COPY, TESTE: WILLIAM T. RYAN, CLERK
BY:  , D.C.

Seen and objected to:


_____, p.d.

V I R G I N I A

IN THE CIRCUIT COURT OF THE CITY OF NORFOLK

PHYSICIAN 392, -

Plaintiff,

v.

THE BOARD OF DIRECTORS OF
MEDICAL CENTER HOSPITALS,
INC.,

Defendants.

In Chancery No. C86-496

AFFIDAVIT

Commonwealth of Virginia)
City of Norfolk) to wit:

NOW COMES Frank Kollmansperger, who deposes and states as follows:

1. I, Frank Kollmansperger, serve as Chairman of the Board of Directors of Medical Center Hospitals.

2. As Chairman of the Board of Directors of Medical Center Hospitals ("Board"), I am knowledgeable of the circumstances concerning the investigation of Physician 392, and of the reasons for the March 25, 1986 Decision of the Board of Directors to suspend the Medical Staff privileges of Physician 392, and to impose the other disciplinary actions, as stated therein.

3. The imposition of disciplinary actions against Physician 392 was deemed necessary by the Board to ensure that the proper standards of patient care at Medical Center Hospitals are

met, to ensure necessary compliance with the rules and regulations of Medical Center Hospitals, to ensure the professional competency of physicians admitting and treating patients at Medical Center Hospitals, and to otherwise ensure the continued safe and efficient operations of Medical Center Hospitals.

4. Continuation of this injunction will irreparably impair and impede the present and future ability of the Board to to ensure that the proper standards of patient care at Medical Center Hospitals are met, to ensure necessary compliance with the rules and regulations of Medical Center Hospitals, to ensure the professional competence of physicians admitting and treating patients at Medical Center Hospitals, and to ensure otherwise the continued safe and efficient operation of Medical Center Hospitals.

5. Continuation of the temporary injunction will have the foregoing injurious effects because, in effect, this Court has denied this Board its legal authority to govern the internal affairs of Medical Center Hospitals, including appointment to, and removal from membership in its Medical Staff.

6. The foregoing injurious effects also will occur as a result of any disclosure of peer review information, including the deliberative processes of Medical Staff committees charged with the review of physician practices at Medical Center Hospitals. Disclosure of such matters and "judicial review" thereof will have a demonstrable "chilling effect" on the willingness of physicians to serve on such committees and to provide candid and critical observations as necessary to such reviews.

7. To the best of my knowledge, information and belief, and based upon my review of the record of the proceedings, the Decision of the Board was made in compliance with all applicable provisions of the By-laws, Rules and Regulations of the Medical Staff of Medical Center Hospitals.

8. The practice of Physician 392 at Medical Center Hospitals as a member of the Medical Staff is not and was not based upon any contract, express or implied, between Medical Center Hospitals and Physician 392.

Frank Kollmansperger
Frank Kollmansperger

Subscribed and sworn to before this this 11th day of April, 1986.

Freida D. Dorlet
Notary Public

My Commission Expires: 4-25-88 I was commissioned notary as Freida D. Bray

**BYLAWS
AND
RULES AND REGULATIONS
OF
THE MEDICAL STAFF
OF
MEDICAL CENTER HOSPITALS**

February 1984

B Y L A W S
AND
RULES AND REGULATIONS
OF
THE MEDICAL STAFF
OF
MEDICAL CENTER HOSPITALS

I N D E X

BYLAWS AND RULES AND REGULATIONS OF THE MEDICAL STAFF OF MEDICAL CENTER HOSPITALS

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BY-LAWS AND
RULES AND REGULATIONS
OF
THE MEDICAL STAFF OF MEDICAL CENTER HOSPITALS

PREAMBLE

WHEREAS, the Medical Staff is responsible for the quality of medical care in the hospitals and must accept and assume this responsibility, subject to ultimate authority of the Board of Directors; and

WHEREAS, the best interests of the patient are protected by the Medical Staff's concerted effort.

THEREFORE, the members of the Medical Staff practicing in Medical Center Hospitals hereby organize themselves in conformity with these By-Laws, Rules and Regulations.

ARTICLE I

DEFINITIONS

A. Board of Directors. "Board of Directors" or "Board" shall mean the Board of Directors of Medical Center Hospitals.

B. Medical Executive Committee. "Medical Executive Committee" shall mean the Executive Committee of the Medical Staff of Medical Center Hospitals.

C. Medical Staff. "Medical Staff" shall mean all physicians, dentists, podiatrists and others who are privileged to attend patients at Medical Center Hospitals.

D. Practitioner. "Practitioner" shall mean any appropriately licensed physician, dentist or podiatrist applying for or exercising clinical privileges at Medical Center Hospitals.

ARTICLE II

NAME

The name of this organization shall be the Medical Staff of Medical Center Hospitals.

ARTICLE III

PURPOSES AND RESPONSIBILITIES

A. The purposes of this organization shall be:

1. To assume that all patients who seek medical treatment receive the best possible medical care.

2. To provide a means which medical and administrative problems may be discussed by the Medical Staff with the Board of Directors and the Administration.

3. To initiate and maintain a Medical Staff organization.

4. To provide medical education and to maintain appropriate educational standards.

B. The responsibilities of this organization shall be:

1. To assure the rendering of efficient and high quality patient care throughout Medical Center Hospitals, and to account therefor to the Board of Directors.

2. To initiate and pursue corrective and disciplinary action against practitioners, when warranted.

3. To assist in the identification of community health needs and institutional goals related thereto, and to implement programs to meet those needs and goals.

ARTICLE IV

MEMBERSHIP

A. Qualifications. Practitioners, in order to acquire and hold membership on the Medical Staff, must have graduated from an approved or recognized medical school, dental school, school of osteopathy or school of podiatric medicine, have satisfactorily completed the Application for Appointment to the Medical Staff (including the receipt by the Medical Center Hospitals of all necessary information and documents pertaining to the application), and be legally licensed to practice in the Commonwealth of Virginia. Practitioners who do not meet the minimum criteria above may also have

privileges which are consistent with the Rules and Regulations of the Healing Arts Licensed and Regulated by the Virginia Board of Medicine, Section 4.3. No applicant shall be denied membership on the Medical Staff on the basis of sex, race, creed, color, or national origin. Privileges awarded apply to all divisions of Medical Center Hospitals, and similarly, the obligations and responsibilities appropriate to the privileges awarded apply in all divisions of Medical Center Hospitals.

B. Appointment Procedures.

1. Initial Appointment. All applications for Medical Staff membership and privileges shall be made on an approved form (see Appendix A) and submitted to the Secretary/Treasurer of the Medical Staff who, in turn, shall transmit such applications to the Departmental Authorities Committee. Failure of the applicant to complete the form accurately and honestly can be grounds for the denial of membership and privileges initially, or revocation of privileges once already granted. The Departmental Authorities Committee shall investigate each application in detail to determine completeness and advise the applicant should any deficiency be found. The Departmental Authorities Committee shall then afford the Department in which the applicant desires to practice an opportunity to review the application, make whatever investigation is deemed advisable, and submit its written recommendation to the Departmental Authorities

Committee. Based upon its own review of the application and investigation of the applicant, and upon consideration of the report of the Department, the Departmental Authorities Committee shall forward its report on the application, with recommendations and supporting data to the Medical Executive Committee. The Medical Executive Committee, after review, may refer the application back to the Departmental Authorities Committee if it desires further information, or it may make its own recommendations and report to the Board of Directors at the Board's next regular meeting. The Departmental Authorities Committee and the Medical Executive Committee shall complete their consideration of the application in sufficient time to enable the Board of Directors to take action within sixty (60) days after submission of the application and providing of all necessary information by the applicant.

2. Reappointment.

a. Three months prior to the expiration date of a member's staff appointment, the Medical Staff Office will provide the member with an application form (see Appendix A) for reappointment. Each member desiring reappointment shall, at least two (2) months prior to such expiration date, submit this application to the Medical Staff Office.

b. The form shall contain the information necessary to maintain a current file on the reapplying

practitioner.

c. The Department Chief shall review the form and the member's file and shall transmit his recommendations to the Departmental Authorities Committee.

d. The Departmental Authorities Committee shall review the member's file together with the recommendation of the Department Chief and other relevant information and forward a written report with its recommendations to the Medical Executive Committee.

e. The Medical Executive Committee shall promptly make its recommendations to the Board of Directors.

f. The reappointment of a practitioner shall not be considered a condonation of any prior misconduct or sub-standard practice and shall not prejudice the Medical Staff or Medical Center Hospitals in any way in the exercise of any of its rights or remedies, including the taking of corrective action, regarding such misconduct or sub-standard practice.

3. Term of Appointment. All appointments to the Medical Staff and renewal of privileges shall be made by the Board of Directors acting upon the report and recommendations of the Medical Executive Committee, and shall be for a term of two years unless otherwise provided.

4. Consultation. The Board of Directors shall take no action on any application for membership, refuse to

renew any application previously made, or cancel any previously made appointment without first conferring with the Medical Executive Committee.

5. Standard of Review. Any recommendation made or action taken by any committee or member of the Medical Staff, whether under this Section B of Article IV or under any other provision of these By-Laws and Rules and Regulations, toward:

- a. denying or withholding from a duly licensed practitioner staff membership or any professional privileges;
- b. excluding or expelling a member from staff membership; and
- c. curtailing, terminating or diminishing in any way a member's professional privileges.

may be based only upon standards of patient care, patient welfare, or the character or competency of the applicant, misconduct by the applicant in any hospital, violation of these By-Laws and Rules and Regulations for the Medical Staff or of any rules or regulations of Medical Center Hospitals or other interference with the objectives or efficient operations of Medical Center Hospitals.

6. Appeals from Adverse Action. Any recommendation of the Medical Executive Committee which would have an

adverse effect upon the practitioner as set out in Article IV, Section B, subsection 5 above shall be in writing, shall state the reasons for the recommendation and shall entitle the affected practitioner to the right to a hearing and appeal set forth in Article X hereof. A copy of such written recommendation shall be provided promptly to the practitioner.

7. Reapplication Forbidden For Six Months. An applicant who has received an adverse decision from the Board of Directors regarding appointment based on the merits of his application shall not be eligible to reapply for a period of six (6) months following the date of such decision or the conclusion of any appeal therefrom. Any such reapplication shall be processed as an initial application, and the applicant must submit such additional information as the Medical Staff or Board of Directors may require to demonstrate that the basis for the earlier adverse action no longer exists.

C. Ethical Obligations. All members shall conduct their practice in accordance with the respective Codes of Ethics of the American Medical Association, the American Dental Association and such other codes or canons as from time to time may be approved by the Medical Staff. Additionally, all members of the Medical Staff will refrain from rebating a portion of a fee or receiving other inducements in exchange for a patient referral, deceiving a patient as to the identity

of another practitioner providing services or treatment, and delegating the responsibilities for diagnosis or treatment of patients to another practitioner who is not qualified.

D. Leaves of Absence.

1. Granted. The Medical Executive Committee may, in its discretion, grant leaves of absence from Medical Staff responsibilities for reasonable periods of time without requiring reclassification (e.g., service in Armed Forces or illness).

2. Reinstatement. A Medical Staff member may request reinstatement of his membership and privileges by submitting a written notice to that effect to the President of the Medical Staff for transmittal to the Medical Executive Committee. If the Medical Executive Committee requests, the member shall also submit a written summary of his relevant activities while on leave. The Medical Executive Committee shall then make a recommendation within forty-five (45) days to the Board of Directors concerning the reinstatement of the member's rights and privileges.

ARTICLE V

MEDICAL STAFF DIVISIONS

The Medical Staff shall be divided into Active, Associate, Courtesy, Consulting, Temporary, Honorary and Affiliate Staffs.

A. The Associate Medical Staff.

1. The Associate Medical Staff shall consist of all new physician and dentist members of the Staff who are eligible and intend to become permanent members of the Medical Staff after a probationary period of one year, during which time the requirements for Active Medical Staff membership are to be fulfilled.

2. Associate Medical Staff members shall attend meetings as specified in Article XI of these By-Laws. They shall not be eligible to make nominations, vote or hold elective office but shall otherwise be subject to those obligations and responsibilities borne by members of the Active Medical Staff, as assigned by the President of the Medical Staff or the chiefs of their respective departments.

3. Associate Medical Staff members may request Active or Courtesy Staff status after one year.. If a member has had Associate Staff status for a period of one year, but has not fulfilled the requirements for advancement to the Active Medical Staff as outlined in this Article IV and elaborated by the President of the Medical Staff, he may be granted an additional one year grace period. If at the expiration of the grace period, he has still not fulfilled the requirements, he will be placed on the Courtesy Staff.

B. The Active Medical Staff.

1. The Active Medical Staff shall consist of physician and dentist members who have completed the requirements of the Associate Staff. The Active Staff is responsible for transacting the business of the Medical Staff and establishing and maintaining standards for the care of patients of the Hospitals.

2. Members of the Active Medical Staff shall participate actively in the inpatient and outpatient service programs as assigned by the Chiefs of their respective departments.

3. Members of the Active Medical Staff shall be eligible to vote for and hold Medical Staff office, shall be required to attend meetings as provided in Article XI and shall serve on at least one staff committee if asked to do so by the President.

4. Members of the Active Medical Staff will be given preference for non-emergency admissions when there is a shortage of hospital beds. A shortage occurs when the occupancy of a particular category of beds (Medical-Surgical, Psychiatric, OB, etc.) is at 90% occupancy or higher.

C. The Courtesy Medical Staff.

1. The Courtesy Medical Staff shall consist of those physician and dentist members who wish to attend a limited number of private patients in Medical Center

Hospitals, but do not desire to become members of the Active or Consulting Staffs.

2. Members of the Courtesy Staff shall not be permitted to make nominations, vote or hold elective office, but shall serve on committees where eligible under these By-Laws and shall be required to attend committee meetings provided in Article XI.

3. A member of the Courtesy Medical Staff is permitted up to twelve (12) inpatient contacts per year. Participation in the care of a patient admitted by him or another Medical Staff member constitutes an inpatient contact. This includes admissions, formal consultations and operations, excluding surgery in the Ambulatory Surgical Center. If his practice exceeds this limit, he shall be required to apply for privileges on the Active Staff. Failure to abide by this provision will be grounds for the revocation of all privileges, pursuant to Articles IX and X of these By-Laws.

The Executive Committee has the authority to grant, at the time of the bi-annual reappointment to the Medical Staff, exemptions to this provision for members of the Courtesy Staff who provide coverage only on weekends, holidays, nights or emergencies for patients being attended by members of the Associate, Active or Consulting Staffs. Such exemption shall be granted only with the unanimous approval of the departments of the practitioners involved.

4. The right and duty of assignment to Emergency Room rotational coverage as well as inpatient and outpatient service responsibilities shall not apply to the Courtesy Staff category.

D. Consulting Medical Staff.

The Consulting Medical Staff shall be divided into two sections: (1) Permanent Consulting Medical Staff and (2) Visiting Consulting Medical Staff.

1. Permanent Consulting Medical Staff.

a. The Permanent Consulting Medical Staff shall consist of physician and dentist members who are fifty-five (55) years of age or older and have served on the Active Medical Staff for a minimum of twenty (20) years or who have reached age sixty-five (65), who possess recognized professional ability and who continue actively to practice medicine while manifesting a continuing interest in the Hospitals' professional standards and medical education program.

b. Members of the Permanent Consulting Medical Staff shall be eligible to vote and hold office and upon accepting a committee appointment shall be required to attend Committee meetings as provided in Article XI.

c. Members of the Permanent Consulting Medical Staff shall participate in the inpatient and outpatient service programs as assigned by the Chiefs of their

respective departments.

2. Visiting Consulting Medical Staff.

a. Members of the Visiting Consulting Medical Staff may be granted temporary membership by the President of the Medical Staff and the President of Medical Center Hospitals. The Visiting Consultant's primary function shall be to assist in the teaching and/or continuing medical education programs of the Hospitals. A Visiting Consultant's qualifications and requested scope of activity shall be presented in writing to the President by the Chief of the department concerned. A Visiting Consultant shall not be required to apply for privileges except to the extent that the scope of the proposed activities must be delineated as part of the request.

b. A member of the Visiting Consulting Medical Staff shall not be eligible to vote or hold office or to serve on committees and shall not be required to pay annual dues.

c. If temporary membership is granted, the Visiting Consultant must sign an agreement to abide by all the By-Laws, Rules and Regulations of the Medical Staff.

E. Temporary Medical Staff.

1. The President of the Hospitals, upon the recommendations of the President of the Medical Staff and the Chief of the department involved, shall have the authority to

grant, as a matter of courtesy, temporary membership (and concurrent limited privileges pursuant to Article VIII.E.2) to a qualified applicant under Article IV for a period of ninety (90) days or until the Departmental Authorities Committee has appropriately reviewed the application. If the applicant's temporary privileges are terminated, membership shall cease immediately.

2. If temporary membership is granted, the applicant must agree, in writing, to obey all the By-Laws, Rules and Regulations of the Medical Staff. Pending final action upon the applicant's application for privileges, and upon the discovery of any information or the occurrence of any event which raises questions about a practitioner's professional qualifications or ability, the President of the Hospitals or the President of the Medical Staff may terminate such temporary membership.

3. A temporary member shall not be entitled to the procedural rights afforded by Articles IX and X of these By-Laws except as provided under Article IV of these By-Laws, nor shall he be entitled to vote, hold office or required to pay dues.

F. The Honorary Medical Staff. The Honorary Staff shall consist of members who have retired from active hospital practice, and whom the Medical Staff desires to honor. Honorary members shall not be permitted to hold elective

office or vote and shall have no assigned duties, nor shall they be required to pay annual dues.

G. The Affiliate Staff.

1. The Affiliate Staff shall include professionals whose occupations involve them in direct patient contact and care, but who are not doctors of Medicine, Osteopathy, or Dentistry. Membership in the Affiliate Staff shall be granted only after appropriate application to the Medical Executive Committee and Board of Directors as prescribed for other categories of staff membership. Members of the Affiliate Staff shall have no voting privileges, may hold no elective office and, except for Podiatrists, may not attend quarterly staff meetings. The Departmental Authorities Committee shall have the authority to assign members of the Affiliate Staff to appropriate departments, and shall require members of the Active, Courtesy or Consulting Medical Staffs to be responsible for any service rendered by an Affiliate Staff member as appropriate.

2. The Affiliate Staff shall be divided into two sections:

- a. The Podiatry Section;
- b. The Health Professional Affiliates Section, which shall be divided into four (4) categories:

- Category I: Psychologists, Speech Pathologists, Social Workers and Audiologists.
- Category II: Certified Physician Assistants and Certified Nurse Practitioners (as recognized by the State Boards of Medicine and Nursing).
- Category III: Certified O.R.T.'s, Certified Surgical Assistants, Certified Dental Assistants, Certified Dental Hygienists, Registered Nurses, Licensed Practical Nurses and Certified Ophthalmic Assistants.
- Category IV: Physicists, Biochemists, Certified Registered Nurse Anesthetists and other health professionals whose occupation requires advanced expertise and training in highly specialized areas of medical science.

3. Rights and Responsibilities of Affiliate Staff Members.

- a. A member of the Podiatry Section shall

have the following rights and responsibilities:

(1) To write orders within the scope of his license, certificate or other legal credential, and to the extent established for him in the Rules and Regulations of the Medical Staff and the Department to which he is assigned.

(2) To serve on Medical Staff, Departmental and hospital committees.

(3) To attend meetings of the Medical Staff and Department to which he is assigned, and Medical Staff and hospital education programs.

(4) To exercise such other rights and responsibilities as may, by resolution or policy adopted by the Medical Staff or by any of its departments or committees and approved by the Medical Executive Committee and the Board of Directors, be accorded to Podiatrists as a group, such as the right to vote on specified matters, to hold defined offices, or any other prerogatives for which medical education, training and experience beyond that which a Podiatrist can demonstrate is not a prerequisite.

(5) To exercise admitting and clinical privileges as specified in Article VIII.

(6) To enjoy the benefits of those procedural rights established in Articles IX and X.

b. Members of the Health Professional Affiliates Section shall have the following rights and

responsibilities:

(1) To provide specified patient care services under supervision or direction of a physician member of the Medical Staff, and subject to any licensure requirements or other legal limitations, exercise independent judgment within the areas of his professional competence.

(2) To write orders within the scope of his license, certificate or other legal credential, and to the extent established for him in the By-Laws and Rules and Regulations of the Medical Staff and the Department to which he is assigned.

(3) To serve on Medical Staff, Department and hospital committees to which he is assigned.

(4) To exercise such other rights and responsibilities as may, by resolution or written policy adopted by the Medical Staff or by any of its departments or committees and approved by the Medical Executive Committee and the Board of Directors, be accorded to Health Professional Affiliates as a group, or to any specific category of Health Professional Affiliates, such as the right to vote on specified matters, to hold defined offices, or any other rights and responsibilities for which medical education, training and experience beyond that which a Health Professional Affiliate or particular group thereof can demonstrate is not a prerequisite.

(5) Members of the Health Professional Affiliates Section shall have no admitting privileges.

(6) Members of the Health Professional Affiliates Section shall not enjoy the procedural rights provided in Articles IX and X.

ARTICLE VI

GOVERNMENT OF THE MEDICAL STAFF

A. Officers.

1. The officers of the Medical Staff shall assume office at the annual meeting and serve for a term of one year or until their successor takes office. The officers shall be:

a. President. The President shall call and preside at all meetings of the Medical Staff and the Medical Executive Committee. The President shall make such appointments as may be authorized by these By-Laws and will be an ex-officio member of all committees.

b. Vice-President and President Elect. The Vice-President shall, in the absence of the President, assume the duties of the President and have the authority of the President. He shall serve as Chairman of the Departmental Authorities Committee and shall also be President Elect.

c. Secretary/Treasurer. The Secretary/Treasurer shall cause to be kept accurate and complete minutes of meetings of the Medical Staff and the

Medical Executive Committee, call meetings on order of the President, attend to all correspondence, collect dues as provided by these By-Laws, keep accurate and complete records of all funds entrusted to him, and perform such other duties as ordinarily pertain to his office. He shall serve as Chairman of the Education Committee.

2. Qualifications. Officers must be members of the Active or Permanent Consulting Medical Staffs at the time of nomination and election, and must remain members in good standing during their tenure in office. The failure to maintain such status shall immediately create a vacancy in the office involved. The President and Vice-President must be physicians or dentists with demonstrated competence in their field of practice and demonstrated experience and ability to direct the medical and administrative aspects of hospital and staff activities.

3. Nominations. A nominating committee shall present a slate of nominations for the office of President (if there be no Vice-President), Vice-President and Secretary/Treasurer at the annual meeting. These nominations may be supplemented by nominations from the floor. The committee shall publish its slate of nominees by posting it in a conspicuous place on Medical Staff bulletin boards in each hospital at least one month prior to the annual meeting.

4. Election. Voting shall be by secret written

ballot, and voting by proxy shall not be permitted. A nominee shall be elected upon receiving the majority of the valid votes cast. If no candidate for the office receives the majority vote on the first ballot, a runoff election shall be held promptly between the two candidates receiving the highest number of votes.

5. Removal. An officer of the Medical Staff may be removed from office by a three-quarters vote of the members of the Medical Staff present at a duly convened meeting of the Medical Staff. Removal shall only be for cause, which shall be defined as proven dishonesty, conviction of a crime involving moral turpitude, failure to attend meetings without just excuse, loss of qualification for membership on the Active or Permanent Consulting Medical Staffs, suspension of privileges or such other neglect of a member's responsibilities as the Medical Staff may judge justifying removal.

6. Succession of Authority. Should the President for any reason be unable or unavailable to exercise his authority as President, this authority shall pass to the Vice-President and subsequently to the Secretary-Treasurer. In the event of their absence, the succession of authority shall be as enumerated below. If the availability of the President is restored, he shall immediately regain his authority as President.

(1) The President

- (2) The Vice President
- (3) Secretary/Treasurer
- (4) Immediate Past President
- (5) Chairman of the Quality Evaluation Committee
- (6) Co-Chairman of the Patient Care Committee - NGH
- (7) Co-Chairman of the Patient Care Committee - LMH
- (8) Chief of Surgery
- (9) Chief of Internal Medicine
- (10) Chief of Family Practice
- (11) Chief of OB/GYN
- (12) Chief of Psychiatry
- (13) Chief of Pediatrics
- (14) and (15) Chiefs of other Departments on
Medical Executive Committee

B. Medical Executive Committee.

1. Duties. The duties of the Medical Executive
Committee shall be:
 - a. to be responsible to the Board of
Directors for the general quality of
medical care rendered to patients in the
hospital.
 - b. to meet at least monthly and have
authority over and be responsible for the
direction of the activities and general
policies of the various departments and

committees;

- c. to represent and to act on behalf of the Medical Staff, subject only to any limitations imposed by these bylaws;
- d. to receive and act upon reports of departments and committees;
- e. to prepare and present programs at meetings of the Medical Staff and report on Executive Committee actions at such meetings;
- f. to implement policies of the Medical Staff which are not the responsibility of the departments;
- g. to provide a liaison among Medical Staff, the President of the Hospitals and the Board;
- h. to recommend action to the President of the Hospitals on matters of a medico-administrative and hospital management nature;
- i. to ensure that the Medical Staff is kept abreast of the Joint Commission on Accreditation of Hospitals accreditation program and informed of the accreditation status of the hospital;

- j. to review the credentials of all applicants and to make recommendations to the Board regarding appointment to the Medical Staff, assignments to departments and delineation of clinical privileges;
- k. to review all information available regarding the performance and clinical competence of persons who hold appointments to the medical staff and as a result of such review to make recommendations to the Board regarding reappointments and renewal of or changes in clinical privileges;

The Medical Executive Committee may delegate to other committees such powers and duties as it may deem proper.

2. Membership.

a. The voting members of the Medical Executive Committee and the method of their appointment shall be:

- (1) The President - (elected)
- (2) The Vice President - (elected)
- (3) Secretary/Treasurer - (elected)
- (4) Immediate Past President - (automatic)
- (5) Chairman of the Quality Evaluation

Committee - (automatic)

- (6) Co-Chairman of the Patient Care Committee
(Norfolk General Division) - (automatic)
- (7) Co-Chairman of the Patient Care Committee
(Leigh Memorial Division) - (automatic)
- (8) Eastern Virginia Medical School
representative (selected by the Medical
Executive Committee from a slate of one or
more persons nominated by the President of
the Eastern Virginia Medical Authority)
- (9) Chief of Surgery - (automatic)
- (10) Chief of Internal Medicine - (automatic)
- (11) Chief of Family Medicine - (automatic)
- (12) Chief of OB/Gyn - (automatic)
- (13) Chief of Psychiatry - (automatic)
- (14) Chief of Pediatrics - (automatic)
- (15) and (16) The Chiefs of as many other
Departments as are necessary to
bring the voting committee
membership to sixteen (elected
by the Department Chiefs, voting
among themselves).

b. Ex-officio members without a vote shall

be:

- (17) The Chairman of the Board of Directors of

Medical Center Hospitals

- (18) The President of Medical Center Hospitals
- (19) The Hospital Administrator of the Norfolk General Division
- (20) The Hospital Administrator of the Leigh Memorial Division
- (21) Administrative Assistant for Medical Staff Affairs

c. The quorum of the Medical Executive Committee shall be fifty-one percent, or nine members so long as sixteen voting members have been chosen.

C. Standing and Ad Hoc Committees. These committees are listed and their duties explained in Appendix B.

ARTICLE VII

CLINICAL DEPARTMENTS

A. Departments.

1. The Departments of the Medical Staff shall be as follows:

Anesthesia	Pathology
Dermatology	Pediatrics
Emergency Medicine	Plastic Surgery
Family Practice	Psychiatry

Medicine	Radiation Oncology
Neurosurgery	Radiology
Obstetrics & Gynecology	Surgery
Ophthalmology	Urology
Orthopedics	
Otolaryngology	

2. New Departments of the Medical Staff may be created only at a meeting of the Medical Staff and upon the two-thirds vote of the members of the Medical Staff present and voting.

3. Divisions within a Department may be formed when appropriate by the majority vote of the members of the Department, with the approval of the Medical Executive Committee.

B. Assignment to Departments. Assignment to Departments shall be made by the Medical Executive Committee at the time of a member's initial appointment and upon the recommendation of the Departmental Authorities Committee. the members of Departments shall not be required to be exclusive specialists, but it is expected that they will be well qualified as provided in Article VIII of these By-Laws in the specialty to which they are assigned.

C. Organization of Departments.

1. Departmental Rules and Regulations.

Departments shall recommend to the Departmental Authorities

Committee rules and regulations pertaining to their Departments. Upon approval by the Medical Executive Committee, such rules and regulations will be binding upon the Department's members.

2. Officers.

a. The Department members eligible to vote shall, in March of each year, elect a Chief who shall serve for a term of one year, starting at the Annual Meeting and continuing until his successor takes office. He may not serve as Chief more than three years consecutively, except in the Departments of Pathology and Radiation Oncology. The Chief shall be responsible to the President of the Medical Staff for the functioning of his department, and shall have general supervision over the clinical work within his department. The Chief shall be responsible for biannual evaluation and recommendation for the renewal of the privileges of each member of the Department. The Chief shall have the authority and responsibility to investigate the actions of any practitioner assigned to his Department regarding patient care or other professional activities within the hospital. Committees may be appointed by the Chief to assist in the investigation and evaluation of Department members. The Chief shall also have the authority to issue a written admonition or censure to a practitioner if the practitioner's professional activities are deemed to be inappropriate, whereupon the

affected practitioner may request the Chief to institute the corrective action procedures provided in Article IX. This request must take place within thirty (30) days of the receipt of a notice of admonition or censure by the affected practitioner.

b. The Department shall also elect a Secretary, whose job shall include but not be limited to those matters specified in 3.c., below. The Department may establish other officers and committees as needed.

c. Departmental Officers may be removed by the same procedures as specified for Medical Staff officers in Article VI.A.5, above, except that the vote of the Department shall be final.

3. Meetings.

a. There shall be monthly departmental meetings, the agenda for which shall include but not be limited to the examination of the care and treatment of the patients served by the Department, the regular business of the Department, the review of the credentials of applicants for appointment to the Department and the making of recommendations thereon to the Medical Executive Committee. A quorum shall be twenty-five percent of the voting members of the Department.

b. Every active and associate member shall attend at least fifty percent of his Departmental meetings,

and shall in no event be absent from a meeting at which one of his patient's clinical course of treatment is scheduled for discussion.

c. The Secretary shall maintain a complete written record of the Departmental meetings. All motions shall take the form of recommendations to the Departmental Authorities Committee, which shall be submitted in the form of Departmental minutes to that committee. The Departmental Authorities Committee shall, upon receipt thereof, either accept, modify, remand or reject the Department's recommendation.

D. Directors of Residency Training Program. (In Departments with Resident Raining Programs).

1. The Director of Residency Training Programs in each Department shall be nominated by the Chairman of the corresponding Department in the Medical School. This appointment shall be approved by the Board of Directors with the advice and consent of the Medical Executive Committee and the Department involved.

2. The Director of Residency Training Programs in each Department has the responsibility and the authority to approve members of the Medical Staff for participation in the graduate teaching program.

3. In the event of dissatisfaction by a Departmental member with the actions of the Director of

Residency Training Programs regarding graduate medical education, he shall direct his complaint to the grievance mechanism of the Graduate School of Medicine.

ARTICLE VIII

PRIVILEGES

A. Admitting Privileges. Admitting privileges shall be awarded to the following classes of members:

1. Active Medical Staff.

a. A physician member may admit as many of his patients as require hospitalization.

b. Dental Staff members may admit patients provided that it is demonstrated, at the time of admission, that a physician member of the Active or Permanent Consulting Medical Staffs has assumed the responsibility for the basic medical appraisal of the patient and for the care of any medical problem that may be present or may arise during hospitalization. This includes the performance by the physician of admission history and physical examination and the recording of his findings in the medical record. The responsible physician shall determine, with consultation if necessary, the overall risk and effect of planned dental surgery on the patient's health. All anesthesia administered in connection with dental surgery shall be under the direct supervision of an Anesthesiologist privileged to practice in

the hospital.

2. Associate Medical Staff. Members of the Associate Medical Staff shall have the same admitting privileges as in subsection 1., above.

3. Permanent Consulting Medical Staff. Members of the Permanent Consulting Medical Staff shall have the same admitting privileges as in subsection 1., above.

4. Temporary Medical Staff. Members of the Temporary Medical Staff shall have the same admitting privileges as in subsection 1., above, subject to such limitations as may be prescribed at the time temporary privileges are granted.

5. Courtesy Medical Staff. Members of the Courtesy Medical Staff shall be privileged to have up to twelve (12) "inpatient contacts" per year (including admissions and consultations). Dental Staff members shall also be subject to the limitations in subsection 1.b., above. An inpatient contact shall mean any participation in the care of a patient admitted by the Courtesy Medical Staff member or another member of the Medical Staff.

6. Affiliate Staff Members in the Podiatric Section. A Podiatrist member may admit patients upon the occurrence of a physician member of the Active or Permanent Consulting Medical Staff, who shall be responsible for the basic medical appraisal of the patient and for the care of any

medical problem that may be present or may arise during hospitalization. This includes the performance by the physician of admission history and physical examination and the recording of his findings in the medical record. The responsible physician shall determine, with consultation if necessary, the overall risk and effect of planned podiatric surgery on the patient's health. All anesthesia administered in connection with podiatric surgery shall be under the direct supervision of an Anesthesiologist privileged to practice in the hospital.

B. Clinical Privileges.

1. To acquire and maintain clinical privileges, an individual must be a member of the Medical Staff of Medical Center Hospitals, as provided in Articles IV and V.

2. Each applicant shall state the specific privileges he seeks in his application for appointment.

3. The determination of privileges shall be based upon an applicant's training, experience, demonstrated competence and judgment.

4. The periodic renewal of privileges shall not constitute a condonation of prior misconduct or sub-standard practice, and shall not prejudice the Medical Staff or Medical Center Hospitals in any way in the exercise of any of its rights and remedies, including the taking of corrective action regarding such misconduct or sub-standard practice.

C. Classification of Clinical Privileges.

1. Surgical.

a. Surgical privileges shall include: cardiothoracic surgery, general surgery, neurological surgery, ophthalmology, orthopedic surgery, otorhinolaryngology, pediatric surgery, plastic surgery, proctology, thoracic surgery, traumatic surgery, urology and vascular surgery.

b. New applicants for surgical privileges shall present evidence of qualification for examination by one of the appropriate Boards. These qualifications must be acceptable to the Departmental Authorities Committee. Privileges granted to Board Qualified applicants are to last only until such reasonable time as Board Certification can be obtained, or as determined by departmental regulations satisfactory to the Departmental Authorities Committee and the Medical Executive Committee.

c. Subject to ordinary periodic review in connection with renewal, staff members who have been granted limited surgical privileges will retain those privileges as long as their standards or practice are satisfactory to the Departmental Authorities Committee. Physicians not having surgical privileges will be allowed to perform such procedures as may be accomplished in the Emergency Room or in general office practice.

2. Obstetrical and Gynecological Privileges.

a. Applicants for major obstetrical and gynecological privileges shall present evidence of qualification for examination by the American Board of Obstetrics and Gynecology. These qualifications must be acceptable to the Departmental Authorities Committee. Privileges granted to Board Qualified applicants are to last only until such reasonable time as Board Certification can be obtained, or as determined by departmental regulations satisfactory to the Departmental Authorities Committee and the Medical Executive Committee.

b. Members of the Staff who have limited major obstetrical and gynecological privileges shall present evidence of their medical training, experience, and demonstrated competence and, subject to ordinary periodic review in connection with renewal, will retain those privileges as long as their standards of practice are satisfactory to the Departmental Authorities Committee.

3. Minor Obstetrics.

a. Minor Obstetrics is defined as the care of uncomplicated obstetrical cases with spontaneous or forceps delivery. Physicians with minor obstetrical privileges are required to have consultations for the following indications:

- (1) forceps deliveries other than outlet forceps;
- (2) Caesarean Section;

- (3) breech delivery;
- (4) sterilization and other obstetrical-surgical procedures;
- (5) presentations other than vertex;
- (6) care of obstetrical complications including the following:
 - (a) prolonged labor (12 hours or longer);
 - (b) prolonged second stage of labor (3 hours or longer);
 - (c) antepartum bleeding or post-partum hemorrhage;
 - (d) toxemia of pregnancy;
 - (e) previous Caesarean Section;
 - (f) multi-gestation;
 - (g) post-maturity;
 - (h) intrauterine growth retardation;
 - (i) premature rupture of the membranes;
 - (j) no prenatal care;
- (7) the use of oxytoxic drugs;
- (8) any patient admitted to the obstetrical service not in labor.

b. Minor obstetrics privileges may be extended to include surgical evacuation of the uterus for

incomplete abortion.

4. Medical Privileges.

a. Shall include: allergy, cardiology, communicable diseases, dermatology, endocrinology, gastroenterology, hematology, nephrology, neurology, oncology, pediatrics, psychiatry, pulmonary and rheumatology.

b. Applicants for privileges shall present evidence of qualifications for examination by an appropriate certifying Board and these qualifications must be acceptable to the Departmental Authorities Committee and the Medical Executive Committee.

c. Applicants for privileges to perform procedures requiring special skills shall present evidence of approved training and competence in such techniques before these procedures may be performed by the applicant. These special medical privileges shall be reviewed and approved annually by the appropriate Department, the Departmental Authorities Committee, and the Medical Executive Committee.

5. Family Practice.

a. Members of the Staff having privileges in Family Practice shall present evidence of qualification for examination by the American Board of Family Practice or meet requirements as may be set forth by the Medical Executive Committee.

b. The Department of Family Practice will

have its own clinical service and in addition the Family Practitioner may be granted hospital privileges in the clinical services of the other Departments (e.g., general medicine, minor surgery, minor obstetrics, pediatrics, etc.), according to his training, demonstrated ability, competence and judgment, as recommended by the Departmental Authorities Committee.

c. Members with Family Practice privileges also holding privileges in other Departments will also be subject to the rules and regulations of the other Departments in which the privileges are granted.

6. Anesthesia. Applicants for privileges in Anesthesia shall present evidence of qualification for examination by the American Board of Anesthesia acceptable to the Departmental Authorities Committee. Applicants are required to have Board Certification after a reasonable time period, or as determined by departmental regulations satisfactory to the Departmental Authorities Committee and the Medical Executive Committee.

7. General Dental and Oral Surgery.

a. Requests for clinical privileges by dentists shall be processed in the same manner as physician requests for privileges. Surgical procedures performed by dentists shall be under the overall supervision of the Chief of Surgery. All dental patients shall receive the same basic

medical appraisal and care as patients admitted for other surgical services.

b. General Dentistry shall include the use of the operating room for uncomplicated extractions of teeth, pre-operative and post-operative procedures relating thereto and other general dental procedures.

c. Oral Surgery shall be limited to diseases of the teeth and jaws and lesions of contiguous soft tissues related to diseases of the teeth and jaws, but excluding malignancies.

8. Radiology.

a. Applicants for privileges in Radiology shall present evidence of completion of an approved Radiology residency and Board qualification by the American Board of Radiology. These qualifications must be acceptable to the Departmental Authorities Committee. Privileges granted to Board qualified applicants are to last only until such reasonable time as Board Certification can be obtained or as determined by departmental regulations, satisfactory to the Departmental Authorities Committee and the Medical Executive Committee.

b. Radiology privileges shall include all forms of diagnostic imaging, nuclear medicine, ultrasound, pediatric radiology, neuroradiology, angiography, computed tomography, xerography, flouroscopy, and other general

diagnostic radiologic procedures and examinations.

9. Radiation Oncology. Applicants for privileges in Radiation Oncology shall present evidence of qualification for examination in Therapeutic Radiology. Their qualifications must be acceptable to the Departmental Authorities Committee and the Medical Executive Committee. Applicants must also have completed an approved residency in Therapeutic Radiology and must be interested in teaching and research and experienced in treatment techniques such as implants, electrons, etc.

10. Pathology. Applicants for privileges in Pathology shall present evidence of qualification for examination by the American Board of Pathology. These qualifications must be acceptable to the Departmental Authorities Committee and the Medical Executive Committee. The applicants will be required to obtain certification from the American Board of Pathology within a reasonable period of time or as determined by departmental rules, or must demonstrate other qualifications satisfactory to the Departmental Authorities Committee and the Medical Executive Committee.

11. Podiatric.

a. Any Podiatrist who is a member of or candidate for membership on the Affiliate Staff may apply for clinical privileges. The determination of the scope of such

privileges shall be based upon the Podiatrist's professional license, experience, competence, ability, judgment and the reasonable objectives, rules and regulations of Medical Center Hospitals. Requests for such privileges shall be evaluated by the Departmental Authorities Committee, which shall consider such requests in the same manner as requests for clinical privileges by dentist members of the Medical Staff.

b. Requests for clinical privileges, if any, shall be reviewed by the Department of Orthopedics. The scope of clinical privileges shall be delineated by the Board of Directors of Medical Center Hospitals upon the recommendation of the Medical Executive Committee.

c. A Podiatrist may exercise clinical privileges in the treatment of patients admitted pursuant to subsection A. 6., above. Surgery within the scope of a Podiatrist's delineated privileges may be performed only pursuant to such program as may be recommended to and approved by the Medical Executive Committee.

12. Health Professional Affiliates. Clinical privileges for Health Professional Affiliates shall be delineated in the Rules and Regulations of Medical Center Hospitals.

D. Interdepartmental Privileges. Any member of the Medical Staff with privileges in one of the foregoing clinical departments may apply for clinical privileges for which he is

qualified in other departments, provided that his application for privileges is recommended by the department of which he is a member and concurred in and approved by the department in which he seeks clinical privileges. The applicant shall specify the procedures he seeks to perform in the second clinical department. The exercise of clinical privileges granted in the second department shall be the responsibility of that department in consultation with the department in which the applicant was originally granted clinical privileges.

E. Limited Clinical Privileges.

1. Emergency Privileges. In case of emergency, a physician shall do all in his power to save the life of the patient. In the performance of such duty, regardless of services or staff status or lack of it, the physician shall be entitled to use all personnel and facilities of the hospital that may be necessary, including the calling for any consultation necessary or desirable. Emergency, as used herein, is defined as a condition in which serious harm to the patient is imminent or the life of the patient is in immediate danger and any delay in administering treatment would increase such danger. A physician whose response to an emergency under this subsection requires treatment or utilization of hospital facilities beyond the scope of his granted privileges will be expected, when time permits, to consult with the Chief of the

Department concerned or an Active or Permanent Consulting Medical Staff member with major privileges in that Department. When an emergency situation no longer exists the broad privilege granted herein shall terminate. Upon termination, the President of the Medical Staff or his designee shall assign the patient for further treatment to an appropriate member of the Medical Staff.

2. Temporary Privileges for Applicants.

a. The President of the Hospitals, upon the recommendation of the President of the Medical Staff and the Chief of the Department involved, shall have the authority to grant, as a matter of courtesy, temporary privileges (admitting and clinical) to a qualified applicant for a period of 90 days or until the Departmental Authorities Committee has appropriately reviewed the application. If his credentials are unacceptable, all privileges will cease immediately.

b. If temporary privileges are granted, the applicant must agree, in writing, to obey all By-Laws, Rules and Regulations of the Medical Staff. Pending final action upon the applicant's application for privileges, and upon the discovery of any information or the occurrence of any event which raises questions about a practitioner's professional qualifications or ability to exercise any or all of the temporary privileges granted, the President of the Hospitals or the President of the Medical Staff may terminate any or all

such privileges.

c. Such an individual shall not be entitled to the procedural rights afforded by Articles IX and X of these By-Laws if his request for temporary privileges is refused or all or any portion of his temporary privileges are terminated. However, the preceding sentence shall not be construed to limit the due process rights of an applicant under Article IV of these By-Laws and Sections 32.1-134.1 and 32.1-134.2 of the Code of Virginia (1950).

ARTICLE IX

CORRECTIVE ACTION

A. Reasons. Corrective action may justifiably be requested when the activities or professional conduct of any practitioner with clinical privileges are likely to be determined to be:

1. Detrimental to patient safety or the delivery of quality patient care.

2. Disruptive to hospital operations.

3. Below the standards and aims of the Medical Staff.

4. Any of the grounds for summary suspension or automatic suspension in the event such action is not taken at the appropriate time.

B. Procedure for Corrective Action.

1. A request for any corrective action under this Article may be made by any officer of the Medical Staff, by the Chief of any department, by the President of Medical Center Hospitals, by the Chairman of any Standing Committee or by the Board of Directors of Medical Center Hospitals. All such requests shall be in writing, addressed to the President, and be supported by reference to specific activities or conduct which constitute the grounds for the request.

2. Whenever the corrective action may result in the reduction or suspension of privileges or suspension or expulsion from the Medical Staff, the President shall immediately forward such request to the Departmental Authorities Committee for investigation and shall inform the member that a charge has been filed against him and forwarded to the Departmental Authorities Committee.

3. Departmental Authorities Committee Action.

a. The practitioner against whom corrective action has been requested shall have an opportunity for an interview with the Departmental Authorities Committee during its investigation. This interview shall not constitute a hearing, shall be preliminary in nature, and none of the procedural rules provided in these By-Laws with respect to hearings shall apply thereto. A record of such interview shall be made by the Departmental Authorities Committee and included with its report to the Medical Executive Committee.

b. Within ten days after the Departmental Authorities Committee's receipt of the request for corrective action, it shall have concluded its investigation, and shall immediately make a report thereon to the Medical Executive Committee.

4. Medical Executive Committee Action.

a. Within ten (10) days following the Medical Executive Committee's receipt of the Departmental Authorities Committee's report, but only if the incident may result in the reduction or suspension of privileges or the suspension or expulsion from the Medical Staff, the affected practitioner shall be permitted to make an appearance before the Medical Executive Committee prior to its taking action on such request. This appearance shall not constitute a hearing, shall be preliminary in nature, and none of the procedural rules provided in these By-Laws with respect to hearings shall apply thereto. A record of such appearance shall be made by the Medical Executive Committee.

b. The action of the Medical Executive Committee on a request for corrective action may be to accept, modify or reject the request for corrective action, to issue a warning, a letter of admonition, or a letter of reprimand, to impose terms of probation or a requirement for consultation, to recommend the reduction, suspension or revocation of privileges, to recommend that an already imposed summary

suspension of privileges be terminated, modified or continued, or to recommend that the practitioner's Medical Staff membership be suspended or revoked.

c. Any recommendation by the Medical Executive Committee for the reduction, suspension or revocation of privileges, or for the suspension or expulsion from the Medical Staff shall entitle the affected practitioner to the procedural rights provided in Article X of these By-Laws and he shall be so informed pursuant to Section X. B.

d. The Secretary/Treasurer shall promptly notify the President of the Hospitals in writing of the recommendations of the Medical Executive Committee concerning the reduction or suspension of privileges or the suspension or expulsion from staff membership, requesting action on such recommendation.

5. In the event that the request for corrective action was initiated by a member of the Departmental Authorities Committee or the Medical Executive Committee, then that member shall not participate in that Committee's decision.

C. Summary Suspension.

1. Grounds for Summary Suspension.

a. The willful disregard by a practitioner of these By-Laws, Rules and Regulations or other hospital policies.

b. Conduct by a practitioner which requires that immediate action be taken to protect the life of any patient or to reduce the substantial risk of immediate injury or damage to the health or safety of any patient, employee or other person present in the hospital, or to any property of the hospital.

c. The conviction of a felony, pursuant to subsection 5, below.

d. Any action taken by the State Board of Medical Examiners placing the practitioner on probation.

e. Any substantial action taken by the practitioner not in the best interest of patient care at Medical Center Hospitals.

2. Suspension Immediate. The President of the Medical Staff or his designee and the President of the Hospitals shall have the authority in the situations enumerated in the preceding subsection to suspend summarily all or any portion of the privileges of a practitioner, and such summary suspension shall become effective immediately upon imposition and notice to the practitioner.

3. Medical Executive Committee Hearing.

a. A practitioner whose privileges have partially or wholly been summarily suspended shall be entitled to request that the Medical Executive Committee hold a hearing on the matter within five (5) days following receipt of the

request.

b. The Medical Executive Committee may recommend the termination, modification or continuance of the terms of the summary suspension.

c. If, as a result of such hearing, the Medical Executive Committee does not recommend the immediate termination of the summary suspension, the affected practitioner shall be entitled to Appellate Review as provided in Article X of these By-Laws.

d. The terms of the summary suspension as modified or continued by the Medical Executive Committee shall remain in effect pending a final decision by the Board of Directors of the Hospitals.

4. Alternate Coverage of Patients. Immediately upon the imposition of a summary suspension, the President of the Medical Staff, upon consultation with the appropriate Department Chief, shall have the authority to provide for alternative medical coverage for the suspended practitioner's patients still in the hospital at the time of such suspension. The wishes of the patients shall be considered in the selection of such alternative coverage.

5. Conviction of a Felony.

a. The conviction by any court of a practitioner of a felony count may be considered prima facie evidence that the professional conduct of the practitioner is

lower than the standards of the Medical Staff, and may be sufficient reason for summary suspension. Such summary suspension may be continued in effect by order of the Medical Executive Committee while any appeals by the practitioner are being adjudicated in the courts. The practitioner, and counsel if the practitioner so desires, are entitled to be present at the Medical Executive Committee meeting at which the summary suspension order is continued. If the conviction is upheld in the final adjudication of the case, this conviction may be deemed sufficient cause for expulsion from the Medical Staff, and such may be recommended by the Medical Executive Committee in its report to the Board of Directors.

b. A practitioner finally determined as guilty of a felony may appeal the terms of the corrective action recommended by the Medical Executive Committee and taken by the Board of Directors, pursuant to the provisions of Article X. He may not, however, challenge the correctness of his felony conviction nor require any evidence to be presented supporting that conviction, nor may he present any evidence refuting it. He may, if he wishes, present witnesses as to his character and professional competence.

D. Automatic Suspension.

1. Grounds: Admitting Privileges. The temporary suspension of a practitioner's admitting privileges shall be imposed automatically in the event of: (i) the violation of

any rule in the Rules and Regulations of Medical Center Hospitals relating to the timely completion of medical records (currently Rule 24).

2. Grounds: All Privileges. The temporary suspension of any or all of a practitioner's privileges shall be automatically imposed in the event of: (i) action by the State Board of Medical Examiners revoking or suspending a practitioner's license to practice medicine.

3. Medical Executive Committee Hearing. If any of a practitioner's privileges are automatically suspended, then the practitioner shall be entitled to a hearing before the Medical Executive Committee as provided for in Section C. 3., above, including the practitioner's right to have counsel present.

4. Alternate Coverage of Patients. If a practitioner's privileges are automatically suspended, alternate coverage of his patients shall be provided for as in Section C. 4., above.

E. Termination of Physicians in Medico-Administrative Positions. Physicians employed by the hospital in a medico-administrative position shall be subject to review and a hearing, if requested, by a joint committee of hospital governing board representatives and representatives of the Medical Staff to determine whether the reason for action involves the individual's medical competence or is purely

administrative in nature. If it is determined that medical competence is involved, the procedures outlined for dealing with a member of the Medical Staff shall be followed. If it is determined that the reason for action is purely administrative in nature, the hospital policies or the terms of the contract, if there is one, shall be followed.

ARTICLE X

HEARING AND APPELLATE REVIEW PROCEDURE

A. Right to Hearing and to Appellate Review.

1. When any practitioner receives notice of a recommendation of the Medical Executive Committee which, if approved by the Board of Directors, will affect his appointment to or status as a member of the Medical Staff or his exercise or clinical or admitting privileges, such notice shall advise him that he is entitled to a hearing before an ad hoc committee of the Medical Staff. If the recommendation of the Medical Executive Committee following such hearing is still adverse to the affected practitioner, he shall then be entitled to an appellate review by the Board of Directors of the Hospitals before the final decision on the matter.

2. All hearings and appellate reviews shall be in accordance with the procedural safeguards set forth in this Article X to assure that the affected practitioner is accorded all rights to which he is entitled.

B. Notice of Hearing.

1. The President of the Medical Staff shall be responsible for immediately giving written notice of an adverse recommendation or decision to any affected practitioner who is entitled to a hearing or to an appellate review, by certified mail, return receipt requested.

2. Notice to the practitioner shall state:

a. The practitioner's right to a hearing pursuant to Article X of the By-Laws.

b. That the practitioner has ten (10) days following the date of receipt of this notice within which to submit his request for a hearing.

c. That his failure to request a hearing within ten (10) days of receipt of this notice shall constitute a waiver of his right to a hearing and to subsequent appellate review of the hearing with the results provided in subsection X. B. 3.

d. That within five (5) days of receipt by the President of the Medical Staff of the practitioner's hearing request, the practitioner will be notified of the date, time and place of the hearing.

e. The grounds upon which the adverse action is based, the specific or representative charts being questioned, and any other reasons or subject matter that were considered in making the adverse recommendation or decision.

3. Waiver.

a. The failure of a practitioner, after notice of his right to a hearing, to so request within ten (10) days and in the manner provided in this Section X. B., shall be deemed a waiver of his right to such hearing and any appellate review to which he might otherwise have been entitled on the matter.

b. When the waived hearing or appellate review pertained to an adverse recommendation of the Medical Executive Committee or of a hearing committee appointed by the Board of Directors, such recommendation shall remain effective against the practitioner pending the Board of Directors' decision on the matter.

c. When the waived hearing or appellate review pertained to an adverse decision by the Board of Directors, the decision shall be effective as the final decision of the Board of Directors provided for in Section G of this Article.

d. In the event waiver occurs, the President of the Medical Staff shall promptly notify the affected practitioner of his new status by certified mail, return receipt requested.

C. Scheduling of Initial Hearing.

1. Within five (5) days after the receipt of a request for hearing from a practitioner so entitled, the Medical Executive Committee shall schedule and arrange for

such a hearing and shall, through the President of the Medical Staff, notify the practitioner of the time, place and date so scheduled, by certified mail, return receipt requested. The hearing date shall be not less than ten (10) days, nor more than thirty (30) days from the date of notice to the practitioner of the scheduled hearing; provided, however, that a hearing for a practitioner who is under a suspension then in effect shall be held as soon as arrangements therefore may reasonably be made, but not later than ten (10) days from the date of such scheduling notice to the practitioner.

2. Postponement of a scheduled initial hearing shall only be permitted with the consent of both the Medical Executive Committee and the affected practitioner, except that the Medical Executive Committee may order postponements for good cause.

D. Composition of Hearing Committee. When a hearing relates to an adverse recommendation of the Medical Executive Committee, the President shall appoint, after consulting with the Medical Executive Committee, an ad hoc hearing committee of not less than seven (7) nor more than eleven (11) members of the Medical Staff, one of whom shall be designated as chairman. No staff member who has actively participated in the consideration of the adverse recommendation shall be appointed a member of this hearing committee.

E. Conduct of Initial Hearing.

1. There shall be at least a majority of the members of the hearing committee present when the hearing takes place, and no member may vote by proxy.

2. The hearing committee shall insure that an accurate record of the hearing be kept by either a court reporter, electronic recording unit, verbatim transcription or by the taking of adequate minutes.

3. The personal presence of the practitioner for whom the hearing has been scheduled shall be required. A practitioner who fails without good cause to appear and proceed at such hearing shall be deemed to have waived his rights in the same manner as provided in subsection X. B. 3. and to have accepted the adverse recommendation or decision involved, and the same shall become final as provided therein.

4. The affected practitioner shall be entitled to be accompanied by and represented at the hearing by a member of the Medical Staff in good standing, a member of his local professional society, or a lawyer, if he so chooses; provided that if either party to the hearing opts to be represented by counsel, twenty-four (24) hours notice must be given to the other party.

5. The chairman of the hearing committee or his designee shall preside over the hearing to determine the order of procedure, rule on matters of law and evidence, assure all participants in the hearing a reasonable opportunity to

present relevant oral and documentary evidence, and maintain decorum.

6. The hearing need not be conducted strictly according to the rules of law relating to the examination of witnesses or presentation of evidence. Any relevant matter upon which responsible persons customarily rely in the conduct of serious affairs shall be considered, regardless of the existence of any common law or statutory rule which might make evidence inadmissible in a civil or criminal action. Each party shall, prior to or during the hearing, be entitled to submit memoranda concerning any issue of procedure or fact and such memoranda shall become a part of the hearing record.

7. The Medical Executive Committee, when its recommendation has prompted the hearing, shall appoint one of its members, some other Medical Staff member or an attorney if the practitioner will be so represented, to represent it at the hearing, to present facts supporting its adverse recommendation, and to examine witnesses. The Medical Executive Committee's representative shall speak first presenting his evidence in support of its adverse recommendation or decision. The affected practitioner shall thereafter be responsible for supporting his challenge to the adverse recommendation or decision by an appropriate showing that the charges or grounds involved lack any factual basis or that such basis or any action based thereon is either

arbitrary, unreasonable or capricious.

8. The affected practitioner shall have the following rights: to call and examine witnesses, to introduce written evidence, to cross-examine any witness present at the hearing, to impeach any witness and to rebut any evidence. If the practitioner does not testify on his own behalf, he may be called and examined as if under cross-examination; provided, however, that the refusal to respond to a question so asked shall not justify any conclusion or inferences regarding affected practitioner's guilt.

9. The hearing committee may, without special notice, recess the hearing and reconvene the same for the convenience of the participants or for the purpose of obtaining new or additional evidence or consultation. Upon conclusion of the presentation of oral and written evidence, the hearing shall be adjourned. The hearing committee may then, at a time convenient to itself, conduct its deliberations outside the presence of the affected practitioner.

10. Within ten (10) days after adjournment of the hearing, the hearing committee shall make a written report and recommendation, based on substantial factual evidence, and shall forward it together with the hearing record and all other ~~documentations~~ to the Medical Executive Committee, which shall within thirty (30) days confirm, modify or reverse its

recommendation in the matter, and within ten (10) days thereafter, so notify the President of the Medical Staff and the practitioner.

F. Appeal to the Board of Directors.

1. Within fifteen (15) days after the receipt of notice by an affected practitioner of an adverse decision made or adhered to by the Medical Executive Committee after a hearing as above provided, he may request an appellate review by the Board of Directors by sending written notice certified mail, return receipt requested to the Board of Directors through the President of the Medical Staff. Such notice may request that the appellate review be held only on the record on which the adverse decision is based, as supported by the practitioner's written statement provided for below, or may also request that oral argument be permitted as part of the appellate review.

2. If such appellate review is not requested within fifteen (15) days, the affected practitioner shall be deemed to have waived his right to the same and to have accepted such adverse recommendation or decision, and the same shall become effective immediately as provided in Section X.

G.

3. Within ten (10) days after receipt of such notice of request for appellate review, the Board of Directors shall schedule a date for such review, including a time and

place for oral argument if requested, and shall, through the President of the Medical Staff by written notice sent certified mail, return receipt requested, notify the affected practitioner of the same. The date of the appellate review shall not be less than ten (10) days, nor more than thirty (30) days, from the date of receipt of the notice of request for appellate review, except that when the practitioner requesting the review is under suspension which is then in effect, such review shall be scheduled as soon as the arrangements for it may reasonably be made, but not more than ten (10) days from the date of receipt of such notice. Postponement of a scheduled initial hearing shall only be permitted with the consent of both the Board of Directors and the affected practitioner, except that the Board of Directors may order postponements for good cause.

4. The appellate review shall be conducted by the Board of Directors or by an ad hoc Appellate Review Committee appointed by the Board of Directors, consisting of not less than seven (7) members, none of whom shall have been involved in prior proceedings regarding the practitioner.

5. The affected practitioner shall have access to the report and record (and transcription, if any) of the initial hearing committee and all other material, favorable or unfavorable, that was considered in reaching its adverse decision against him.

6. The affected practitioner shall be allowed not less than five (5) days to submit a written statement. He shall state those facts, conclusions and procedural matters with which he disagrees and his reasons therefor. The written statement may cover any matters raised at any step in the procedure to which the appeal is related, and legal counsel may assist in its preparation. Such written statement shall be submitted to the Board of Directors through the President of the Medical Staff by certified mail, return receipt requested, at least four (4) days prior to the scheduled date for the appellate review. A similar statement may be submitted by the Medical Executive Committee or by the chairman of the initial hearing committee, and if submitted, the President of the Medical Staff shall provide a copy thereof to the practitioner at least four (4) days prior to the date of such appellate review by certified mail, return receipt requested.

7. The Board of Directors or its appointed Appellate Review Committee shall act as an appellate body. It shall review the record created in the prior proceedings, and shall consider the written statements submitted for the purpose of determining whether the adverse decision against the affected practitioner was justified and was not arbitrary or capricious. If oral argument is requested as part of the review procedure, the affected practitioner and his attorney,

if he has retained one, shall be present at such appellate review, and each shall be permitted to speak against the adverse recommendation or decision. The practitioner shall answer questions put to him by any member of the appellate review body; provided, however, that a refusal to respond to any such question shall not permit any conclusions or inferences regarding the guilt of the practitioner. The Medical Executive Committee shall also be represented by an individual, who may be an attorney if the practitioner is also represented by counsel, who shall be permitted to speak in favor of the adverse decision and who shall answer questions put to him by any member of the appellate review body.

3. New or additional matters not raised during the original hearing or in the hearing committee record, and not otherwise reflected in the record, shall only be introduced at the appellate review under unusual circumstances, and the Board of Directors or the Appellate Review Committee shall in its sole discretion determine whether such new matters shall be considered.

9. If the appellate review is conducted by the Board of Directors, it may, based on substantial factual evidence, affirm, modify, reverse or, in its discretion, remand the matter to the Medical Executive Committee for further review and recommendation within ten (10) days. Such referral may include a request that the Medical Executive

Committee arrange for a further hearing to resolve specified disputed issues.

10. If the appellate review is conducted by an Appellate Review Committee such committee shall, within ten (10) days after the conclusion of its appellate review, make a written report recommending, based on substantial factual evidence, that the Board of Directors affirm, modify, reverse the initial hearing's result or remand the matter to the Medical Executive Committee to arrange for a further hearing to resolve specified disputed issues. The Board of Directors shall so act within ten (10) days after receipt of such recommendation. If the matter is remanded to the Medical Executive Committee, it shall report back to the Board of Directors within ten (10) days, unless further hearing was required, in which case twenty (20) days shall be allowed.

11. The appellate review shall not be deemed to be concluded until all of the procedural steps provided herein have been completed or waived. Where permitted by the hospital By-Laws, all action required of the Board of Directors may be taken by a committee of the Board of Directors duly authorized to act.

G. Final Decision by Board of Directors. Within ten (10) days after the conclusion of the appellate review, the Board of Directors shall make its final decision in the matter and shall send notice thereof to the Medical Executive

Committee and, through the President of the Medical Staff, to the ~~affected practitioner~~, by certified mail, return receipt requested. This decision shall be made immediately effective and final, and shall be subject to further hearing or appellate review. ^{Not (?)}

H. Number of Reviews.

Notwithstanding any other provision of these By-Laws, no practitioner shall have ~~the right to more than one~~ evidentiary hearing and one appellate review with respect to an adverse recommendation or decision.

ARTICLE XI

MEETINGS

A. The Annual Meeting.

The Annual Meeting of the Staff shall be held in April. At this meeting, the incumbent officers and committee chairmen shall make such reports as may be desirable, officers for the ensuing year may be nominated from the floor and shall be elected, recommendations for appointment and reappointment to the several divisions of the Medical Staff shall be made, and assignment and reassignment of privileges shall be confirmed. The fiscal year of the Medical Staff shall be from May 1 through April 30.

B. Regular Meetings.

Quarterly meetings of the Staff shall be held in

January, April, July and October, the annual meeting being the April meeting. The primary objective of staff meetings is the improvement in the care and treatment of patients in the hospitals, but other business, including members' appointment and reappointment to the several divisions of the Medical Staff and the assignment and reassignment of their privileges, shall also be considered.

C. Special Meetings.

1. Special meetings of the Medical Staff may be called at any time by the President, the Board of Directors, the Medical Executive Committee, or any ten (10) members of the Active or Permanent Consulting Medical Staff.

2. Sufficient notice of any meeting shall be a notice posted on the bulletin board in the physician lounges at both Divisions at least forty-eight (48) hours before the time set for the meeting.

3. At a special meeting, no business shall be transacted except that stated in the notice calling the meeting. The agenda at special meetings shall be:

- a. Call to order
- b. Reading of the notice for the meeting
- c. Transaction of the business for which the meeting was ordered
- d. Adjournment

D. Attendance at Meetings.

1. Rule of Attendance.

a. Active and Associate Medical Staff members, and members of the Podiatric section of the Affiliate Staff, shall attend at least fifty percent (50%) of the assigned Committee, Departmental and Medical Staff meetings unless excused by the Medical Executive Committee for exceptional reasons. A member's absence from more than one-half of any of the above categories of meetings during the fiscal year may be considered as resignation from the Active, Associate or Affiliate Medical Staff and constitute grounds for the Medical Executive Committee to place the absentee on the Courtesy Medical Staff or on probation, with specific terms. Such action shall entitle the members to the procedural rights afforded in Articles IX and X of these By-Laws.

b. Consulting, Courtesy and Honorary Medical Staff members shall not be required to attend regular meetings, but it is expected that they will attend and participate in these meetings unless unavoidably prevented from doing so.

c. Members of the Temporary Medical Staff shall not be entitled to attend meetings, unless expressly invited.

2. Reinstatement. Members of the Active, Associate or Affiliate Medical Staff whose membership status has been changed because of absenteeism from meetings may

apply for reinstatement of their status after three (3) months, the procedure being the same as for reinstatement after the termination of a leave of absence in subsection IV.

D. 2.

E. Quorum.

Twenty-five percent of the total membership of the Active and Permanent Consulting Medical Staff shall constitute a quorum at any annual, regular or special meeting.

F. Procedure.

Procedure at all meetings shall be in accordance with the latest edition of Sturgis Parliamentary Procedure unless otherwise specified in these By-Laws.

ARTICLE XII

IMMUNITY AND CONFIDENTIALITY

A. Confidentiality of Information.

1. Information with respect to any practitioner submitted, collected or prepared by any representative of this or any other health care facility or organization or medical staff for the purpose of achieving and maintaining quality patient care, reducing morbidity and mortality, or contributing to clinical research shall, to the fullest extent permitted by law, be confidential and shall not be disseminated to any one other than a representative, nor used in any way except as provided herein. Such confidentiality

shall also extend to information as described above that may be provided by other individuals or organizations providing information to any representative. This information shall not become part of any particular patient's file or of the general hospital records.

2. "Representative" shall mean a board of a health care facility and any director or committee thereof; a chief executive officer; a medical staff organization and any member, officer, department or committee thereof; and any individual authorized by any of the foregoing to perform specific information gathering or disseminating functions.

B. Immunity From Liability.

1. For Action Taken. No representative of the Hospitals or Medical Staff shall be liable for damages or other relief for any decision, action, statement or recommendation made within the scope of his duties as a representative, if such representative acted in good faith and without malice after a reasonable effort under the circumstances to ascertain the truthfulness of the facts and the representative reasonably believes the decision, opinion, action, statement or recommendation is warranted by such facts. Regardless of the provisions of state law, trust shall be an absolute defense in all circumstances.

2. For Providing Information. No representative of the Hospitals or the Medical Staff nor any third party

shall be liable for damages or other relief by reason of providing information, including information otherwise privileged or confidential, to a representative of these Hospitals or the Medical Staff, or to any other health care facility or organization of health professionals concerning a practitioner who is or has been an applicant to or member of the Staff, or who did or does exercise clinical privileges or provide specified services at this Hospital; provided, that such representative or third party has acted in good faith and without malice, and such information is reasonably related to the exercise of the practitioner's professional obligations.

3. Indemnification for Liability. In the event that a representative of Medical Center Hospitals, the Medical Staff or of a third party (pursuant to the preceding subsection 2.), shall be held liable for damages or other relief under either of the foregoing subsections, the Hospitals or the Medical Staff, depending upon which organization employed the representative, shall indemnify that representative for the full amount of his liability.

ARTICLE XIII

MISCELLANEOUS PROVISIONS

A. Rules and Regulations.

The Medical Executive Committee shall adopt such Rules and Regulations and amendments thereto as may be

necessary for the proper conduct of the Medical Staff's work. The Rules and Regulations shall become effective when approved by the Board of Directors, and shall then be presented at the next Medical Staff meeting. Such Rules and Regulations shall be a part of these By-Laws, except that they may be amended, without previous notice, at any Medical Staff meeting where a quorum exists by a majority vote of the Medical Staff present and voting.

B. Professional Liability Insurance.

Every practitioner granted clinical privileges in Medical Center Hospitals shall maintain in force professional liability insurance in not less than the minimum amounts from time to time determined by resolutions of the Board of Directors. The Board of Directors, upon the recommendation of the Medical Executive Committee and in the Board's sole discretion, may waive the foregoing requirement of professional liability insurance for practitioners unable to obtain such insurance because of reasons unrelated to their professional competence.

C. Staff Dues.

The Medical Executive Committee shall have the power to set the amount of annual dues for each category of staff membership, and the amount of the processing fee for initial applications and to determine the manner of expenditure of funds received. These dues and processing fees shall be

principally employed for social and educational activities of the Medical Staff, and shall not be construed as a charge for the privilege of practicing at Medical Center Hospitals.

D. Amendments.

These By-Laws may be amended by two-thirds of the members present and voting at any regular meeting or at a special meeting called for that purpose, provided that notice of intent to amend has been given to the Medical Staff at least thirty (30) days in advance. Such notice may be given at a previous meeting or by continuous posting on the bulletin boards in the physician lounges in both Divisions. The proposed amendment shall be referred to an appropriate committee by the President, and such committee may make recommendations to the Medical Staff regarding the proposed amendment. Amendments so made shall be effective when approved by the Board of Directors.

E. Adoption.

These By-Laws, when adopted at a regular meeting of the Medical Staff of Medical Center Hospitals, shall become effective and replace any previous By-Laws. The Rules and Regulations shall become effective when approved by the Board of Directors of Medical Center Hospitals. The By-Laws and the Rules and Regulations shall, when adopted and approved, be equally binding on the Board of Directors and the Medical Staff.

Adopted by the Medical Staff of Medical Center Hospitals, Inc., at a meeting on October 11, 1983, to be effective upon approval by the Board of Directors.

President

Secretary

APPROVED by the Board of Directors of Medical Center Hospitals, Inc., at a meeting on November 1, 1983.

President

Secretary

APPENDIX A

**APPLICATION FOR APPOINTMENT
TO THE MEDICAL STAFF OF
MEDICAL CENTER HOSPITALS**

**APPLICATION FOR APPOINTMENT TO THE MEDICAL STAFF
OF MEDICAL CENTER HOSPITALS, NORFOLK, VIRGINIA**

PLEASE TYPE OR PRINT. USE ADDITIONAL PAPER WHERE NECESSARY.

I. LAST NAME	FIRST	M.I.	DATE	
OFFICE ADDRESS	CITY	STATE	ZIP	PHONE
HOME ADDRESS	CITY	STATE	ZIP	PHONE
DATE OF BIRTH	NAME OF SPOUSE			

II. PREMEDICAL EDUCATION	COLLEGE/UNIVERSITY	DEGREE/MAJOR
	COMPLETE ADDRESS	DATE OF GRADUATION
MEDICAL EDUCATION	MEDICAL SCHOOL	DEGREE
	COMPLETE ADDRESS	DATE OF GRADUATION

INCLUDE A COPY OF YOUR MEDICAL DEGREE OR A CERTIFIED LETTER FROM DEAN OF MEDICAL SCHOOL TO VERIFY YOUR GRADUATION.

III. POST-GRADUATE TRAINING: List below the internships, residencies, fellowships, assistantships, and appointments you have served. Give name and address of institutions, and specify dates in detail. You must account for every year since medical school.

1. NAME OF INSTITUTION	DATES ATTENDED
COMPLETE ADDRESS	
2. NAME OF INSTITUTION	DATES ATTENDED
COMPLETE ADDRESS	
3. NAME OF INSTITUTION	DATES ATTENDED
COMPLETE ADDRESS	

IV. Please list below all present and previous hospital affiliations and medical staff memberships, in chronological order. Include the name and address of the hospital, your status at the hospital, the department in which you had privileges, and the dates during which you practiced.

V. VIRGINIA MEDICAL LICENSE NUMBER	DATE ISSUED	EXPIRATION DATE
OTHER STATE MEDICAL LICENSES	DATE ISSUED	EXPIRATION DATE
1.		
2.		
FEDERAL NARCOTICS REGISTRATION NUMBER	EXPIRATION DATE	

Include a copy of your Virginia state license and any registrations with your application.

VI. CERTIFICATION/ RECERTIFICATION	CERTIFIED BY THE AMERICAN BOARD OF _____ DATE _____ IF NOT CERTIFIED, ARE YOU BOARD ELIGIBLE? YES _____ NO _____ WHEN WILL YOU BE BOARD CERTIFIED? _____ IF NECESSARY, HAVE YOU RECERTIFIED? YES _____ NO _____ IF NOT, WHEN WILL YOU RECERTIFY? _____
---------------------------------------	---

VII. What is the nature of your practice? Solo: _____ Partnership (list associates): _____
 _____ Group Practice (name of group): _____

If you have a solo practice, please list a member of the Medical Staff of Medical Center Hospitals who will answer your calls in case of emergencies or when you are out of town.

VIII. MEDICAL REFERENCES List at least two former chiefs of departments or residency preceptors. You are responsible for having two references letters sent to the Medical Staff Office.	NAME	ADDRESS	
	CITY	STATE	ZIP
	NAME	ADDRESS	
	CITY	STATE	ZIP
	NAME	ADDRESS	
	CITY	STATE	ZIP

IX. MEMBERSHIP/ FELLOWSHIP	AMERICAN COLLEGE OF _____	APPOINTMENT DATE _____
	AMERICAN ACADEMY OF _____	APPOINTMENT DATE _____
	MEMBERSHIP IN MEDICAL SOCIETIES _____	

X. CONTINUING MEDICAL EDUCATION	On a separate sheet, list all postgraduate activities which you have attended, or for which you have received credit in the past three years, including dates.
	List all scientific papers or essays you have written.
	List scientific meetings you have attended during the past three years.

XI. Have you had teaching experience? Yes _____ No _____ If so, please specify _____

What committee are you willing to serve on? (See attached list) _____

XII. LIABILITY INSURANCE (Minimum coverage allowed: \$250,000)	INSURANCE CARRIER	AMOUNT OF COVERAGE
	ADDRESS	POLICY NUMBER

Have any claims of malpractice or claims of unprofessional conduct been asserted against you? If so, please provide the following: (1) claim filed, (2) name of claimant, (3) nature of claim, (4) current status, (5) whether the claim was disposed of by either judgment or settlement. Have you been denied liability insurance or had a policy cancelled or not renewed? If so, please explain in detail.

XIII. IF THE ANSWER TO ANY OF THE FOLLOWING QUESTIONS IS "YES," PLEASE GIVE DETAILS ON A SEPARATE SHEET OF PAPER.

- | | |
|---|--------------------|
| A. Has your license to practice medicine ever been limited, suspended, or revoked? | Yes _____ No _____ |
| B. Have you ever been refused membership on a hospital medical staff? | Yes _____ No _____ |
| C. Has your request for any specific clinical privilege ever been denied or granted with stated limitations? | Yes _____ No _____ |
| D. Have your privileges at any hospital ever been suspended, diminished, revoked or not renewed? | Yes _____ No _____ |
| E. Has your narcotics registration ever been suspended or revoked? | Yes _____ No _____ |
| F. Have you ever been denied membership or renewal thereof, or been subject to disciplinary action in any medical organization? | Yes _____ No _____ |

XIV. To which department do you desire appointment?

- | | | | |
|---|---|---|---|
| <input type="checkbox"/> Anesthesiology | <input type="checkbox"/> Neurosurgery | <input type="checkbox"/> Pathology | <input type="checkbox"/> Radiology |
| <input type="checkbox"/> Dermatology | <input type="checkbox"/> OB-GYN | <input type="checkbox"/> Pediatrics | <input type="checkbox"/> Surgery |
| <input type="checkbox"/> Emergency Medicine | <input type="checkbox"/> Ophthalmology | <input type="checkbox"/> Plastic Surgery | <input type="checkbox"/> Urology |
| <input type="checkbox"/> Family Practice | <input type="checkbox"/> Orthopedics | <input type="checkbox"/> Psychiatry | <input type="checkbox"/> Other (Specify): |
| <input type="checkbox"/> Internal Medicine | <input type="checkbox"/> Otolaryngology/HNS | <input type="checkbox"/> Radiation Oncology | _____ |

XV. SPECIAL PROCEDURES: _____

I fully understand that any misstatements in or omissions from this application constitute cause for denial of appointment or cause for summary dismissal from the medical staff. All information submitted by me in this application is true to my best knowledge and belief.

In making this application for appointment to the medical staff of Medical Center Hospitals, I acknowledge that I have received and read the Bylaws and Rules and Regulations of the Medical Staff of Medical Center Hospitals and that I am familiar with the principles and standards of the Joint Commission on Accreditation of Hospitals and the principles, standards and ethics of the national, state and local associations that apply to and govern my specialty and/or profession, and I agree to be bound by the terms thereof if I am granted membership or clinical privileges, and I further agree to be bound by the terms thereof without regard to whether or not I am granted membership or clinical privileges in all matters relating to the consideration of my application for appointment to the medical staff, and I further agree to abide by such hospital and staff rules and regulations as may be from time to time enacted.

By applying for appointment to the medical staff I hereby signify my willingness to appear for the interviews in regard to my application, authorize Medical Center Hospitals, its medical staff and their representatives to consult with administrators and members of medical staffs of other hospitals or institutions with which I have been associated and with others, including past and present insurance carriers, who may have information bearing on my professional competence, character and ethical qualifications.

I hereby further consent to the inspection by Medical Center Hospitals, its medical staff and its representatives of all records and documents, including medical records, at other hospitals, that may be material to an evaluation of my professional qualifications and competence to carry out the clinical privileges requested as well as my moral and ethical qualifications for staff membership. I hereby release from liability all representatives of Medical Center Hospitals and its medical staff for their acts performed in connection with evaluating my application and my credentials and qualifications, and I hereby release from any liability any and all individuals and organizations who provide information to Medical Center Hospitals, or its medical staff, concerning my professional competence, ethics, character and other qualifications for staff appointment and clinical privileges, and I hereby consent to the release of such information.

I understand and agree that I, as an applicant for medical staff membership, have the burden of producing adequate information for proper evaluation of my professional competence, character, ethics and other qualifications and for resolving any doubts about such qualifications.

I will not participate in any form of fee-splitting and pledge myself to abide by the Code of Ethics of the American Medical Association.

I have not requested privileges for any procedures for which I am not certified. Furthermore, I realize that certification by a board does not necessarily qualify me to perform certain procedures. However, I believe that I am qualified to perform all procedures for which I have requested privileges.

I hereby further authorize and consent to the release of information by this hospital, or its medical staff, to other hospitals, medical associations and other interested persons on request regarding any information Medical Center Hospitals and the medical staff may have concerning me as long as such release of information is done in good faith and without malice, and I hereby release from liability Medical Center Hospitals and its staff for so doing.

DATE _____ SIGNATURE OF APPLICANT _____

DO NOT WRITE BELOW THIS LINE

MEDICAL STAFF DEPARTMENT

☐ APPOINTMENT RECOMMENDED ☐ APPOINTMENT NOT RECOMMENDED ☐ APPOINTMENT DEFERRED
COMMENTS: _____

DATE _____ CHIEF, MEDICAL STAFF DEPARTMENT _____

DEPARTMENTAL AUTHORITIES COMMITTEE

☐ APPOINTMENT RECOMMENDED ☐ APPOINTMENT NOT RECOMMENDED ☐ APPOINTMENT DEFERRED
COMMENTS: _____

DATE _____ CHAIRMAN, DEPARTMENTAL AUTHORITIES COMMITTEE _____

MEDICAL EXECUTIVE COMMITTEE

☐ APPOINTMENT RECOMMENDED ☐ APPOINTMENT NOT RECOMMENDED ☐ APPOINTMENT DEFERRED
COMMENTS: _____

DATE _____ PRESIDENT, MEDICAL STAFF _____

GOVERNING BOARD

☐ APPOINTMENT RECOMMENDED ☐ APPOINTMENT NOT RECOMMENDED ☐ APPOINTMENT DEFERRED
COMMENTS: _____

DATE _____ CHAIRMAN, GOVERNING BOARD _____

APPENDIX B

STANDING AND AD HOC COMMITTEES

I STANDING COMMITTEES.

Unless otherwise expressed, the President shall appoint the members of the various committees hereinafter mentioned.

A. Departmental Authorities Committee.

1. The Vice-President shall be the Chairman.

2. Purpose. The Departmental Authorities Committee's purposes shall be to investigate the credentials of all applicants for membership in detail; to investigate any breach of ethics that may be reported; to review any items that may be referred to it; to make decisions regarding the competence of staff members; and as a result thereof, to make recommendations for the granting of privileges, reappointments, and the assignment of members to the various divisions and departments as provided in the By-Laws.

3. Powers. It shall be within the power of this Committee to recommend to the Medical Executive Committee withdrawal of any or all privileges from any member on the Medical Staff for reasons of professional misconduct, unethical practice, incompetence, or poor caliber of practice.

4. Membership. The Committee shall consist of the Vice-President and Chiefs of the Departments. The Committee will meet monthly and report to the Medical Executive Committee.

B. Quality Evaluation Committee.

1. The Chairman shall be appointed by the President.

2. Purpose. The Quality Evaluation Committee's purposes shall be to assess in a continuing manner the quality of medical care rendered to patients and the competence of the members of the Medical Staff of the Hospital to provide such care; to ensure that each department conducts evaluations of the medical or surgical care rendered to hospital patients in keeping with accreditation requirements; to guarantee that hospital facilities are properly and efficiently utilized by making available physician advisors and physician advisor consultants to comply with the utilization review plan of the Hospitals; to hear appeals of adverse decisions rendered under the utilization review plan; to ascertain that all tissue removed in operations is analyzed, that all surgery is justified in those cases where normal tissue is removed and that the use of blood and blood products is appropriate; to confirm that medical records meet the Medical Staff standards; and to undertake other quality assurance activities as may be assigned by the Medical Executive Committee.

3. Powers. If in its function of monitoring the quality of care received by patients, the Committee should become concerned about an unacceptable pattern of practice by any Medical Staff member, it shall have the power to investigate the problem fully, requiring (as a condition of continued staff membership) the cooperation of any staff member. Recommendations regarding the termination, suspension or reduction of privileges may be made to the Medical Executive Committee as provided for in the By-Laws.

4. Membership: The Committee shall consist of at least one member from each Department, appointed by the President of the Medical Staff after consultation with the Chairman. The Committee shall meet at least monthly to receive and review reports of these activities within each department and to report and make recommendations to the Medical Executive Committee on the quality of care assurance

programs of the Medical Staff.

C. Patient Care Committee.

1. There shall be a Patient Care Committee for each Hospital Division with co-chairmen appointed by the President of the Medical Staff, one co-chairman representing the Norfolk General Division (NGD), and the other co-chairman representing the Leigh Memorial Division (LMD).

2. Purposes. The purposes of the Patient Care Committee shall be to assure the appropriate and efficient functioning of the ancillary patient care services, the special care programs and the various services of the Hospitals.

3. Powers. The Committee shall make recommendations concerning: the operation and policies of the special units; the operating and delivery suites; diagnostic radiology; radiation therapy; laboratory facilities; dietary facilities; pharmacy; the ambulatory care, trauma and disaster facilities; the respiratory, cardiology, gastroenterology and other specialty diagnostic and therapeutic facilities; infection control procedures; liaison with nursing services; and such other considerations of patient care as may be directed by the Medical Executive Committee.

4. Membership. The Committees shall consist of at least six (6) members representing each division appointed by the President. These Committees shall meet at least monthly and report their findings and recommendations to the Medical Executive Committee.

D. Education Committee.

1. The Secretary/Treasurer shall be the Chairman.

2. Purposes. The purposes of the Education Committee shall be to assure the highest quality of the educational programs of the Medical Staff, including the

continued medical education programs of the Staff, the graduate medical residency programs and the undergraduate medical student programs.

3. Powers. The Committee shall consider and recommend actions to the Medical Executive Committee for the use of the Medical Staff funds for continuing education. The Committee shall report its findings and recommendations to the Medical Executive Committee.

4. Membership. The Permanent Committee shall consist of the Chairman and such other members, if any, as may be appointed by the President of the Medical Staff.

E. Nominating Committee.

1. The Committee shall elect its Chairman.

2. Purposes and Powers. It shall be the duty of this Committee to present a slate of nominations for the office of President (if there be no President-elect), Vice-President (President-elect), and the Secretary/Treasurer at the Annual Meeting. The Committee shall publish its slate of nominees by posting same in a conspicuous place on the Medical Staff bulletin boards in each Division one month prior to the Annual Meeting.

3. Membership. This Committee shall consist of five (5) members of the Active or Permanent Consulting Medical Staffs, to be elected by the Medical Staff at the regular meeting prior to the Annual Meeting of the Medical Staff. No members of the Staff shall be elected to serve on the Nominating Committee more than once in any three consecutive years.

II. OTHER STANDING COMMITTEES AND AD HOC COMMITTEES.

A. Formation. All other standing committees and ad hoc committees shall be created by the Medical Executive Committee.

B. Purpose. The purpose of other standing committees and ad hoc committees shall be to advise the Medical Executive Committee and other committees in the carrying out of their functions in a more efficient and orderly fashion.

C. Membership. The President shall appoint the members of these various committees and specify meeting requirements.

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MEDICAL CENTER HOSPITALS, INC.

RULES AND REGULATIONS

1. Patients may be admitted only by physicians, dentists, and podiatrists who have been duly appointed to membership on the Medical Staff, unless herein provided.
2. Each member of the Medical Staff shall name a member of the Medical Staff who may be called to attend patients in emergency. In case of failure to name such associate, the President of the Hospitals shall have authority to call any member of the staff should he consider it necessary.
3. Physicians admitting patients shall be held responsible for giving any such information as may be necessary to assure the protection of other patients from those who are a source of danger from any cause whatever.
4. Except in emergency, no patient shall be admitted to the hospital until after a provisional diagnosis has been stated and the consent of the President of the Hospitals secured.
5. All designated medical indigents shall be the responsibility of members of the Medical Staff and shall be assigned to the section (service) concerned in the treatment of the disease or condition which necessitated admission. Pay patients shall be attended by their own private physicians. Pay patients applying for admission who have no attending physician shall be assigned to the members of the Medical Staff on duty in the section (service) to which the illness of the patient indicated assignment.
6. Admissions shall be made according to the following order of priority:
 - a. Emergency Admissions. The attending physician, upon request of the President of the Medical Staff or the President of the Hospitals shall document the need for the particular admission and shall be subject to disciplinary action for willful or continued misuse of this admission category.
 - b. Urgent Admissions. The attending physician shall

designate a request for admission falling into this category. When all such admissions for a specific day are not possible, priority within this category shall be determined by the Utilization Committee.

- c. Pre-Operative Admissions. Admit as scheduled for surgery.
- d. Elective Admissions. On any day that elective or pre-operative admissions, or both, are cancelled, each emergency and urgent admission shall be reviewed by a standing committee of the Staff appointed by the President.

7. The various categories of admissions are defined as follows:

- a. Emergency Admissions. Immediate hospitalization imperative because patient's life is in immediate jeopardy or acute, serious illness necessitating immediate admission.
- b. Urgent Admissions. Serious illness, warranting high priority admission status.
- c. Pre-Operative Admissions. Patients already scheduled for surgery.
- d. Elective Admissions. Those patients in whom admission can be delayed without jeopardizing their health.

8. The following protocol shall apply to admission procedures from the Emergency Room:

- a. No elective admissions should come through the Emergency Room but should come through the Admitting Office.
- b. When a patient is to be admitted through the Emergency Room, and there is a delay in transfer to the inpatient service, the Emergency Room physician should take responsibility for checking the patient and that the vital signs should be recorded at the time of transfer.
- c. An Emergency Room admission requires an exchange of information between private Emergency Room physician and attending physician to determine the severity of the patient's condition, agreement on the holding

orders and an exchange of information between Emergency Room physician as to the need for the attending physician to visit the patient.

- d. The Emergency Room physician will take the responsibility for seeing that adequate admission information is provided as part of the permanent medical record indicating the pertinent history, physical and diagnostic features of the patient, and that adequate orders are written on admission.
9. a. All orders for treatment shall be in writing. A verbal order for treatment shall be considered to be in writing if transmitted to a registered nurse and signed by the ordering physician. Orders transmitted over the telephone shall be accepted by a registered nurse, a licensed practical nurse who has successfully completed the medication transcription course, or other administratively designated personnel acceptable to the Medical Executive Committee. Telephone orders for treatment shall be signed by the person to whom transmitted with the name of the physician per his or her own name. The ordering physician shall countersign his telephone order within 24 hours.
- b. Physicians Attending Family Members - Entry of information or medical orders into the patient's medical record shall be restricted to the attending physician, medical consultant or operating surgeon, to residents and interns under the direction of the attending physician and to those hospital employees acting within the scope of their duties. This rule is not intended to exclude the physician family member from reviewing, at the request of the attending physician or patient, the patient's medical record.

Medical orders entered into the clinical chart by the non-attending physician family member shall not be valid and need not be carried out until and unless countersigned by the attending physician.

10. There shall be no standing orders.
11. a. If, 72 hours after the initiation of an order for Schedule II drugs (i.e., narcotics, sedatives and hypnotics found in such schedule), the prescriber has not renewed the order, or the order as originally written had no time limit within the

order, the order will be automatically discontinued after 24 additional hours.

- b. Anticoagulants are to be reordered daily until a therapeutic level is established and appropriate lab tests should be ordered to monitor the therapeutic effect.
12. The hospitals operate under a drug formulary system. Drugs included in and deleted from the formulary are approved by the Medical Staff upon the recommendation of the Pharmacy & Therapeutics Committee. Generic names should be used for all single drug orders. When a drug is ordered by trade-name the same drug that has been obtained from another acceptable manufacturer, selected under guidelines approved by the Pharmacy & Therapeutics Committee and the Medical Staff, may be dispensed and administered unless the prescribing physician specifies otherwise in the order.
13. The attending physician shall be held responsible for the preparation of a complete medical record for each patient. This record shall include identification data, complaint, medical history, physical examination, special reports such as consultations, clinical laboratory, x-ray and any other special reports, provisional diagnosis, medical or surgical treatment, pathological findings, progress notes, final diagnosis, condition of discharge, follow-up and autopsy report when available. No medical record shall be filed until it is complete, except on order of the Quality Evaluation Committee. A daily progress note shall be required on all patients in the hospital. /
14. A current complete history and physical examination shall in all cases be appended to the chart (or dictated for transcription) within 24 hours after admission of the patient. In the event the history and physical examination are dictated, it is a requirement that an initial progress note defining the problem necessitating admission be written on the chart within 24 hours of admission.
15. When ~~such history~~ and physical examination are not recorded before the time stated for operation, the operation shall be cancelled unless the attending surgeon states in writing that such delay would constitute a hazard to the patient and completes in writing the pertinent history and physical findings.

16. All operations performed shall be fully described by the operating surgeon within twenty-four hours following surgery. All specimens removed at operation shall be sent to the hospital pathologist who shall make such examinations as he may consider necessary to arrive at a pathological diagnosis and he shall render a written signed report of his findings to be a part of the patient's permanent hospital record.
17. A surgical operation shall be performed only on consent of the patient or his legal representative, except in emergencies.
18. All anesthesiologists having privileges in this hospital shall be required to write ~~a pre- and post-anesthesia note~~ on the medical records of ~~all patients~~ to whom they administer anesthesia.
19. All records are the property of the hospital and shall not be taken away without subpoena. In case of re-admission of a patient, all previous records shall be available for the use of the attending physician.
20. Access to all medical records of all patients shall be afforded to staff physicians in good standing for study and research, consistent with preserving the confidentiality of personal information concerning the individual patients upon approval of the Medical Executive Committee. Subject to the discretion of the President of the Hospitals, former members of the Medical Staff shall be permitted free access to information from the medical records of their patients covering all periods during which they attended such patients in the hospital.
21. Patients shall be discharged only on physician's order. The physician, whenever possible, shall signify his intent to discharge patient on the order sheet the day prior to discharge.
22. Every member of the Medical Staff is expected to be actively interested in securing autopsies. No autopsy shall be performed without legal consent of a relative. All autopsies shall be performed by the hospital pathologist or by a physician to whom he may delegate the duty. The Quality Evaluation Committee will provide the Medical Executive Committee with a quarterly report on the number of autopsies performed.
23. Any PG-1 or PG-2's dictated reports must be countersigned

by a PG-3 or above on clinic patients provided that he/she is familiar with the case or the attending physician on private patients to demonstrate evidence of supervision.

24. A record will be judged incomplete by Medical Record Library Personnel fifteen (15) days after the patient's discharge, provided all written reports (Pathology, Clinical Pathology, X-ray, ECG, etc.) have been attached to the medical record and that all that remains to be done is for the admitting physician to complete the record.

The physician will be notified by mail that, if the record has not been completed within an additional fifteen (15) days, he will automatically lose all admitting privileges. This notification made by the Medical Records Department of the hospital will be by registered letter, return receipt requested. In addition, a phone call will be placed to the physician's office by the Medical Records Department to ascertain that they are aware that the physician is being placed on final notice.

If the physician is a member of a group, the admitting privileges of the entire group shall be suspended. If either ill or absent from the city, the physician will be excused for a reasonable period of time. Should the doctor have an emergency admission denied because of having incomplete records, and should he not wish to refer the patient to another hospital or another doctor for admission, he may call the administrator on call and explain that he will complete his incomplete records within forty-eight (48) hours. The administrator may then authorize the admission of that particular patient. Admitting privileges may be restored after records have been satisfactorily completed.

The penalty for non-completion of records two months after a Staff member has had his admitting privileges suspended shall be that his clinical privileges shall also be revoked. The Quality Evaluation Committee shall be responsible for making the recommendation to the President of the Medical Staff that all privileges be automatically revoked pursuant to Article IX, Section D of the By-Laws. Once privileges have been revoked, reinstatement will require new application.

25. All physicians shall comply with the rules and regulations duly adopted and approved by the various

clinical departments and committees. Whenever a physician receives a letter from a committee or the chief of any department, or the President or other officer of the staff, and a reply is requested, a reply in writing must be made within forty-eight (48) hours of receipt. Failure so to reply, or failure otherwise to comply with any reasonable request of the above bodies or persons, may result in summary suspension of a physician's privileges until such time as he satisfactorily explains his conduct to the Medical Executive Committee.

26. No service may be closed without prior approval of the President of the Hospitals.
27. Patients may not be transferred from one service to another without the mutual agreement of both physicians concerned.
28. Medically ill or potentially ill patients shall not be admitted or transferred to the psychiatric unit without specific communication between the physician involved and the nursing service as to the potential nursing needs.
29. The Quality Evaluation Committee and its subcommittees shall have the authority to complete, to the best of its ability, any records left incomplete by the death of a physician or by physicians whose privileges have been revoked. When this procedure is followed, a note of explanation shall be made on the face sheet of the record and signed by the Chairman of the Quality Evaluation Committee.

30. Research/Experimentation within Medical Center Hospitals

All research and/or experimentation involving patients within Medical Center Hospitals must be finally approved by the Board of Directors prior to initiation of such research and/or experimentation.

Approval procedures are as follows:

- a. Physicians wishing to conduct research and/or experimentation (including investigational drugs) which involve patients must file the appropriate information with the Eastern Virginia Medical School Sub-Committee on Human Experimentation and Research.
- b. If approved by the above Committee, a written request describing the proposal along with a copy of

approval as granted by the EVMS Sub-Committee on Human Experimentation and Research should be forwarded to:

- (i) The Medical Executive Committee for recommendation to the Board of Directors. Prior to a recommendation, the Medical Executive Committee may, at its option, forward the request to an Ad Hoc Committee for review.
 - (ii) Hospital Administration for recommendation to the Board of Directors.
 - (iii) Final decision will be made by the Board of Directors.
- c. After obtaining approval by the Board of Directors, investigators are encouraged to place their supply of investigational drugs in the Pharmacies of the Medical Center Hospitals for dispensing. Nurses will administer to patients only those investigational drugs that have been dispensed by the Pharmacies of the hospital.
 - d. The Pharmacies will establish departmental policy/procedure to ensure appropriate control of the dispensing of all investigational drugs for which they have been given responsibility. A copy of the approved protocol and any other informational material available on the drug should also be placed in the Pharmacy. This provides a central resource for the medical and nursing staffs for information on the drugs.
 - e. A principal investigator should supply the Pharmacy with names of all other physicians whom he wishes to authorize to order the drug covered by the protocol.
 - f. It is the responsibility of the principal investigator or his designee to obtain a properly executed approved Informed Consent Form from the patient which should be filed in the patient's chart. A hospital form which can be used for this purpose is available on each of the nursing units. A drug shall not be administered by the nurse until consent form is obtained, even if the drug has been dispensed by the Pharmacy.

32. Annual Membership dues for the Medical Staff will be \$50.00 unless otherwise stipulated, payable thirty days after the annual meeting of the Staff. Privileges of members whose dues are in arrears more than one year shall be revoked in accordance with Article IX of the By-Laws. Funds in the Medical Center Hospitals Medical Staff Fund will be deposited in non-interest bearing accounts and in the event of dissolution, any and all unused funds will inure to the benefit of the hospital and no funds will inure to the benefit of contributors.
33. The President is authorized to spend up to \$100.00 for a doctor's memorial and up to \$100.00 for gifts to hospital employees on appropriate occasions. Other expenditures may be authorized by the Medical Executive Committee.
34. The Medical Disaster team outlined by the Medical Staff Trauma and Disaster Committee shall have absolute authority to direct the duties of all physicians at such time as the Disaster Plan is implemented by the Hospitals.
35. Operations for the sole purpose of sterilization of male or female patients shall be performed in accordance with the provisions of Title 54, Article 8, Code of Virginia (1950), as amended or under the provisions of any subsequent amendments and revisions thereto. The following rules and regulations shall govern such procedures:
 - a. Minors. Sexual sterilization operations shall not be performed:
 - (i) On children younger than fourteen (14) years old, under any circumstances.
 - (ii) On children ages fourteen (14) through seventeen (17), inclusive, except after full compliance with Section 54-326.02, Code of Virginia (1950).
 - b. Adults. Sexual sterilization operations shall not be performed:
 - (i) On adults incapable of giving their informed consent, except after full compliance with Section 54-326.03, Code of Virginia (1950).

- (ii) On adults capable of informed consent, except upon meeting the following conditions:
- (a) Prior to or at the time of the request for sterilization by a patient, a full, reasonable and comprehensible medical explanation as to the meaning and consequences of such an operation and as to alternative methods of contraception shall be given the patient by the attending physician. The form required by subsection (b), below, shall include a statement that the patient signing it has received such an explanation and fully understands it.
 - (b) Before a sterilization operation may begin, there must be included in the patient's hospital records a completed and witnessed hospital form for permission of sterilization, signed by the patient. This form shall be completed and filed with the medical records of the patient a minimum of thirty (30) days prior to any sterilization performed under the circumstances noted in subsection (c), below. This rule is intended to apply only to those operations and parts of operations done primarily for the purpose of limiting individual's capacity for reproduction. It should not be so construed as to restrict the use of any medical or surgical treatment which sound therapeutic treatment may indicate is necessary, even though such treatment may incidentally deprive the patient of reproductive functions. When a hysterectomy is done primarily as a sterilization procedure, the procedures of this Rule 35 shall be followed.
 - (c) No person who has not previously become the natural or adoptive parent of a child may be sexually sterilized prior to the lapse of thirty (30) days from the date of the signed written request that the operation be performed.

36. Special Units Within Medical Center Hospitals:

The special units of Medical Center Hospitals are so designated because the work made possible by these facilities is sufficiently complex to require individuals using these facilities to have special skills. Within these units, special circumstances are often required to ensure the best patient care, for example, a "team approach" or concentration of experience upon limited numbers of individuals to permit maintenance of proper skills. In this regard, the requirements of each of these units are unique. Moreover, there will be times in the future where a given unit may benefit from the admission of new physicians to the units and times when the admission of new physicians may be detrimental to the care and service provided to patients therein. Because of the above considerations, privileges to work in a special unit should be granted only after stringent criteria are satisfied, agreed to, and maintained.

- a. The Unit Director, selected by a Search Committee, must be approved by the Medical Executive Committee and appointed by the Board of Directors. The Search Committee will be appointed by the President of the Medical Staff and must include at least one member from the Eastern Virginia Medical School faculty who is also a member of the medical staff of Medical Center Hospitals. The Director so appointed will be responsible to the Medical Executive Committee to oversee the operation and maintenance of the Special Unit and all its equipment, to acquire and supervise the training of technical staff required to operate safely and efficiently the Special Unit and its equipment and to be responsible for the proper acquisition, utilization and disposition of all supplies and materials. The Director will be responsible for and have the authority to delegate responsibility as appropriate.

The appointment of the Director shall be reviewed every three years by the Medical Executive Committee and subsequently forwarded to the Board of Directors for approval.

- b. All physicians desiring to work within the framework of a Special Unit will make appropriate application, and their qualifications, experience and credentials shall be determined by the appropriate Special Unit Credentials Committee prior to evaluation by the

Departmental Authorities Committee. The Special Unit Credentials Committee must report on the completed application within thirty days. Under no circumstances will temporary privileges be granted. No physician will be allowed to utilize the facilities of the Special Unit prior to a proper evaluation of his credentials and the granting of privileges by the Medical Staff. There will be no discrimination made because of organizational membership, faculty status, or practicing status of the applicant physician. An application by a qualified individual is to be granted or denied based upon thorough consideration by the above Committees of the effect that the granting of such privileges will have upon the quality of care provided to patients within the unit. In keeping with the open staff policy of Medical Center Hospitals it is anticipated that well-qualified individuals will be granted special unit privileges if the applicant will either enhance or not detract from the quality of care within the unit.

- c. All physicians who participate in the work of the facility will have an appointment to the Unit and shall be considered a part of it. They will agree to abide by the policies and procedures of the Unit and each participating physician will have a written agreement (or contract) setting forth, in addition to the established operational policies and guidelines of the Unit, the specific details of his individual obligations and arrangements for remuneration, if any.

Policies and agreements which affect the hospital operations or finances shall be sent to the Hospital Administration for approval. Policies and procedures will be established for such matters as scheduling the studies, requests for provisions of new equipment or services, utilization of a standardized format of reporting, maintenance of primary records, reports, special recordings such as angiograms, etc., within the Unit. All such records and documents will be the property of the Unit and will not be removed without consent of the Unit Director.

- d. Each participating physician must agree to maintain his skills by performing such minimum caseload of procedures as may be from time to time established

within the operational policies and guidelines by members of the Unit. He must agree to accept assignment of patients where necessary to achieve and maintain the agreed upon minimum level of experience. Any physician failing to maintain such level may have his privileges suspended upon recommendation of the Director of the Unit to the Departmental Authorities Committee and approved by the Medical Executive Committee.

- e. Each participating physician will agree to accept a pro rata share of responsibilities for the study and care of indigent patients however referred without expectation of recompense. He shall be encouraged to share in all educational and conference responsibility, including the teaching of medical students, residents and others under the direction of the Director where appropriate, and in addition maintain regular attendance at all conferences organized within the framework of the Unit. He will be encouraged to have input into the discussions concerning the patients of others as well as allowing free discussion of his own patients at such conference. He will be encouraged to agree to participate in any quality evaluation program that might be instituted, and to conduct such evaluation as he may be from time to time requested. He shall be encouraged to co-operate in research projects of the Unit and participate in projects designed to improve the quality of patient care within the Unit.
- f. In addition to existing units, additional units may be created or present units modified or phased out by the Medical Executive Committee with concurrence of the Medical Staff and the approval of the Board of Directors.
- g. Each person who has privileges in a Special Unit must actively reapply for such privileges on an annual basis. With each reapplication the particular physician's competency to maintain privileges in the Special Unit must be reviewed by the Special Unit Credentials Committee.
- h. Any physician failing to abide by the Special Unit rules and regulations may be referred by the Special Unit Director to the President of the Medical Staff for corrective action.

i. The below listed Units are considered to be Specialty Units of Medical Center Hospital and each is a section of one or more of the departments of the Medical Staff of Medical Center Hospitals.

- (i) Cardiac Diagnostic Unit - Department of Medicine and Pediatrics.
- (ii) Renal Dialysis Unit - Department of Medicine
- (iii) The Burn Unit - Department of Surgery and Department of Plastic Surgery
- (iv) G. I. Station - Department of Medicine
- (v) Cardiac Surgery - Department of Surgery
- (vi) Renal Transplantation - Department of Medicine, Surgery and Urology
- (vii) V.I.P. Unit - Department of OB/GYN

37. Health Professional Affiliates Section of the Affiliate Staff.

The following shall apply to the application for and granting of privileges for members of the Health Professional Affiliates Section of the Affiliates Staff as provided for under Section V.G. and VIII. C.12. of the By-Laws of the Medical Staff of Medical Center Hospitals:

a. Category I

- (i) Category I members are obligated to abide by the direction of the chief of the department for which they are assigned in addition to all By-Laws and Rules and Regulations of the Hospital and the Medical Staff.
- (ii) Category I members must have acquired and provided documentation for any licensure and certification requirements provided for under the Code of Virginia and required by the State Board of Medicine, and other official licensure and certification agencies within the State.
- (iii) Category I members shall have in addition to all other application requirements a written

recommendation from the chief of the department to which they are to be assigned.

(iv) The chief of the department to which they are assigned shall recommend annually to the Departmental Authorities Committee continuation of their membership on the Affiliate Staff, and the renewal of their privileges.

(v) Individuals must be members of the Affiliate Staff prior to functioning in any capacity within the hospital confines.

(vi) Category I Health Professional Affiliates may neither admit patients nor serve as an attending physician to any patient.

b. Category II

(i) Category II members are individuals who have been authorized by specific physicians or dentists to carry out specific duties on behalf of their responsible physicians or dentists within the confines of Medical Center Hospitals. These persons must be members of the hospital's Affiliate Staff prior to functioning in any capacity within the hospital confines. They may write orders for medication only when transcribing or executing specific orders for medication at the direction of the specific physician or dentist for whom he is acting as an agent or assistant. However, the order cannot be carried out until countersigned by the physician or dentist.

(ii) Non-hazardous orders, as defined by the Quality Evaluation Committee, may be written by Certified Nurse Practitioner or Certified Physician's Assistant performing under the supervision or direction of individual physicians or dentists. These orders may be carried out without countersignature or oral authorization of the responsible physician or dentist. However, the order will include the name of the prescribing physician or dentist when written. Non-hazardous orders include:

(a) Orders for EKG, EEG and laboratory tests (except those requiring administration of medication) and all x-ray orders (except those

involving radioactive iodine, nuclear medication or invasive x-ray techniques).

(b) Orders of an administrative nature such as:

- (1) Transfer to other floors or rooms, except from units involved in specialized care, such as Intensive Care Unit.
- (2) Visitation orders.
- (3) Dietary orders.
- (4) Consultation orders.
- (5) Surgical preparation orders.
- (6) Request for intake or output record.
- (7) Request for record of vital signs.
- (8) Orders for preparation of radiographic examinations.
- (9) Administrative consent orders.
- (10) Order to discharge patient or transfer to nursing home.

(iii) Each physician or dentist will be required to determine and document the extent of responsibility granted to their respective assistant within the guidelines described above. The duties and responsibilities granted by a specific physician or dentist to his assistant are subject to review by the department to which the physician or dentist is a member.

The purpose and effect of this documentation is to give that assistant an official capacity within the confines of the Medical Center Hospitals and to minimize Medical Center Hospitals' legal responsibility for any actions taken by that assistant on behalf of the specific physician or dentist.

(iv) The Medical Staff office will maintain a file

of the names of Certified Physician's Assistants and Certified Nurse Practitioners with the document of authorization duly signed by the respective physician or dentist. Each department, nursing station and admitting office will be provided with a list of names of the assistants and their responsible physicians or dentists.

(v) Acts authorized to be performed by Certified Physicians's Assistants or Certified Nurse Practitioners must be performed under the supervision or direction of the physician or dentist responsible for their conduct. No Certified Physician's Assistant or Certified Nurse Practitioner authorized to act hereunder shall have any discretionary authority to function within Medical Center Hospitals. The term supervision and direction shall have the meaning ascribed to said terms under regulations of the State Boards of Medicine and Nursing governing Certified Physician's Assistants and Certified Nurse Practitioners.

(vi) The Board of Directors, the President of the Hospitals, the President of the Medical Staff or the Chairman of the Department in which the responsible physician or dentist is a member may immediately and without notice terminate the authority of any Certified Physician's Assistant or Certified Nurse Practitioner who exceeds the authority conferred by the protocol or otherwise violates his employment terms.

c. Category III

(i) These persons must be registered with the Medical Staff Office as specific assistants to a physician, dentist or group, unless they are employees of Medical Center Hospitals. Their applications must be approved by the Departmental Authorities Committee.

(ii) These persons, if other than Medical Center Hospitals employees, must perform the following duties within the hospital confines under the direct supervision of their employer physician or dentist:

(a) Transcribing specific oral or written non-hazardous orders as handled in Category II, above, which may only be carried out after

signature or oral authorization by the physician or dentist. The oral authorization must be countersigned within 24 hours.

(b) Progress notes dictated and countersigned by the specific attending physician or dentist.

(c) Obtain certain information from the patient chart as requested by the attending physician or dentist.

(d) Assisting their responsible physician or dentist under his direct supervision and in only those surgical procedures as requested and approved on their application form.

(iii) Each supervising physician or dentist shall be required to provide written documentation of the specific duties the individual may perform. However, in no case shall these duties be performed without the direct supervision of the physician or dentist.

(iv) Category III individuals must be members of the Affiliate Staff prior to functioning in any capacity within the hospital confines.

(v) The Board of Directors, the President of the Hospitals, the President of the Medical Staff or the Chairman of the Department in which the responsible physician or dentist is a member may immediately and without notice terminate the authority of any Category III member who exceeds the authority conferred by the protocol or otherwise violates his employment terms.

d. General Rules for Category II and III

(i) Granting of membership for Categories II and III is additionally conditional upon the fact the responsible physician or dentist has, and continues to maintain his Medical Staff membership and privileges. Failure of the responsible physician or dentist to maintain membership and privileges, for whatever reason, shall immediately and without notice terminate the membership and privileges of the respective Affiliate Staff member.

(ii) Membership for Categories II and III is

conditional upon an evaluation of the physician's or dentist's capability to supervise and control the Affiliate Staff member. As such, in the event that the employer/employee relationship terminates between the physician or dentist and Affiliate Staff member for whatever reason, membership and privileges of the Affiliate Staff shall terminate immediately and without notice. The physician or dentist has the responsibility to notify the Medical Staff Office of any change in the employer/employee relationship.

(iii) For Categories II and III of the Affiliate Staff membership, the individual is not authorized to perform any duties except those specifically listed in these Rules and Regulations and the By-Laws and approved for the respective individual.

e. Category IV

(i) Category IV applicants must submit details of their functions to the Executive Committee.

(ii) For all categories, Affiliate Staff membership is additional conditional upon and subject to any contractual and other working relationships between the hospital and other agencies or institutions.

f. The Medical Staff office shall maintain a file of all Affiliate Staff members.

38. All suicidal attempt and overdose patients should have a psychiatric consultation considered. The recommendation to obtain a psychiatric consultation shall be documented in the Emergency Room or hospital record. If, in the judgment of the attending physicians, such a consult is not deemed to be in the best interest of the patient, no psychiatric consult need be recommended and such determination shall be entered in the chart.

39. That emergency care by attending physicians be allowed if the patient or family are unable to give consent.

ADDENDA

The Committee recommends to the Medical Staff and the Board of Directors of the Hospital:

1. That these By-Laws, Rules and Regulations shall be reviewed at least once every two years and brought up to date as needed.

R E V I E W E D

April 1982

December 1983

R E V I S E D

October 1981

October 1982

February 1984

CHANGES APPROVED AT THE JULY 1984
QUARTERLY MEDICAL STAFF MEETING

The rule for completion of the Validation Sheet will become part of Rule 24. The existing rule regarding completion of charts remains unchanged and will become part (a) of Rule 24. Rule 24 (b) is the new rule relating to the Validation Sheet.

- 24b. The Final Diagnoses and Procedures sheet validating the diagnoses and procedures performed during an inpatient stay must be completed in order for Medicare insurance claims to be filed. This Validation Sheet should be signed on the floor on the day of discharge. In the event it is not signed or all of the required information is not included, Medical Records shall produce a computer generated Validation Sheet for the physician's signature.

Upon notification by telephone by Medical Record library personnel that the computer generated Final Diagnoses and Procedures sheet is available, the sheet must be signed by the physician within 72 hours. If this is not done, the Validation Sheet shall be considered delinquent and the physician shall be given first notice by telephone. If the Final Diagnoses and Procedures sheet has not been completed by the fifth day, a final notice by telephone shall be given. On the seventh day the Validation Sheet is incomplete, the physician and each member of his group, shall have his admitting privileges suspended. Extenuating circumstances preventing the completion of the Validation Sheet, i.e. excused absence and illness, shall be considered before privileges are suspended.

The physician who does not complete the Final Diagnoses and Procedures sheet within 21 days of the suspension of his privileges or who has his privileges suspended more than four times in one year because of an incomplete Validation Sheet, shall have his individual clinical privileges revoked. The DRG Committee shall be responsible for recommending to the President of the Medical Staff that all privileges be suspended as outlined in ARTICLE IX, Section D of the Bylaws. Once privileges have been revoked, reinstatement of the individual will require new application.

Rule 24a applies independently of this provision.

Down-sizing Appellate Review Body of the Governing Body

With regard to the down-sizing of the Board of Medical Center Hospitals Board of Directors, the Bylaws Committee recommends that under ARTICLE X, entitled Hearing and Appellate Review Procedure, Section F, Subsection 4, be revised as follows:

The Appellate Review shall be conducted by the Board of Directors or by an ad hoc Appellate Review Committee appointed by the Board of Directors, consisting of not less than three (3) ~~members,~~ none of whom shall have been involved in prior proceedings regarding the practitioner.

This change is made in order that an ad hoc Appellate Review Committee of fewer directors will be used during the appeals process.

CHANGES APPROVED AT THE APRIL 1984
QUARTERLY MEDICAL STAFF MEETING

Medical Staff Funds/Dues. The Bylaws Committee recommends that with respect to the investment of Medical Staff funds Rule No. 32 of the Bylaws and Rules and Regulations should be re-stated as follows: Rule No. 32, line 6: Funds in the Medical Center Hospitals Medical Staff funds will be appropriately deposited at the direction of the Medical Executive Committee, and in the event of dissolution, any and all unused funds will inure to the benefit of the hospital and no funds will inure to the benefit of contributors.

This change is made so that the Medical Staff funds can be deposited in an interest-bearing account.

Institutional Review Committee and Bylaws. The Bylaws Committee recommends that the Appendix B of the Bylaws and Rules and Regulations of the Medical Staff of Medical Center Hospitals be appropriately edited to include the Institutional Review Committee as a committee which reports to the Executive Committee of the Medical Staff. This will also require corresponding editing to be done to the Patient Care Committee and Quality Review Committee as listed in Appendix B.

BYLAWS

OF

MEDICAL CENTER HOSPITALS

ARTICLE I

General

Section 1. Philosophy of Medical Center Hospitals - Medical Center Hospitals (the "Hospital") is dedicated to the providing of the highest quality medical care attainable and to the providing of educational and community service programs for the community of Norfolk and the surrounding areas of Tidewater Virginia. It is our goal that all patients receiving care within the inpatient and outpatient facilities of the Hospital be provided a single standard of high quality care which will be made available to all without regard to race, color, religion, sex, age, national origin, or ability to pay.

It is our belief and therefore our commitment that the following be achieved:

- a) Location and organization of health services so as to increase accessibility to those in need of such services.
- b) Participation and involvement in and coordination with the Eastern Virginia Medical School and other educational programs for the undergraduate, graduate and continuing education of physicians and other medical and health care personnel.
- c) Education of individuals receiving care as to their need for care and modes of obtaining such necessary care.
- d) Cooperation with other providers of health services in the planning and providing of such services considering the needs of the community and the resources available for the delivery of such services.
- e) Development of policies and programs designed to promote career mobility and advancement of Hospital employees without regard to race, color, religion, sex, age or national origin.
- f) Through our own leadership and through cooperation with government and non-governmental agencies and organizations to improve our community in its social, cultural, educational and economic development. These efforts are in addition to our primary goals of medical care and health related education.

Section 2. Conflicts of Interest - The following policy on Conflicts of Interest is hereby adopted:

- a) Members of the Executive Board of Directors, officers and employees ("interested parties") should exercise the utmost good faith in all

transactions touching upon their duties to the Hospital and its property. In their dealings with and on behalf of the Hospital they are held to a strict rule of honest and fair dealing between themselves and the Hospital. They shall not use their positions, or knowledge gained therefrom, so that a conflict might arise between the Hospital's interest and that of the individual.

b) All acts of interested parties shall be for the benefit of the Hospital in any dealing which may affect the Hospital adversely.

c) No interested party shall accept any favor which might influence his actions affecting the Hospital or its member.

d) After becoming subject to this policy on conflicts of interest, interested parties shall avoid any new employment, activity, investment, or other interest which might involve obligations which may compete with or be in conflict with the interest of the Hospital or its member and shall promptly disclose the same as they may exist upon becoming subject to this policy.

e) Annually the President of Medical Center Hospitals shall send to all directors, officers and selected employees a questionnaire which shall be completed and returned to him.

f) The President of Medical Center Hospitals shall submit a confidential report to the Executive Board of Directors concerning any disclosed interests of directors and officers, and he shall report to the Executive Board of Directors concerning any interest of selected employees so disclosed, together with his actions concerning the same.

g) New interested parties shall participate in a similar procedure immediately upon assumption of their responsibilities.

ARTICLE II

Members

Section 1. The Hospital has one member which is Alliance Health System and which shall have those rights and powers prescribed by law, the Articles of Incorporation, and these Bylaws.

Section 2. Meetings - Meetings of the member may be held at such place either within or without this State, as may be provided in the notice of such meeting. Meetings of the member may be called by the Chairman of the Executive Board of Directors, the President of the Hospital, the Executive Board of Directors, or the member. (An annual meeting of the member shall be held in October preceding the annual meeting of the Directors.)

Section 3. Voting - The member shall be entitled to one vote on all matters.

Section 4. Rights of Member - The member shall have in addition to those rights granted by law and by the Articles of Incorporation, the following specific powers, and all actions of the Executive Board of Directors respecting

the powers hereby granted shall first be approved by the member:

- (i) To elect and remove Directors in the manner provided by the Articles of Incorporation;
- (ii) To approve any alteration, amendment or repeal of the Articles of Incorporation, these bylaws, or the adoption of new bylaws;
- (iii) To approve the operating and capital budgets of the Hospital, and approve all formal long-range plans to be adopted by the Hospital;
- (iv) To approve any transaction for which the Hospital would be required to obtain Certificate of Need approval under Virginia law;
- (v) To approve all borrowing or debt incurred by the Hospital, whether secured or unsecured and including but not limited to leases, which in any one transaction or related series of transactions exceeds \$500,000;
- (vi) To approve any plan of a merger or consolidation, any sale, lease, exchange, mortgage, pledge or other disposition of all, or substantially all, the property and assets of the Hospital, the voluntary dissolution of the Hospital, or revocation of voluntary dissolution proceedings;
- (vii) To review the books and records of the Hospital, conduct audits of the Hospital and approve the selection of auditors chosen to conduct audits of the Hospital;
- (viii) To approve the creation or acquisition of any subsidiary of the Hospital, or the creation of any other corporation of which the hospital is to be a member, and to approve any dissolution or other change in any such legal relationship previously approved by the member.

Section 5. Reports - Following the completion of the annual audit of the Hospital, the Chairman of the Board of Directors shall submit to the member the audited financial statement of the Hospital during the preceding fiscal year, together with a report of the general financial condition of the Hospital, and of the condition of its property. The officers and directors of the Hospital shall submit to the member such further reports as the member may reasonably require.

ARTICLE III

Executive Board of Directors

Section 1. The affairs of the Hospital shall be under the control and direction of an Executive Board of Directors ("Executive Board"), subject to the rights of the member of the Hospital as provided herein, and with the aid of such committees and officers as are provided for herein.

Section 2.

a) The Directors, except ex officio Directors, shall be divided into three (3) classes, with each class as nearly equal in number as possible. The term of office of the Directors of each class shall be three (3) years, with the term of Directors of one class expiring upon the adjournment of each annual meeting.

b) The number of Directors, including ex officio Directors, shall be 20.

c) The Executive Board shall include as ex officio members, with vote, the President of Alliance Health System and the President of Medical Center Hospitals. As ex officio members, their term of directorship is defined by their office and not by the provisions outlined below.

d) Directors shall be elected by the members of the Hospital in accordance with the Articles of Incorporation of the Hospital.

e) Directors shall be eligible for re-election upon the expiration of their respective terms. No Director shall serve for more than three (3), three (3) year terms in succession; provided, however, that any Director holding the office of Chairman-Elect, Chairman or Immediate Past Chairman may continue to serve for the full term of directorship in which he is elected to office. Directors who have completed three (3) consecutive terms shall be eligible for re-election after an absence of at least one (1) year.

f) No person who has attained the age of sixty-five (65) years shall be elected for the first time as Director. No Director who has attained the age of seventy (70) years shall be re-elected.

g) A Director who has served four terms and has attained the age of seventy (70) years shall assume the status of "Director Emeritus" upon the termination of the term of directorship for which elected or upon his voluntary retirement from directorship.

h) A former Director who has served for a period of four (4) or more terms may, at the pleasure of the Executive Board, be elected to the status of "Director Emeritus."

i) A Director Emeritus shall be welcome at all Executive Board or committee meetings and shall be extended the courtesy and opportunity of participating in the discussions. He shall not be considered a member of the Executive Board of Directors nor shall he be counted among the twenty (20) members of the Executive Board. A Director Emeritus shall have no liability for the management of the Hospital nor shall he be eligible to hold office or vote on matters before the Board or its committees.

Section 3. Meetings - The Executive Board shall hold regular meetings monthly at such times and places as the Chairman of the Executive Board may designate. Special meetings may be called at any time by the Chairman, the President of Medical Center Hospitals, the member of the Hospital, or by any five (5) members of the Executive Board. The annual meeting shall be held in October. At least two (2) days notice of the time and place of each regular and special meeting shall be given to the Directors in person, by telephone, or by ordinary mail. A quorum for the transaction of the business at any meeting shall be one-third (1/3) of the Directors then in office. The President of the Eastern Virginia Medical Authority and the President of the Medical Staff shall be invited to attend all Executive Board meetings in an advisory capacity.

Section 4. Voting - Each Director shall be entitled to one (1) vote on all matters. All actions of the Executive Board shall be taken by majority vote of those present, unless otherwise prescribed by law, the Articles of Incorporation or these bylaws.

Section 5. Qualifications of Membership - It is an honor and a privilege to serve as a member of the Executive Board of Directors of the Hospital and its Directors should be selected with care with reference to the following attributes and characteristics:

- a) Commitment to improvement and development of the community's health and welfare;
- b) Demonstrated competencies that relate to organizational governance;
- c) Adequate time to serve;
- d) A sense of cooperation and sensitivity to others;
- e) Willingness to learn;
- f) Loyalty; and
- g) Physical capability.

Efforts should be made to balance various personalities and qualifications in order to provide a socially as well as professionally dynamic Board.

ARTICLE IV

Officers

Section 1. Officers - The elected officers of the Hospital shall consist of a Chairman of the Executive Board, a Chairman-Elect, a President, a Secretary, a Treasurer, and one or more Vice Presidents, who shall be elected for terms of two (2) years, or until their successors be elected and qualify. Any of these officers may be re-elected for a further term or terms without limitation. Upon completion of his term of office, the Chairman shall serve as Immediate Past Chairman for one (1), two (2) year term only. One or more Vice Chairmen of the Executive Board and such other officers as may be deemed necessary may be provided for by the Executive Board of Directors. Any two (2) or more offices may be held by one (1) person, except the offices of President and Secretary.

Section 2. Qualification for Presidency - To be eligible for election, the President of the Hospital shall be an officer of Alliance Health System. If at any time the President not be so elected or appointed, an officer of Alliance Health System and be then serving in such capacity, he shall be disqualified from service as President and a successor to him shall be elected as herein provided.

Section 3. Removal - Any officer or agent may be removed, with or without cause, at any time whenever the Executive Board of Directors, in its absolute discretion shall consider that the best interests of the Hospital will be served thereby. Vacancies in office may be filled by the Directors at any regular or special meeting of the Executive Board.

Section 4. Duties

a) **Chairman of the Executive Board of Directors** - The Chairman of the Executive Board of Directors shall conduct the meetings of the Directors but shall have no authority to act on behalf of the Hospital individually, and the Directors shall act only as an Executive Board.

b) **Chairman-Elect** - The Chairman-Elect of the Executive Board of Directors shall perform the duties of the Chairman in his absence, shall serve as Chairman of the Advisory Board and shall perform such other duties as are incident to the office or properly required of him by the Board of Directors.

c) **Immediate Past Chairman** - The Immediate Past Chairman shall offer any assistance as the Chairman might require regarding the affairs of the Executive Board and shall perform any duties properly required of him by the Executive Board.

d) **Vice Chairman** - Any Vice Chairman, who may be elected, shall assist the Chairman and Chairman-Elect in the fulfillment of their responsibilities.

e) **President** - The President shall have general supervision of the business and affairs of the Hospital, shall sign or countersign contracts

and other instruments of the Hospital that may require his signature; shall make reports to the Directors; and shall perform all such other duties as are incident to the office or are properly required of him by the Executive Board of Directors. The President shall have the authority to employ such subordinates as he deems advisable and to delegate to them such duties in the conduct of the affairs of the Hospital as he may deem advisable.

f) Vice Presidents - The Vice Presidents shall make such reports and perform such other duties as are incident to their office or are properly required of them by the President or Executive Board of Directors.

g) Secretary - The Secretary shall issue a notice for all meetings, and shall keep their minutes, shall have charge of the Hospital books and seal; shall sign or countersign such instruments as require his signature; and shall make such reports and perform such other duties as are incident to his office or are properly required of him by the President or Executive Board of Directors.

h) Treasurer - The Treasurer shall have general supervision of the method of handling and custody of the monies and securities of the Hospital; shall supervise the maintenance of financial records and books; shall sign or countersign such instruments as require his signature; and shall make such reports and perform such other duties as are incident of his office or are properly required of him by the President or Executive Board of Directors.

ARTICLE V

Committees

Section 1. Standing Committees - The Hospital shall have two (2) Standing Committees, the membership and duties of which shall be as determined from time to time by the Executive Board.

a) Finance Committee - The Finance Committee shall be responsible for monitoring the Hospital's financial structure and recommending action to the Executive Board and shall have the following responsibilities:

- 1) Consider all major financial policies including:
 - income requirements
 - short and long-term investments
 - credit and collections
 - insurance
 - depreciation funding
 - borrowing
- 2) Review the Hospital's financial position and results of operations and recommend action when necessary.
- 3) Receive and review external audits for the Hospital.
- 4) Review the performance of investment trustees and investment managers and recommend changes when necessary.

5) Review financial plans submitted by management for all major capital expenditures.

6) Recommend strategies to improve the Hospital's return on investments.

7) Review and recommend annual operating and capital budgets.

b) Planning and Building Committee - The Planning and Building Committee shall be responsible for reviewing and recommending to the Executive Board plans through which the Hospital can fulfill its mission, role and objectives, including construction, demolition and alternation of the Hospital, and shall have the following responsibilities:

1) Review the continuous planning process and recommend short, interim and long-range plans for the Hospital consistent with the strategy and long-range plans of Alliance Health System and to recommend changes in Alliance Health System plans and strategies when deemed advisable.

2) Review and make the recommendations concerning specific proposals as submitted by management for capital outlays in excess of a dollar amount which is established from time to time by the Executive Board.

3) Review the overall status of projects in progress, including, but not limited to, time schedules, budgets and conflicts between Hospital and contractors, architects and engineers.

4) Furnish other committees of the Executive Board with information and data resulting from actions of the Planning and Building Committee.

5) Receive from management periodically a summary of capital equipment purchases.

Section 2. Special Committees - There shall be Special Committees as the Executive Board may determine from time to time.

Section 3. Appointment - The Chairman of the Executive Board shall appoint the members of all committees, subject to confirmation by the Executive Board.

ARTICLE VI

Finances

Section 1. Depositories - The monies of the Hospital shall be deposited in such banks or trust companies as the Executive Board shall designate and all payments, so far as practicable, shall be made by checks. Checks and drafts may be signed in the name of the Hospital by any officer or employee who may be designated by resolution of the Executive Board. All notes, bonds and other instruments creating or evidencing an obligation for the payment of money shall be signed in the name of the Hospital as the Executive Board shall direct.

Section 2. Securities - Securities of the Hospital may be registered in the name of the Hospital, in the name of a nominee, or may be in bearer form. Securities may be placed in the custody of such banks or trust companies as the Executive Board may direct and responsibility for the investment of funds may be delegated to such entities as the Executive Board may determine.

ARTICLE VII

Medical Staff

Section 1. Authority - The Executive Board of Directors delegates to the Medical Staff the authority to evaluate the professional competence of its members and applicants for medical staff privileges subject to the conditions set forth in Sections 2 through 9 below. It also delegates to the Medical Staff the responsibility for medical care of all MCH patients. The Medical Staff is to maintain standards of medical care appropriate for a large regional hospital. The Executive Board also expects the Medical Staff to review the medical care provided to MCH patients and to provide the Executive Board with the results of all reviews conducted. The Medical Staff is given the responsibility to carry out Hospital approved educational programs including its own continuing education; support patient care efforts of Hospital personnel and participate in their career and professional development; coordination for the appropriate utilization of Hospital facilities in an effective and efficient manner.

Section 2. Composition - The Medical Staff shall consist of all physicians, dentists and affiliate Medical Staff appointed by the Executive Board and granted privileges to practice in the Hospital. It shall be relied upon to provide for the Hospital the highest practical standard of medical and dental practice and educational programs.

Section 3. Organization - The Medical Staff shall be organized in accordance with bylaws adopted by it and approved by the Executive Board. Such bylaws shall establish policies to assure that only a member of the Medical Staff with proper admitting privileges shall admit patients to Medical Center Hospitals and that only an appropriately licensed practitioner with clinical privileges shall be directly responsible for a patient's diagnosis and treatment. The members shall be divided into such categories and the members in each category shall have such duties, privileges and voting and other rights as may be prescribed in the Medical Staff bylaws.

Section 4. Appointment - To be eligible for appointment to the Medical Staff, practitioners shall be legally licensed to practice in the Commonwealth of Virginia and shall be qualified by education, experience and ethical standards to carry on a professional practice of a competence commensurate with that being provided by the Medical Staff of the Hospital. The granting of privileges shall be controlled by the Executive Board upon written application of the practitioner. Each application for appointment shall be referred to the Medical Staff for recommendation prior to consideration thereof by the Executive Board. Each appointment to the Medical Staff shall be for a period ending with the next ensuing April 30 and shall specify the category of the Medical Staff to which appointment is made and the privileges of practice granted.

Section 5. Reappointment - Prior to April 1 of each year, the Medical Staff shall submit to the Executive Board recommendations for the reappointment, classification and granting of privileges for the ensuing year for practitioners who were members of the Medical Staff on March 1. The Executive Board shall act upon such recommendations prior to April 30 of each year.

Section 6. Termination or modification of staff status - In the event the Executive Board shall deem it in the best interest of patients or to foster competent and ethical professional practice or education in the Hospital, it may, at any time upon recommendation of the Medical Staff or upon its own motion, terminate or suspend the appointment of a physician or dentist, change the category in which a staff member is classified, or reduce, modify or condition the privileges granted. Before any such action is taken by the Executive Board, the practitioner shall be given written notice of the proposed termination or modification of ~~staff~~ status and be advised that he will be afforded the protection of due process as outlined in the bylaws of the Medical Staff and approved by the Executive Board of Directors. Anything hereinabove to the contrary notwithstanding, the Executive Board may modify or suspend all privileges of practice of a practitioner, if it deems such suspension necessary or desirable to the maintenance of the quality of the medical care of the Hospital.

Physicians employed by the Hospital in a Medico-Administrative position shall be subject to review and a hearing, if requested, by a joint committee of Hospital governing board representatives and representatives of the Medical Staff to determine whether the reason for action involves the individual's medical competence or is purely administrative in nature. If it is determined that medical competence is involved, the procedures outlined for dealing with a member of the Medical Staff shall be followed. If it is determined that the reason for action is purely administrative in nature, the Hospital policies or the terms of the contract, if there is one, shall be followed.

Section 7. When the Executive Board does not concur with a Medical Staff recommendation relative to a Medical Staff appointment, re-appointment or termination of appointment, and the granting or curtailment of clinical privileges, a special committee consisting of the officers of the Executive Board of Directors and the officers of the Medical Staff shall review the recommendation and the circumstances under which the decision is being made before the Executive Board makes the final decision.

Section 8. Temporary Appointments - Upon the written recommendations of the President of the Medical Staff and the Chief of the Department within the specialty of which privileges are to be granted, the President shall have authority to make a temporary appointment of not more than ninety (90) days to the Medical Staff and grant privileges to a practitioner. In unusual circumstances, and for good cause shown, an extension beyond ninety (90) days may be granted by resolution of the Executive Board.

Section 9. Rules and Regulations of Practice - The Medical Staff shall establish, subject to the approval of the Executive Board, rules and regulations to govern the practice of medicine and dentistry in the Hospital.

Section 10. Liaison with Executive Board of Directors - The President of the Medical Staff shall be invited to attend, in an advisory capacity, meetings of the Executive Board, at which time he shall be provided an opportunity to make, & report upon medical practice in the Hospital and other matters of concern to the Medical Staff and to comment upon matters under consideration at the meetings.

ARTICLE VIII

Advisory Board

Section 1. The Hospital shall seek to involve interested community leaders in the affairs of the Hospital by inviting them to serve as members of the Advisory Board of Medical Center Hospitals (Advisory Board). Members from time to time will be asked by the Chairman to advise the Executive Board regarding areas with which they have particular expertise. Members may also be invited by the Chairman to serve on various standing and ad hoc committees of the Hospital. Members shall perform additional tasks as may be deemed appropriate by the Executive Board. The Advisory Board members shall serve as good will ambassadors for the Hospital. A member of the Advisory Board shall have no liability for the management of the Hospital nor shall he be eligible to vote on matters before the Executive Board.

Section 2.

- a) Members shall be elected by the Executive Board of Directors.
- b) The Advisory Board shall include no more than thirty (30) members.
- c) The term of office of all members of the Advisory Board shall be three (3) years.
- d) Members shall be eligible for re-election upon the expiration of their respective terms.

Section 3. Meetings - The Advisory Board shall meet at least six (6) times a year.

Section 4. Offices - The Chairman-Elect of the Executive Board shall serve as Chairman of the Advisory Board.

ARTICLE IX

Auxiliary

Section 1. Purpose - The Executive Board shall foster and support an Auxiliary to render such services to the Hospital and their patients as are particularly within the province of such an organization and to assist the Hospital in its relations with the public by conveying to the people of the community information as to the resources of the Hospital available for their health care and the needs and problems of the Hospital in furnishing such care.

Section 2. Organization - The Auxiliary shall be organized in accordance with bylaws adopted by it and approved by the Executive Board. A large and broadly representative membership is to be encouraged.

Section 3. Liaison with Executive Board of Directors - The President of the Auxiliary shall be invited to attend all meetings of the Executive Board and shall be provided an opportunity to report on the affairs of the Auxiliary and to comment upon matters under consideration at the meetings.

ARTICLE X

Amendment

These bylaws may be amended, repealed, or altered in whole or in part by the Executive Board at any regular or at any special meeting where such action has been announced in the notice of such meeting, and after approval by the member of the Hospital of such amendment, repeal, or alteration.

REPORT OF AD HOC COMMITTEE

**to evaluate the medical care rendered by
Physician 392**

formed at the direction of

THE MEDICAL EXECUTIVE COMMITTEE

and appointed by

ALVIN J. CICCONE, M. D.

**REPORT OF AD HOC COMMITTEE FORMED AT THE DIRECTION OF THE
MEDICAL EXECUTIVE COMMITTEE AND APPOINTED BY ALVIN J. CICCONE,
M.D.**

I. GENERAL COMMENTS

The committee's charge was to review available medical records of all patients cared for by Physician 392 while on the Medical Center Hospitals medical staff. The purpose of the review was to evaluate the appropriateness of medical care rendered by that physician and to make a report of those findings to the Departmental Authorities Committee.

A total of 211 medical records were reviewed. Some of those records have been maintained on microfilm. Of those microfilm charts, some are records of patients who otherwise had more current charts maintained in paper folders. No attempt was made to determine and document the numbers of separate charts on the same patients. It is estimated, however, that ten percent of the charts are separate records for the same patients.

Each member of the committee reviewed approximately one third (70) of the charts. Two physicians, each of a different medical specialty, reviewed each chart. The physicians first reviewed the medical records independently and then met to evaluate those charts together. A few charts with special concerns were reviewed by the entire committee. Committee members developed a set of statements regarding each chart during their final review.

The committee offers several preliminary comments. It was noted that the records reviewed represent a population of patients with extremely difficult, complicated problems. Many patients were referred to Physician 392 from distant locales for procedures which required specialized care, thoughtful evaluation, and lengthy procedures. In many cases, the treatment rendered was quite unique.

II. FINDINGS OF THE COMMITTEE

A. Inadequate histories and physicals were noted in 57 charts. Listed in Table I are numbers of charts in which there were no histories and physicals or inadequate histories and physicals. A history and physical was defined as inadequate if the examination, in its brief form, failed to include any of the following components:

1. pertinent physical exam for neurologic deficit recognized,
2. history of previous procedures, and/or previous complications,

3. documentation of the effectiveness or lack of effectiveness of any prior procedures,
4. notation of a preexisting physical problem,
5. detailed history of any preexisting studies performed before the surgical procedure that might have been pertinent to that surgery (9 additional chart numbers at the end of Table I.)

B. Informed consent for surgical procedures was found to be inadequate in forty-five (45) charts. A consent form was defined as inadequate for any of the following reasons:

1. The procedure was different from that for which the consent was given.
2. A consent form was not in the medical record.
3. The consent lacked the physician's signature.
4. The consent form failed to specify the procedure or body part, or named the wrong body part, or more procedures were done than named on the consent.
5. The consent was not witnessed by anyone or the physician signed as a witness.
6. There was no signature by the patient or the guardian on the consent form.
7. The consent was not complete or inappropriately signed.

A list of the relevant chart numbers is found in Table II. It should be noted that the chief surgeon (Physician 392) signed only a bare minority of the operative consents which were found to be appended to patients' charts.

C. There was an absence of notes by the attending physician regarding patients' status, both preoperative and postoperative. Documentation would be acceptable either in the form of a signed note, a co-signed note, or mention of Physician 392 having seen the patient by the individual writing the note. In fact, documentation by Physician 392 was absent in most of the medical records reviewed. Table III is a list of those medical record numbers in which some notes by Physician 392 were present.

Fifty-five incident reports were noted, and for the most part, these were felt to be of minor import. They concerned breaches of operating room rules, such as the failure to wear masks. They also concerned lost needles after prolonged surgery and incomplete sponge counts, which on one occasion proved to be associated with a postoperative wound abscess. (Medical Record No. 231261494)

- D. The most difficult aspect of the committee review dealt with the issue of the appropriateness of surgery. Numbers for thirty-three (33) medical records, together with synopses of the concerns raised, are listed in Table IV. The committee or the reviewing physicians will be available to discuss these questions if desired.
- E. Listed in Table V are the medical record numbers of charts in which there are concerns regarding operative notes. There were five charts in which there was no operative note, and four charts in which the operative note was inadequate. There were also an additional three charts in which the operative notes were not properly signed. There was a lack of documentation of the presence of the attending surgeon in the operating room on five more charts.
- F. In Table VI are listed medical record numbers for five (5) charts in which it was felt that consultation was not appropriately sought.
- G. Table VII is a list of medical record numbers for patients for whom complications were noted during chart review.
- H. Finally, Table VIII contains a list of the medical record numbers of twenty-three (23) patients for which there were concerns regarding the quality of patient care.

III. SUMMARY

In conclusion, your committee has reviewed 211 charts and, after this review, is concerned about the poor documentation of work performed by Physician 392 in this hospital. The committee felt that there were many instances of insufficient documentation for use in making judgments concerning the appropriateness of care. We would, however, be remiss if we did not comment that we greatly missed seeing notes by Physician 392, as his/her writing appears to be legible when it is present. We feel that if he/she had made notes in the chart, not only would we be able to better understand thoughts and concerns he/she had prior to operations, but the proposed procedure to be performed and expected outcomes as well. We realize we are evaluating procedures that have long term expected results, and we recognize that results cannot be documented within the record as it exists at Norfolk General Hospital. The committee also feels, however, that the standard of medical care practiced by Physician 392 is not consistent with that of most other physicians on the Medical Center Hospitals medical staff.

As a committee, we feel that the findings appearing on the subsequent pages should be a part of the information used in evaluating the medical care rendered by Physician 392:

- A. There were many brachial plexis surgeries performed. Many of the procedures are new and often difficult to evaluate in the immediate post operative period. We feel that he/she should present data that documents the effectiveness of this surgery relating to the time of an incident to the time of surgery, and the expected outcome of the surgery and indeed operative results where they can be documented. This type of information will facilitate a better understanding of the surgeries performed at Medical Center Hospitals and Eastern Virginia Medical School.

- B. Likewise, there are procedures performed related to distal extremities concerning nerve functions in circumstances that the committee had difficulty evaluating. The proposed surgery and the expected outcome are not delineated within the record, and consequently, the expected outcome is difficult to evaluate.

- c. Procedures performed for facial paralysis after facial nerve injury fall into the same question area. We would like to see some documentation as to the effectiveness of these procedures in the long term, relating to the age of the patients on which the procedures were performed, and the time from injury to the time of surgery related to the outcome.

- D. The committee also had concerns regarding the reimplantation of severed extremities. Examples are Medical Records Numbers 800115024 and 800091126. Criteria used by Physician 392 for reimplantation seems to differ from that set forth in the literature (references appended).

TABLE I

INADEQUATE/ABSENT HISTORY AND PHYSICAL (57 CHARTS)

3. 230149456 (inadequate history and physical)
4. 010382134 (no documentation upper extremity exam - inadequate physical)
6. 230178710 (probably inadequate history and physical for 6 1/2 hour procedure - no attending signature on history and physical)
7. 442505644 (inadequate documentation of status of prior nerve grafts)
8. 460925788 (3rd admission--no neurologic documentation - inadequate history and physical for 14 hour procedure; 4th admission--no documented history and physical)
9. 270262986 (no neurological exam - inadequate physical)
10. 101501210 (history does not adequately document 1 procedure)
15. 112046818 (inadequate neurological exam)
25. 094544105 (inadequate history and physical on both admissions)
27. 227080174 (4 admissions - 2/4 inadequate history and physicals)
28. 261759838 (inadequate history and physical)
29. 274744361 (inadequate history and physical)
30. 711006692 (inadequate history and physical)
31. 800142499 (inadequate history and physical)
32. 119381066 (inadequate history and physical)
33. 100125424 (history and physical poor and inadequate)
35. 230665237 (substandard - bad - history and physical)
36. 281767651 (history and physical inadequate)
37. 223561003 (history and physical inadequate)
38. 230807133 (history and physical inadequate)
39. 101584391 (history and physical inadequate)
40. 228204672 (history and physical inadequate)
41. 229124283 (no documentation of injury)
42. 229883234 (history and physical inadequate)
43. 242585461 (history and physical inadequate)
45. 338244393 (eventually done by infectious disease consultant)
51. 227505540 (inadequate physical)
54. 229825509 (Adm. #1: no pulses recorded; Adm. #2: no history and physical)
56. 151425469 (inadequate history and physical)
57. 265594537 (physical exam marginal)
68. 800145558 (no history and physical)
70. 142709349 (inadequate)
89. 110540994 (no neurologic exam on chart)
90. 227040291 (no documentation of left arm function)
92. 214713356 (no neurovascular hand exam documented pre-op)
97. 250536760 (physical exam of arms and hand not adequate)
99. 243108102 (neurologic exam not adequate - no documentation lower CN function)

- 132. 236947121 (inadequate history and physical for surgery performed)
- 145. 223769831 (inadequate)
- 146. 261835132 (inadequate)
- 147. 227786333 (history poor - what were previous operations?)
- 149. 010832134 (inadequate physical)
- 158. 224980142 (inadequate physical)
- 164. 235645850 (no physical exam)
- 167. 622890853 (physical exam inadequate)
- 180. 225066176 (poor physical - no pulses recorded)
- 184. 201484292 (inadequate physical - no neurovascular exam for brachial plexus case)
- 186. 223766438 (inadequate physical)
- 187. 223767238 (poor physical - no pulses recorded)
- 198. 237903360 (no documentation of neurologic function in brachial plexus)
- 199. 388308960 (physical exam does not document post cutan n. status)
- 204. 227849864 (physical exam marginal for an inpatient procedure - no M.D. signature)
- 211. 229382277 (etiology of original problem not documented; diagnosis of reflex sympathetic dystrophy not considered; PE does not document status of ulnar nerve function)
- 213. 296287078 (PE does not adequately document nature and extent of injury - 1st admission--no documentation of right arm neurovascular function)
- 216. 213528879 (inadequate exam of affected arm in brachial plexus - injury)
- 220. 041500682 (no detailed neurological exam for brachial plexus case)
- 228. 153344694 (inadequate history and physical)

Inadequate Lab Studies (pertinent pre-existing studies)

- 8. 460925788 (EMG not documented)
- 9. 270262986 (no EMG)
- 41. 229124283 (no outpatient studies on chart)
- 57. 265594537 (EMG's and nerve conduction studies not in chart)
- 94. 261835132 (bilateral brachial plexus injuries not documented by EMG)
- 149. 010832134 (EMG and myelogram "done" but not in chart)
- 211. 229382277 (no EMG or clinical data)
- 220. 041500682 (no patient PTT for myelogram)
- 225. 711006692 (no EMG in chart)

TABLE II

CONCERNS REGARDING CONSENT (45 CHARTS)

Procedure performed different from that for which consent given (3)

- 6. 230178710 (not exactly)
- 35. 230665237 (carpal tunnel release - but cubital tunnel also done - why not documented need for this and no consent)
- 96. 223444525 (permit for Guyon release; carpal tunnel release performed)

Not in chart (5 charts)

- 93. 117013348 (incomplete chart?)
- 200. 230888761
- 203. 228864263
- 209. 218673770
- 213. 296287075 (no consent form, but surgery proceeded anyway - incident report)

No M.D. signature (21 charts)

- 1. 229668735
- 6. 230178710
- 8. 460925788 (orthopedics consent not signed by surgeon - Adm. #2)
- 10. 101501210
- 17. 229826175
- 21. 307429345 (7/18/84 admission)
- 27. 227080174 (Adm. #3 not signed by M.D.)
- 31. 800142499 (inadequately signed)
- 34. 229227805
- 39. 101584391
- 41. 229124283 (also inadequate)
- 86. 149180439
- 91. 190422887
- 98. 227126885 (incomplete)
- 100. 526387701
- 122. 225169112
- 124. 187568514 (also question of consent's adequacy)
- 173. 463397557
- 180. 225066176
- 205. 136502365
- 219. 062621781

Does not specify procedure/body part or names wrong/body part or more procedures done than named on consent (5 charts)

- 74. 230769722 (inadequate - does not say which side; not witnessed)

- 81. 262027059 (inadequate - does not designate which arm injured)
- 89. 110540994 (exact procedure not specified; no M.D. signature)
- 156. 435458038 (vague - 16 hour operation - no mention of grafts)
- 158. 224980142 (vague)

No witness/M.D. signed as witness (6 charts)

- 7. 442505644 (no independent witness)
- 87. 245023800 (incomplete - no witness)
- 88. 167409317 (same individual was witness and counselling M.D.)
- 92. 214713356 (incomplete - same individual signed as counselling M.D. and witness)
- 97. 250536760 (incomplete)
- 211. 229382277 (no witness)

No signature by patient/guardian

- 23. 418156138

Consent not complete

- 11. 223767238 (Adm. #1)

Inadequate (4 charts)

- 24. 050508840
- 29. 274744361
- 57. 265594537 (resection of median nerve with possible nerve graft)
- 70. 142709349 (hospital consent not adequate)

Inappropriately signed

- 25. 094544105 (1st and 2nd admission)

" TABLE III

*392 NOTES/DOCUMENTATION PRESENT (16 CHARTS)

- 6. 230178710 (countersigned operative note)
- 14. 525239120 (signed history and physical)
- 23. 418156138 (pre- and postoperative note)
- 113. 231722506 (signed operative permit)
- 117. 229825509 (10/83 admission - note)
- 118. 229984610 (10/21/83 signed discharge note; 10/21/82 signed history and physical)
- 119. 230178710 (3/83 - history and physical and operative permit signed)
- 123. 570271513 (seen on post operative day #3 by #392)
- 124. 187568514 (dictated and signed operative note)
- 125. 206525016 (signed notes)
- 131. 525239120 (3/83 signed operative note; seen by #392)
- 135. 800111424 (signed operative note)
- 161. 225962394 (signed discharge note and operative note; operative permit acceptable; 2 pre operative notes and 3 post operative notes)
- 185. 231261494 (10/83 signed discharge note; signed operative note)
- 195. 450048153 (3/83 operative permit acceptable; operative note signed x3; 4/84 - signed operative note and discharge note, also attending note present)
- 226. 800098892 (countersigned some progress notes)

TABLE IV

QUESTIONS REGARDING INDICATIONS FOR/APPROPRIATENESS OF SURGERY
(33 CHARTS)

8. 460925788 (Adm. #1: Intercostal transfer - injury 9/82 - probably experimental; result not documented & apparently not achieved; Adm. #2: Tendon transfers suggesting poor functional result. EMG not documented/comparison with preoperative status admission #1 not feasible from chart data. Was patient worse after Procedure #1? Adm. #4: admitted for wrist fusion indicating inadequate result.)
11. 223767238 (Prior procedure ineffective - readmitted for same problem)
24. 050508840 (questionable indications for surgery)
35. 230665237 (no justification given to do cubital tunnel)
40. 228204672 (question appropriateness of operation. 7 operations, including free vascular pedicle graft, for 5th finger tip injury; eventually came to amputation.)
41. 229124283 (no documentation of injury or expected result of surgery; inappropriate operation - 66 year old female with peroneal nerve palsy post excision Bakers cyst.)
54. 229825509 (question appropriateness of operation - Adm. #2)
56. 151425469
60. 231113122 (why was ulnar nerve not repaired?)
70. 142709349 (Was surgery necessary? laceration of radial artery)
74. 230769722 (questions procedures)
85. 238624568 (finger tip necrosed question of relationship to 19 hour delay in surgical treatment/required amputation.)
86. 149180439 (questionable indication for reinnervation procedure in setting of ongoing staph infection.)
88. 167409317 (indications moot in patient 3 mos. post operative for malignant tumor with immunosuppression and minimal disability. Wound infection resulted.)
94. 261835132 (possible myelopathy not considered. Was 2 procedure necessitated by poor 1 procedure? Who did 1 procedure?)
96. 223444525 (no documentation of entrapment syndromes despite multiple lesions and unusual clinical presentation.)
99. 243108102 (questionable indication for crossed facial procedure 4 years post operative)

118. 229984610 (serial and intercostal nerves to reinnervate penis - experimental surgery?)
127. 112046818 (experimental procedure?)
137. 800115024 (question surgical judgement - no preoperative, intraoperative or postoperative note.)
140. 800091126 (question surgical judgement to cover thumb during initial hospitalization.)
147. 227786333 (cannot understand or make sense of operation done; is this an ill-conceived operation?)
149. 010382134 (Inappropriate surgery : Adm. #1: Paralyzed and insensate arm for 8 years prior to operation - doubt arm could ever recover - muscles are good. Adm. #2: Ulnar nerve taken to reconstruct C8-T1 - these are same nerves.)
158. 224980142 (multiple admissions with extensive prolonged surgery for no result.)
167. 622890853 (Is the operation appropriate? T12 paraplegic - bilateral serial nerve graft; femoral cutaneous nerve to dorsal penile nerve.)
184. 201484292 (question appropriateness of procedure. Omentum used to "reinnervate" radiated brachial plexus - radiation therapy for cancer of the breast.)
198. 237903360 (Indication questionable 3 years post injury doing neurotization.)
207. 229544966 (Indications for angiography questionable; inadequate ulnar nerve transposition - later required re-exploration)
209. 218673770 (What were indications for delayed - 18 months - repair of sciatic nerve (gluteal) laceration)
210. 227683577 (Failed, probably injudicious attempt to re-implant a dirty extremity.)
211. 229382277 (Indications: long ulnar repair in 40+ year old patient.)
214. 239721878 (Indications: preganglionic lesions C567 - probably ganglionic C8T1. All lesions pre-ganglionic. Used intercostals - what were therapeutic expectations - not documented in chart.)
215. 429565578 (Questionable indication for burial of distal end of nerve graft for reconstruction of digital nerve in fingertip in 48 year old male.)

TABLE V

CONCERNS REGARDING OPERATIVE NOTES

Absent/Inadequate Operative Note (9 charts)

- 11. 223767238 (Adm. #2)
- 18. 231261494 (no operative note dictated by #392 or residents)
- 31. 800142499
- 35. 230665237 (One-half of op note not dictated - part on cubital tunnel.)
- 72. 286446269 (inadequate operative note)
- 73. 224980142 (Poor documentation of operative note)
- 80. 800140308
- 90. 227040291 (Incomplete operative note)
- 93. 117013348 (Chart incomplete - no operative record or report)

Operative Note Not Properly Signed (3 charts)

- 19. 122264394
- 20. 262300832 (incorrectly signed)
- 25. 094544105 (one operative note not signed properly.)

Absence of #392 in Operating Room During Surgery (5 charts)

- 79. 518661624 (No record of surgeon being present in OR)
- 151. 800111635
- 152. 800116935 (Operations 9/19, 9/21, 9/28, 9/30, 10/4 - #392 listed as surgeon or primary surgeon. Was the physician there? His/her presence is not noted in anesthesia or nursing notes.)
- 155. 800116936 (Listed as surgeon, but was he/she there?)
- 208. 354563567 (Anesthesia record does not document #392's presence.)

TABLE VI

INAPPROPRIATE/INADEQUATE CONSULTATION (5 CHARTS)

- 32. 119381066 (No appropriate use of consultant)
- 54. 229825509 (Adm. #1: No vascular consult or angio; Adm. #2:
No appropriate consultation>)
- 66. 800141437 (Diabetic: 9 1/2 hour operation - never had
medical - i.e., diabetic, consult.)
- 86. 149180439 (Prompt action by consultant prevented major
complications post operatively due to lower
cranial nerve palsies.)
- 95. 228868066 (No Infectious Disease consultation.)

TABLE VII

COMPLICATIONS (15 CHARTS)

- 14. 525239120 (Major procedure - major complications - respiratory insufficiency)
- 17. 229826175 (Loss in flaps resulting in amputation of fingertips)
- 20. 262300832 (Surgery complicated by hypotension (80 mm. of mercury.)
- 22. 307507167 (Hypotension during surgery.)
- 24. 050508840 (Post operative complication : left chest fluid on X ray.)
- 27. 227080174 (Post operative wound infection - thigh abcess.)
- 73. 224980142 (Median nerve palsy, radial lart. lac.)
- 82. 227721011 (Dysrrhymia - wound not closed in ER.)
- 106. 228209308 (Narcotic addiction)
- 137. 800115024 (Coagulopathy & pulmonary edema complications.)
- 140. 800091126 (Subsequent necrosis of thumb; complication of infection, emotional disturbance)
- 198. 237903360 (Complications - seroma of the thigh)
- 214. 239721878 (Post operative complications - leg edema from donor site)
- 219. 062621781 (Complications - increase in blood pressure, infections, & necrosis; required multiple procedures.)
- 223. 223323382 (Sluff graft.)

TABLE VIII

OTHER CONCERNS REGARDING THE QUALITY OF PATIENT CARE (23 CHARTS)

9. 270262986 (Very unusual lesions; neuroma following thoracic outlet syndrome + multiple nerve entrapments)
28. 261759838 (Poor plastics department followup pre- and post operatively)
37. 223561003 (EKG abnormal, but not evaluated)
42. 229883234 (Bili <.1 - not investigated)
50. 091098048 (Cancer of the lung shown by xray - ?missed - no note regarding this finding)
54. 229825509 (Adm. #1: Partial anylosis of ankle; 2 hour tourniquet time - which leg? Operation did not work. Adm. #2: Angiogram not reviewed appropriately preoperatively; one hour anesthesia, but no operation.)
56. 151425469 (Chart is so poor - standard of care cannot be determined.)
57. 265594537 (7 hour operation terminated because of concern regarding "downgrading" arm - making it worse; no note by #392 about this)
70. 142709349 (Difficult to determine surgery from operative note)
72. 286446269 (10 hour operation - patient had one kidney)
78. 800126596 (Surgeon out of OR x2 hours during surgery (1548 -1745 hrs) no surgery progress.)
90. 227040291 (Listed as median nerve palsy - top sheet procedures re ulnar nerve)
92. 214713356 (Incident report documents no MD clearance - patient discharged from SDU with long lasting auxillary blood.)
95. 228868066 (Who was 1 treating MD?)
97. 250536760 (Was this patient a nerve graft failure? Who did 1 reconstruction?)
100. 526387701 (Mask off during surgery - per incident report)
132. 236947121 (No admit note)
136. 800112224 (Surgery by resident - ER)
140. 800091126 (Amputation to right - 23 hour replantation)
167. 622890853 (I&D wound infection post operative day #6 - no culture taken)
199. 388308960 (Operative note states neuroma resected - pathology report does not confirm.)
201. 007380062 (Single cross covering note on complicated patient)
211. 229382277 (s/p multiple procedures. Neuroma 19 cm. gap repaired with multiple interposition grafts.)

3. Report of the Departmental Authorities Committee

REPORT OF THE SPECIAL MEETING
OF THE DEPARTMENTAL AUTHORITIES COMMITTEE
, November 5, 1985

MEMBERS ATTENDING:

Dr. E. Stanley Avery
Dr. Bruce I. Bodner
Dr. David M. Bridges
Dr. Jon L. Crockford
Dr. Anas M. El-Mahdi
Dr. Benjamin P. Eng
Dr. George C. Hoffman
Dr. Edward L. Lilly
Dr. John B. McCraw
Dr. Robert S. Neff
Dr. Jerry O. Penix
Dr. Albert L. Roper, II
Dr. Michael J. Solhaug
Dr. John F. Stecker
Dr. Charles B. Windle
Ms. B. Paige Martin

GUESTS:

Dr. William P. Edmondson, Jr.
Dr. Wladimir T. Liberson
Dr. Hellene Maragh
Dr. Jeffrey Posnick
Physician 392
Mr. Greg Luce

The Departmental Authorities Committee met at 4:00 p.m. on November 5, 1985, at Norfolk General Hospital to afford Physician 392 an opportunity for an informal interview concerning an investigation of his/her medical practice at Medical Center Hospitals. Central to that investigation was the "Report of the Ad Hoc Committee Formed at the Direction of the Medical Executive Committee and appointed by Alvin J. Ciccone, M.D." Other materials incident to an evaluation of Physician 392's practice were also discussed, including chart #136345310.

A total of 211 medical records had been reviewed, summarized for apparent pertinent discrepancies, and submitted to the Departmental Authorities Committee by the ad hoc committee. These cases represented the known cases in which Physician 392 had been involved at Medical Center Hospitals from the time at which he/she was granted privileges until June 1985.

Ample opportunity was provided for Physician 392 and members of the Departmental Authorities Committee to question and discuss the report of the ad hoc committee, as well as any other materials agreed upon. Dr. Edmondson represented the ad hoc committee and Drs. Maragh, Posnick and Liberson assisted Physician 392 in providing responses to the ad hoc committee report.

Findings of the Departmental Authorities Committee

- A. Inadequate Histories and Physicals were noted in a significant number of charts. Specific deficient components were:

1. Pertinent physical examination for neurologic deficit
 2. History of previous procedures, results, and/or complications
 3. Notation of significant pre-existing physical problem
 4. Detailed History of any pre-existing studies or evaluations which might have been significantly pertinent to that particular surgery
- B. Informed consent for surgical procedures was found to be inadequate in a significant number of charts as manifested by:
1. Discrepancies between the procedure performed and the procedure listed on the operative consent
 2. The absence of a consent form in the medical record
 3. Absent physician's signature
 4. Absent witness signature
- C. There was a paucity of notes and/or countersignatures by the attending physician regarding the patients' medical status, both pre-operatively and post-operatively. Many of the cases reviewed were of difficult, complicated problems requiring sophisticated specialty care. In only 16 cases was there documentation in the progress notes that Physician 392 had indeed seen the patient outside of the immediate operative environment, although nursing notes did occasionally document the presence of Physician 392 at the bedside.
- D. ~~Questions were raised as to the appropriateness of surgery~~ in a significant number of cases. Many of these cases were resolved by discussion; however, the lack of pertinent information recorded in the chart made evaluation on this basis virtually impossible in most of the cases cited.
- E. Concerns were raised regarding a number of operative notes which were felt to be:
1. absent
 2. inadequate
 3. incomplete, or
 4. vague concerning the presence of Physician 392, as the surgeon in attendance

- F. Concerns were raised regarding the quality of patient care in a number of charts. The standard of care could not adequately be evaluated in many of these from the material available in the hospital chart. Additional information from Physician 392's private records (which appeared to be voluminous, meticulous, and pertinent) was presented. Several charts contained information suggesting the need for cross-specialty consultation and/or alternative responses to pre-operative laboratory and radiologic findings.

Comments

The entire investigation was severely hampered by the lack of pertinent documentation in the chart. Although daily progress notes by a resident physician or a "Fellow" were present, there was little documented evidence of the continued guidance, approval, and involvement by Physician 392 in the pre- or post-operative handling of extremely complicated patients who had been exposed to lengthy and sophisticated procedures requiring housing in the intensive care unit. Not a few of these patients required sophisticated handling of post-operative problems or return to the operating room for unscheduled secondary procedures in response to post-operative developments. It was not construed by the Departmental Authorities Committee, in the context of this investigation, that these medical problems and complications represent any lack of skill or care, but that the unique nature of the surgical procedures performed in sometimes high risk patients demands a higher level of documented involvement by the attending physician than could be found in the medical record.

Summary

The Departmental Authorities Committee concluded that the pattern of practice of Physician 392 is:

1. Below the standards and aims of the Medical Staff
2. Disruptive to hospital operations
3. Detrimental to patient safety or the delivery of quality patient care.

It was further considered by the Departmental Authorities Committee that Physician 392 has the potential to be a valuable member of the Medical Staff and that strong recommendations for corrective action, rather than punitive action, should be attempted on a trial basis.

Recommendations

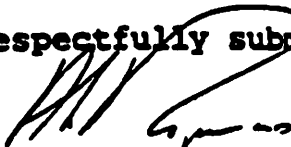
The following motion was duly made, seconded, and unanimously approved for recommendation to the Medical Executive Committee:

- 1) That Physician 392 be placed on indefinite probation.
- 2) That the Departmental Authorities Committee review all charts of Physician 392 at least quarterly, through a committee appointed by the Departmental Authorities Committee.
- 3) That Physician 392 be mandated to maintain medical records to meet without exception the standards of practice of the medical staff and the Bylaws, Rules and Regulations by the inclusion of the following items in each patient hospital record:
 - a. Pertinent History and Physical examinations
 - b. Plan of care
 - c. Indications for surgery
 - d. Complete operative permit
 - e. Operative record
 - f. Progress notes by the physician
 - g. Discharge Summary
 - h. Evidence of continuing physician involvement in patient care by signature or countersignature
 - i. Any other pertinent documentation required or necessary for the care and treatment of the patient
- 4) That appropriate consultation be obtained where medically indicated
- 5) That mandatory preoperative consultations be obtained by Physician 392 from another appropriate member of the Medical Staff, other than one who is a member of the Department of Plastic Surgery.
- 6) That if standards as outlined at Numbers 3, 4, and 5 are not upgraded and constantly maintained to the satisfaction of the Departmental Authorities Committee, then the Departmental Authorities Committee shall recommend to the Medical Executive Committee that further disciplinary action be taken by the Medical Executive Committee or the President of the Medical Staff based upon failure to comply with the

above standards and upon the deficiencies in past practice as documented in this report.

Appended are lists of cases, with comments which were specifically available for review from the ad hoc committee. Comments and rebuttals were made on a case-by-case basis, although case-by-case resolution of every chart was not rendered. Instead, the report summarizes the conclusions of the Departmental Authorities Committee in each category as an overall evaluation of the pattern of practice of Physician 392.

Respectfully submitted,



Albert L. Roper, II, M.D.
Chairman
Departmental Authorities Committee

ALR:BPM:sm

TABLE I

INADEQUATE/ABSENT HISTORY AND PHYSICAL (57 CHARTS)

3. 230149456 (inadequate history and physical)
4. 010382134 (no documentation upper extremity exam - inadequate physical)
6. 230178710 (probably inadequate history and physical for 6 1/2 hour procedure - no attending signature on history and physical)
7. 442505644 (inadequate documentation of status of prior nerve grafts)
8. 460925788 (3rd admission--no neurologic documentation - inadequate history and physical for 14 hour procedure; 4th admission--no documented history and physical)
9. 270262986 (no neurological exam - inadequate physical)
10. 101501210 (history does not adequately document 1 procedure)
15. 112046818 (inadequate neurological exam)
25. 094544105 (inadequate history and physical on both admissions)
27. 227080174 (4 admissions - 2/4 inadequate history and physicals)
28. 261759838 (inadequate history and physical)
29. 274744361 (inadequate history and physical)
30. 711006692 (inadequate history and physical)
31. 800142499 (inadequate history and physical)
32. 119381066 (inadequate history and physical)
33. 100125424 (history and physical poor and inadequate)
35. 230665237 (substandard - bad - history and physical)
36. 281767651 (history and physical inadequate)
37. 223561003 (history and physical inadequate)
38. 230807133 (history and physical inadequate)
39. 101584391 (history and physical inadequate)
40. 228204672 (history and physical inadequate)
41. 229124283 (no documentation of injury)
42. 229883234 (history and physical inadequate)
43. 242585461 (history and physical inadequate)
45. 338244393 (eventually done by infectious disease consultant)
51. 227505540 (inadequate physical)
54. 229825509 (Adm. #1: no pulses recorded; Adm. #2: no history and physical)
56. 151425469 (inadequate history and physical)
57. 265594537 (physical exam marginal)
68. 800145558 (no history and physical)
70. 142709349 (inadequate)
89. 110540994 (no neurologic exam on chart)
90. 227040291 (no documentation of left arm function)
92. 214713356 (no neurovascular hand exam documented pre-op)
97. 250536760 (physical exam of arms and hand not adequate)
99. 243108102 (neurologic exam not adequate - no documentation lower CN function)

- 132. 236947121 (inadequate history and physical for surgery performed)
- 145. 223769831 (inadequate)
- 146. 261835132 (inadequate)
- 147. 227786333 (history poor - what were previous operations?)
- 149. 010832134 (inadequate physical)
- 158. 224980142 (inadequate physical)
- 164. 235645850 (no physical exam)
- 167. 622890853 (physical exam inadequate)
- 180. 225066176 (poor physical - no pulses recorded)
- 184. 201484292 (inadequate physical - no neurovascular exam for brachial plexus case)
- 186. 223766438 (inadequate physical)
- 187. 223767238 (poor physical - no pulses recorded)
- 198. 237903360 (no documentation of neurologic function in brachial plexus)
- 199. 388308960 (physical exam does not document post cutan n. status)
- 204. 227849864 (physical exam marginal for an inpatient procedure - no M.D. signature)
- 211. 229382277 (etiology of original problem not documented; diagnosis of reflex sympathetic dystrophy not considered; PE does not document status of ulnar nerve function)
- 213. 296287078 (PE does not adequately document nature and extent of injury - 1st admission--no documentation of right arm neurovascular function)
- 216. 213528879 (inadequate exam of affected arm in brachial plexus - injury)
- 220. 041500682 (no detailed neurological exam for brachial plexus case)
- 228. 153344694 (inadequate history and physical)

Inadequate Lab Studies (pertinent pre-existing studies)

- 8. 460925788 (EMG not documented)
- 9. 270262986 (no EMG)
- 41. 229124283 (no outpatient studies on chart)
- 57. 265594537 (EMG's and nerve conduction studies not in chart)
- 94. 261835132 (bilateral brachial plexus injuries not documented by EMG)
- 149. 010832134 (EMG and myelogram "done" but not in chart)
- 211. 229382277 (no EMG or clinical data)
- 220. 041500682 (no patient PTT for myelogram)
- 225. 711006692 (no EMG in chart)

TABLE II

CONCERNS REGARDING CONSENT (45 CHARTS)

Procedure performed different from that for which consent given (3)

- 6. 230178710 (not exactly)
- 35. 230665237 (carpal tunnel release - but cubital tunnel also done - why not documented need for this and no consent)
- 96. 223444525 (permit for Guyon release; carpal tunnel release also performed)

Not in chart (3 charts)

- 93. 117013348 (incomplete chart? Where was surgery done?)
- 200. 230888761
- 203. 228864263 (facial laceration required; no note about repair of laceration, may have been done in E.R.)

No M.D. signature (21 charts)

- 1. 229668735 signed 10-20-85 (1984 case)
- 6. 230178710
- 8. 460925788 (orthopedics consent not signed by surgeon - Adm. #2) signed 10-20-85 (surgery May 84)
- 10. 101501210 signed 10-20-85 (August 1984 case)
- 17. 229826175 April 1984 case; signed 10-20-85
- 21. 307429345 (7-18-84 admission) signed 10-20-85
- 27. 227080174 (Adm. #3: not signed by M.D.)
- 31. 800142499 (inadequately signed) copy of op note signed 10-20-85
- 34. 229227805 June 1984 case; signed 10-20-85
- 39. 101584391
- 41. 229124283 (also inadequate) October 1984 case; signed 10-20-85
- 86. 149180439 August 1984 case; signed 10-20-85
- 91. 190422887
- 98. 227126885 (incomplete) August 1984 case; signed 10-20-85
- 100. 526387701
- 122. 225169112
- 124. 187568514 (also question of consent's adequacy)
- 173. 463397557
- 180. 225066176
- 205. 136502365
- 219. 062621781

Does not specify procedure/body part or names wrong/body part or more procedures done than named on consent (5 charts)

- 74. 230769722 (inadequate - does not say which side)
- 81. 262027059 (inadequate - does not designate which arm injured)
- 89. 110540994 (exact procedure not specified; no M.D. signature) signature now; not on copy
- 156. 435458038 (vague - 16 hour operation - no mention of grafts)
- 158. 224980142 (vague)

No witness/M.D. signed as witness (6 charts)

- 7. 442505644 (no independent witness)
- 87. 245023800 (incomplete - no witness) (M.D. was witness)
- 88. 167409317 (same individual was witness and counselling M.D.) no M.D. on consent for CVP line
- 92. 214713356 (incomplete - same individual signed as counselling M.D. and witness)
- 97. 250536760 (M.D. and witness same)
- 211. 229382277 (M.D. signed as witness; no signature in M.D. blank)

Inadequate (4 charts)

- 24. 050508840
- 29. 274744361
- 57. 265594537 (resection of median nerve with possible nerve graft)
- 70. 142709349 (hospital consent not adequate)

Inappropriately signed

- 25. 094544105 1st Admission: Countersigned op note 10-20-85 and consent 10-20-85; no problem found on 2nd (top) admission.

TABLE III

#392 NOTES/DOCUMENTATION PRESENT (16 CHARTS)

- 6. 230178710 (countersigned operative note)
- 14. 525239120 (signed history and physical)
- 23. 418156138 (pre- and postoperative note)
- 113. 231722506 (signed operative permit)
- 117. 229825509 (10/83 admission - note)
- 118. 229984610 (10/21/83 signed discharge note; 10/21/82
signed history and physical)
- 119. 230178710 (3/83 - history and physical and operative
permit signed)
- 123. 570271513 (seen on post operative day #3 by #392)
- 124. 187568514 (dictated and signed operative note)
- 125. 206525016 (signed notes)
- 131. 525239120 (3/83 signed operative note; seen by #392)
- 135. 800111424 (signed operative note)
- 161. 225962394 (signed discharge note and operative note;
operative permit acceptable; 2 pre operative
notes and 3 post operative notes)
- 185. 231261494 (10/83 signed discharge note; signed operative
note)
- 195. 450048153 (3/83 operative permit acceptable; operative
note signed x3; 4/84 - signed operative note and
discharge note, also attending note present)
- 226. 800098892 (countersigned some progress notes)

TABLE IV

QUESTIONS REGARDING INDICATIONS FOR/APPROPRIATENESS OF SURGERY
(32 CHARTS)

8. 460925788 (Adm. #1: Intercostal transfer - injury 9/82 - probably experimental; result not documented & apparently not achieved; Adm. #2: Tendon transfers suggesting poor functional result. EMG not documented/comparison with preoperative status admission #1 not feasible from chart data. Was patient worse after Procedure #1? Adm. #4: admitted for wrist fusion indicating inadequate result.)
11. 223767238 (Prior procedure ineffective - readmitted for same problem)
24. 050508840 (questionable indications for surgery)
35. 230665237 (no justification given to do cubital tunnel)
41. 229124283 (no documentation of injury or expected result of surgery; inappropriate operation - 66 year old female with peroneal nerve palsy post excision Bakers cyst.)
54. 229825509 (question appropriateness of operation - Adm. #2)
56. 151425469
60. 231113122 (why was ulnar nerve not repaired?)
70. 142709349 (Was surgery necessary? laceration of radial artery)
74. 230769722 (questions procedures)
85. 238624568 (finger tip necrosed question of relationship to 19 hour delay in surgical treatment/required amputation.)
86. 149180439 (questionable indication for reinnervation procedure in setting of ongoing staph infection.)
88. 167409317 (indications moot in patient 3 mos. post operative for malignant tumor with immunosuppression and minimal disability. Wound infection resulted.)
94. 261835132 (possible myelopathy not considered. Was 2 procedure necessitated by poor 1 procedure? Who did 1 procedure?)
96. 223444525 (no documentation of entrapment syndromes despite multiple lesions and unusual clinical presentation.)
99. 243106102 (questionable indication for crossed facial procedure 4 years post operative)
118. 229954610 (serial and intercostal nerves to reinnervate penis - experimental surgery?)
127. 112046818 (experimental procedure?)
137. 800115024 (question surgical judgement - no preoperative, intraoperative or postoperative note.)
140. 800051126 (question surgical judgement to cover thumb during initial hospitalization.)
147. 227786333 (cannot understand or make sense of operation - done; is this an ill-conceived operation?)
149. 010382134 (Inappropriate surgery: Adm. #1: Paralyzed and

insensate arm for 8 years prior to operation -
doubt arm could ever recover - muscles are good.
Adm. #2: Ulnar nerve taken to reconstruct C8-T1 -
these are same nerves.)

- 158. 224980142 (multiple admissions with extensive prolonged surgery for no result.)
- 167. 622890853 (Is the operation appropriate? T12 paraplegic - bilateral serial nerve graft; femoral cutaneous nerve to dorsal penile nerve.)
- 184. 201484292 (question appropriateness of procedure. Omentum used to "reinnervate" radiated brachial plexus - radiation therapy for cancer of the breast.)
- 198. 237903360 (Indication questionable 3 years post injury doing neurotization.)
- 207. 229544966 (Indications for angiography questionable; inadequate ulnar nerve transposition - later required re-exploration)
- 209. 218673770 (What were indications for delayed - 18 months - repair of sciatic nerve (gluteal) laceration)
- 210. 227683577 (Failed, probably injudicious attempt to reimplant a dirty extremity.)
- 211. 229382277 (Indications: long ulnar repair in 40+ year old patient.)
- 214. 239721878 (Indications: preganglionic lesions C567 - probably ganglionic C8T1. All lesions preganglionic. Used intercostals - what were therapeutic expectations - not documented in chart.)
- 215. 429563578 (Questionable indication for burial of distal end of nerve graft for reconstruction of digital nerve in fingertip in 48 year old male.)

TABLE V

CONCERNS REGARDING OPERATIVE NOTES

Absent/Inadequate Operative Note (7 charts)

- 11. 223767238 (Adm. #2)
- 31. 800142499
- 35. 230665237 (One-half of op note not dictated - part on cubital tunnel.)
- 72. 286446269 (inadequate operative note)
- 73. 224980142 (Poor documentation of operative note)
- 80. 800140308
- 90. 227040291 (Incomplete operative note)

Operative Note Not Properly Signed (3 charts)

- 19. 122264394
- 20. 262300832 (incorrectly signed)
- 25. 094544105 (one operative note not signed properly.)

Absence of #392 in Operating Room During Surgery (5 charts)

- 79. 518661624 (No record of surgeon being present in OR)
- 151. 800111635
- 152. 800116935 (Operations 9/19, 9/21, 9/28, 9/30, 10/4 - #392 listed as surgeon or primary surgeon. Was the physician there? His/her presence is not noted in anesthesia or nursing notes.)
- 155. 800116936 (Listed as surgeon, but was he/she there?)
- 208. 354563567 (Anesthesia record does not document #392's presence.)

TABLE VI

OTHER CONCERNS REGARDING THE QUALITY OF PATIENT CARE

- 9. 270262986 (Very unusual lesions; neuroma following thoracic outlet syndrome + multiple nerve entrapments)
- 42. 229883234 (Bili <.1 - not investigated)
- 50. 091098048 (Cancer of the lung shown by x-ray - ?missed - no note regarding this finding)
- 54. 229825509 (Adm. #1: Partial anylosis of ankle; 2 hour tourniquet time - which leg? Operation did not work. Adm. #2: Angiogram not reviewed appropriately preoperatively; one hour anesthesia, but no operation.)
- 70. 142709349 (Difficult to determine surgery from operative note)
- 72. 286446269 (10 hour operation - patient had one kidney)
- 92. 214713356 (Incident report documents no MD clearance - patient discharged from SDU with long lasting auxillary blood.)
- 100. 526387701 (Mask off during surgery - per incident report)
- 132. 236947121 (No admit note)
- 167. 622890853 (I&D wound infection post operative day #6 - no culture taken)
- 211. 229382277 (s/p multiple procedures. Neuroma 19 cm. gap repaired with multiple interposition grafts.)

CONCERNS REGARDING QUALITY OF PATIENT CARE DUE TO POOR DOCUMENTATION IN HOSPITAL CHART

- 56. 151425469 (Chart is so poor - standard of care cannot be determined.)
- 57. 265594537 (7 hour operation terminated because of concern regarding "downgrading" arm - making it worse; no note by #392 about this)

ADDITIONAL CHART CONSIDERED

136345310

REPORT OF THE MEDICAL EXECUTIVE COMMITTEE
PHYSICIAN 392

INTRODUCTION

The Medical Executive Committee met on Tuesday, November 19, 1985, and Wednesday, November 20, 1985, to review the report of the Departmental Authorities Committee evaluating the medical practice of Physician 392 at Medical Center Hospitals. Initially, the Medical Executive Committee met with Physician 392 in order to obtain his/her perspective and comments on the issues involved. The committee also interviewed the following physicians who constituted the Ad Hoc Committee to Evaluate the Medical Care Rendered by Physician 392:

Dr. William P. Edmondson, Jr.
Dr. David A. Gilbert
Dr. Frank W. Gwathmey
Dr. George C. Hoffman
Dr. Isabelle Richmond
Dr. Robert S. Neff

The Committee also interviewed four physicians who had participated in the care of certain patients with Physician 392. The medical records of these patients have been of particular concern to the Medical Executive Committee. These physicians were:

Dr. John T. Bowers
Dr. Stanley O. Snyder
Dr. James J. Stark
Dr. Robert Michael Matchett

The Medical Executive Committee also interviewed Dr. Robert Brickman, who provided information regarding the circumstances surrounding Physician 392's knowledge of problems connected with incident reports.

In reaching its findings and recommendations, the Committee considered the comments of Physician 392, the reports of the Ad Hoc Committee and Departmental Authorities Committee, and the comments of other physicians interviewed. A quorum of the Medical Executive Committee was continuously present to hear the statements of Physician 392 and those of other physicians interviewed. A quorum of this Committee voted unanimously to approve the findings and decision to take corrective action as described in this report.

FINDINGS OF THE MEDICAL EXECUTIVE COMMITTEE

- A. Inadequate histories and physicals were noted in a significant number of charts (see Table I). Specific deficient components were:
1. Absence of pertinent medical history and physical examination for neurological deficit;
 2. Absence of history of previous procedures, results, and/or complications;
 3. Absence of notation regarding significant pre-existing medical problem;
 4. Lack of detailed history of any pre-existing studies or evaluations which might have been significantly pertinent to that particular surgery;
 5. Lack of indications for surgery and anticipated results.
- B. Informed consent for surgical procedures was found to be inadequate in a significant number of charts (see Table II) as manifested by:
1. Discrepancies between the procedure performed and the procedure listed on the operative consent;
 2. The absence of a consent form in the medical record;
 3. Absence of physician's signature;
 4. Absence of witness's signature.
- C. There was a paucity of notes and/or countersignatures by the attending physician regarding the patient's medical status, both preoperatively and postoperatively. Many of the cases reviewed were of difficult, complicated problems, requiring sophisticated specialty care. In only 15 cases was there documentation in the progress notes that Physician 392 had indeed seen the patient outside of the immediate operative environment (See Table III.)
- D. In a number of charts, operative notes were either absent, inadequate, or incomplete (See Table IV).
- E. Concerns were raised as to the appropriateness of surgery in a significant number of cases (See Table V). The lack of

pertinent information recorded in the chart made evaluation on this basis virtually impossible in some of the cases cited.

In the following cases, however, sufficient facts were available, either from the hospital chart, statements of Physician 392, or information obtained through interviews with other physicians involved in the care of these patients, to conclude that the decision to proceed with surgery was inappropriate:

<u>Ad Hoc</u> <u>Study Number</u>	<u>Medical Record Number</u>
40	228204672
54	229625509
88	167409317

- F. Concerns were raised regarding the quality of patient care in a number of charts (See Table VI). The standard of care could not adequately be evaluated in some of these from the material available in the hospital chart.

In the following charts, however, there were sufficient facts available, either from the hospital chart, the statements of Physician 392, or information obtained through interviews with other physicians involved in the care of patients which support the conclusion that the care provided is less than the standard of practice in this hospital. Moreover, the following charts contained information showing the need for cross specialty consultation and/or alternative responses to preoperative laboratory and radiologic finding.

<u>Ad Hoc</u> <u>Study Number</u>	<u>Medical Record Number</u>
50	091098048
88	167409317
N.A.	136345310

- G. In the following cases or incident reports, the explanations offered by Physician 392 were not supported and, in some cases, were directly contradicted by other physicians or nurses involved in the cases, incident reports, or the statements of other responsible members of the medical staff:

1. Statements regarding incident reports dated:

4/14/82
2/18/82,,
6/19/82
6/8/82
6/9/82
7/20/82
7/14/83
4/5/84
10/25/84

2. Ad Hoc Study Number 54, Medical Record Number 229825509
3. Ad Hoc Study Number 88, Medical Record Number 167409317
4. Medical Record Number 136345310

CONCLUSIONS

The foregoing findings, support the following conclusions:

1. That the practice of Physician 392 fails to meet the Rules and Regulations of the Medical Staff set forth in Rules No. 13, 14, 16, and 17;
2. That the practice of Physician 392 fails to meet the standard of practice of the Medical Staff; and
3. In his/her appearance in these proceedings, serious questions were raised as to the veracity of Physician 392's statements.

These conclusions support corrective action under the Bylaws, Section IX.A., because the conduct of Physician 392 has been determined to be:

1. Detrimental to patient safety or the delivery of quality patient care;
2. Disruptive to hospital operations; and
3. Below the standards of the Medical Staff. //

CORRECTIVE ACTION

The decision to impose corrective action is as follows:

1. That all of Physician 392's clinical privileges be suspended for a period of thirty (30) days, during which time unaltered patient records from Physician 392's personal files shall be appended, with the date of attachment, to the hospital chart by Medical Records personnel so that the records are complete and conform to the Rules and Regulations of the hospital

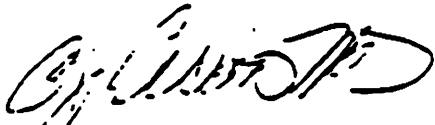
Contingent on the above requirements being met to the satisfaction of the Departmental Authorities Committee within the period of suspension, clinical privileges will be reinstated without reapplication at the end of thirty (30) days.

2. Upon completion of the period of suspension, that Physician 392 be placed on probation for a period of one (1) year
3. That the Departmental Authorities Committee review all charts of Physician 392 at least quarterly, through a committee appointed by the Departmental Authorities

Committee.

4. That Physician 392 be mandated to maintain Medical Records to meet without exception the standards of practice of the Medical Staff and the Bylaws and Rules and Regulations through the inclusion of the following items in each patient's hospital record:
 - a. Pertinent history and physical examination
 - b. Plan of care
 - c. Indications for surgery
 - d. Complete operative permit
 - e. Operative record
 - f. Progress notes by the physician
 - g. Discharge summary
 - h. Evidence of continuing physician involvement in patient care by signature or countersignature
 - i. Any other pertinent documentation required and necessary for the care and treatment of patients
5. That a timely consultation be obtained from a member of the Medical Staff with privileges in one of the following areas: Medicine, Vascular Surgery, Neurology/Neurosurgery, Plastic Surgery, and Orthopedics, when appropriate.
6. That if the terms of probation outlined above are not constantly maintained to the satisfaction of the Medical Executive Committee, then the Medical Executive Committee shall recommend further disciplinary action be taken.

Respectfully submitted,



Alvin G. Ciscone, M. D.
President of the Medical Staff

AJC/EPK:alm

TABLE I

INADEQUATE/ABSENT HISTORY AND PHYSICAL OR DOCUMENTATION OF PRIOR STUDIES (55 CHARTS)

<u>Ad Hoc Study Number</u>	<u>Medical Record Number</u>	<u>Comments</u>
6.	230178710	(probably inadequate history and physical for 4 1/2 hour procedure - no attending signature on history and physical) (10-10-84, no eye exam)
7.	442505644	(inadequate documentation of status of prior nerve grafts, aims of surgery; "EENT exam normal," 10 hour surgery)
8.	460925788	(3rd admission--no neurologic documentation - inadequate history and physical for 14 hour procedure; 4th admission--no documented history and physical) (EMG not documented)
9.	270262986	(no neurological exam - inadequate physical, no EMG, which hand? Surgery cancelled by pulmonary consultant)
10.	101501210	(history does not adequately document 1st procedure-inadequate)
15.	112046818	(inadequate neurological exam)
25.	094544105	(inadequate history and physical on both admissions)
27.	227080174	(4 admissions - 2/4 inadequate history and physicals)
28.	261759838	(inadequate history and physical)
29.	274744361	(inadequate history and physical)
30.	711006692	(inadequate history and physical)
31.	800142499	(inadequate history and physical)
32.	119381066	(inadequate history and physical)
33.	100125424	(history and physical poor and inadequate)
35.	230665237	(substandard - bad - history and physical)
36.	261767651	(history and physical inadequate)
37.	223561003	(history and physical inadequate)
38.	230807133	(history and physical inadequate)
39.	101584391	(history and physical inadequate)
40.	228204672	(history and physical inadequate)
41.	229124283	(no documentation of injury) (no outpatient studies on chart)
42.	229883234	(history and physical inadequate)
43.	242585461	(history and physical inadequate)
45.	338244393	(eventually done by infectious disease consultant)
51.	227505540	(inadequate physical)
54.	229825509	(Adm. #1: no pulse recorded; Adm. #2: no history and physical)
56.	251425469	(inadequate history and physical)
57.	265594537	(physical exam marginal) (EMGs and nerve conduction studies not on chart)

68. 800145558 (no history and physical)
70. 142709349 (inadequate)
89. 110540994 (no neurologic exam on chart)
92. 214713356 (no neurovascular hand exam documented pre-op)
94. 261835132 (bilateral brachial plexus injuries not documented by EMG)
97. 250536760 (physical exam of arms and hand not adequate, inadequate neurological exam)
99. 243108102 (neurologic exam not adequate - no documentation lower CN function)
132. 236947121 (inadequate history and physical for surgery performed)
145. 223769831 (inadequate; transfer note: not a complete H&P)
146. - 261835132 (inadequate)
147. 227786333 (history poor - what were previous operations?)
149. 010832134 (inadequate physical; checklist H&P for major reconstruction) (EMG and myelogram "done" but not in chart)
158. 224980142 (inadequate physical; checklist H&P)
164. 235645850 (no physical exam-describes injury, but no other physical)
167. 622890853 (physical exam inadequate; checklist H&P)
180. 225066176 (poor physical - no pulses recorded)
184. 201484292 (inadequate physical - no neurovascular exam for brachial plexus case; poor description of deficits)
187. 223767238 (poor physical - no pulses recorded)
198. 237903360 (no documentation of neurologic function in brachial plexus)
199. 358308960 (physical exam does not document post cutan n. status)
204. 227849864 (physical exam marginal for an inpatient procedure - no M.D. signature)
211. 229362277 (etiology of original problem not documented; diagnosis of reflex sympathetic dystrophy not considered; PE does not document status of ulnar nerve function) (no EMG or clinical data)
213. 296287073 (PE does not adequately document nature and extent of injury - 1st admission--no documentation of right arm neurovascular function)
216. 213528679 (inadequate exam of affected arm in brachial plexus - injury; no neurological exam or consult)
220. 241500682 (no detailed neurological exam for brachial plexus case) (no patient PTT for myelogram)
225. 711006692 (no EMG in chart; 12 hour operation; no record of post-op. visits by Physician 392)
228. - 253344694 (inadequate history and physical on patient with history of reticulum cell sarcoma - expected result?)

TABLE II

CONCERNS REGARDING CONSENT (44 CITES)

Procedure performed different from that for which consent given
(2 charts)

<u>Ad Hoc</u> <u>Study</u> <u>Number</u>	<u>Medical</u> <u>Record</u> <u>Number</u>	<u>Comments</u>
35.	230665237	(carpal tunnel release - but cubital tunnel also done - why not documented need for this and no consent)
96.	223444525	(permit for Guyon release; carpal tunnel release also performed)

Not in chart (2 charts)

<u>Ad Hoc</u> <u>Study</u> <u>Number</u>	<u>Medical</u> <u>Record</u> <u>Number</u>	<u>Comments</u>
93.	217013348	(incomplete chart? Where was surgery done?)
200.	230888761	

No M.D. signature (21 charts)

<u>Ad Hoc</u> <u>Study</u> <u>Number</u>	<u>Medical</u> <u>Record</u> <u>Number</u>	<u>Comments</u>
1.	229668735	signed 10-20-85 (1984 case)
8.	460925788	(orthopedics consent not signed by surgeon - Adm. #2) signed 10-20-85 (surgery May 84)
10.	201501210	signed 10-20-85 (August 1984 case)
17.	229826175	signed 10-20-85; insertion of CVP and A-line and neurovascular free flap left toe to third finger
21.	307429345	(7-18-84 admission) signed 10-20-85
27.	227080174	(Adm. #3: not signed by M.D.)
31.	800142499	(inadequately signed) copy of op note signed 10-20-85)
34.	229227805	June 1984 case; signed 10-20-85
39.	201584391	
41.	229124283	(also inadequate) October 1984 case; signed 10-20-85
72.	286446269	(No M.D. signature)
86.	249180439	August 1984 case; signed 10-20-85
91.	290422867	(signed 10-20-85)
96.	223444525	(Adm. #1: no M.D. signature)
96.	227126885	(incomplete) August 1984 case; signed 10-20-85
100.	326387701	(phone consent 6/11/85; no M.D. signature)

160. 225066176
205. 136502365

Does not specify procedure/body part or names wrong/body part or more procedures done than named on consent (6 charts)

<u>Ad Hoc Study Number</u>	<u>Medical Record Number</u>	<u>Comments</u>
41.	229124283	(inadequate consent - which side?)
57.	265594537	(which side)
74.	230769722	(inadequate - does not say which side)
81.	262027059	(inadequate - does not designate which arm injured)
89.	110540994	(exact procedure not specified; no M.D. signature) signature now; not on copy
156.	224980142	(vague)

No witness/M.D. signed as witness (9 charts)

<u>Ad Hoc Study Number</u>	<u>Medical Record Number</u>	<u>Comments</u>
7.	442505644	(no independent witness)
20.	262300832	(M.D. signed as witness)
57.	265594537	(M.D. signed as witness)
87.	245023800	(incomplete - no witness) (M.D. was witness)
88.	167409317	(same individual was witness and counselling M.D.) no M.D. on consent for CVP line
92.	214713356	(incomplete - same individual signed as counselling M.D. and witness)
96.	223444525	(Adm. #2 and Adm. #3: M.D. signed as witness)
97.	230536760	(M.D. and witness same)
211.	229362277	(M.D. signed as witness; no signature in M.D. blank)

Inadequate (4 charts)

<u>Ad Hoc Study Number</u>	<u>Medical Record Number</u>	<u>Comments</u>
24.	030508840	M.D. same as witness
29.	274744361	only Plas. Spec. consent; no M.D. signature on form
57.	265594537	(resection of median nerve with possible nerve graft)
70.	142709349	(<u>hospital</u> consent not adequate) see no M.D. signature

Inappropriately signed (1 chart)

<u>Ad Hoc</u> <u>Study</u> <u>Number</u>	<u>Medical</u> <u>Record</u> <u>Number</u>	<u>Comments</u>
25.	094544105	1st Admission: Countersigned op note 10-20-85 and consent 10-20-85; no problem found on 2nd (top) admission

TABLE III

#392 NOTES/DOCUMENTATION PRESENT (15 CHARTS)

<u>Ad Hoc</u> <u>Study</u> <u>Number</u>	<u>Medical</u> <u>Record</u> <u>Number</u>	<u>Comments</u>
6.	230178710	(countersigned operative note)
14.	525239120	(signed history and physical)
113.	231722506	(signed operative permit)
117.	229625509	(10/83 admission - note)
118.	229984610	(10/21/83 signed discharge note; 10/21/82 signed history and physical; signed op note)
119.	230178710	(3/83 - history and physical and operative permit signed)
123.	570271513	(seen on post operative day #3 by #392)
124.	187568514	(dictated and signed operative note)
125.	206525016	(signed notes)
131.	525239120	(3/83 signed operative note; seen by #392)
135.	800111424	(signed operative note)
161.	225962394	(signed discharge note and operative note; operative permit acceptable; 2 preoperative notes and 3 postoperative note)
185.	231261494	(10/83 signed discharge note; signed operative note)
195.	450048153	(3/83 operative permit acceptable; operative note signed x 3; 4/84 - signed operative note and discharge note, also attending note present)
226.	800098892	(countersigned some progress notes; none from 7-16 through 8-6 when patient transferred to CHKD. Surgery 7-28, 8-6)

BEFORE THE MEDICAL EXECUTIVE COMMITTEE
OF MEDICAL CENTER HOSPITALS

REPORT OF THE AD HOC HEARING COMMITTEE
REGARDING PHYSICIAN 392

Introduction

In accordance with Article X of the Bylaws Rules and Regulations of the Medical Staff of Medical Center Hospitals ("Bylaws") an Ad Hoc Hearing Committee ("Hearing Committee") was appointed upon receipt of a request by Physician 392 for a hearing to review the decision of the Medical Executive Committee dated November 22, 1985 (the "Decision"). The Hearing Committee Chairman was Dr. J. Parker Cross. Other members of the Committee were: Dr. Patrick Devine; Dr. Arthur S. Kaplan; Dr. Howard I. Kruger; Dr. Willette LeHew; Dr. Jock R. Wheeler; and, Dr. George Grinnan. Gregory M. Luce served as legal counsel to the Hearing Committee.

I. Procedural Summary

A pre-hearing conference was called by Dr. Cross, and attended by counsel for Physician 392, counsel for the MEC and counsel to the Committee on January 22, 1986 at 2:30 p.m. The hearing was held by the Committee in accordance with the Bylaws on January 27, January 28 and January 29, 1986 and transcribed by certified court reporter.

In accordance by the Bylaws, Dr. George C. Hoffman was designated to represent the Medical Executive Committee during

the hearing. Dr. Hoffman was assisted by legal counsel, John R. Franklin. Physician, 392 appeared in person and was assisted by her legal counsel, Thomas J. Harlan, Jr.. Each of the participants was permitted to have a consulting physician present to assist in the presentation of the case. Present on behalf of the Medical Executive Committee was Dr. Alvin J. Ciccone, and present on behalf of Physician 392 was Dr. Charles Horton.

In addition to the evidence in the record of these proceedings identified in the Pre-hearing Conference Report, including the materials developed by the Ad Hoc Review Committee, the Departmental Authorities Committee and the Medical Executive Committee, the Hearing Committee also accepted as evidence testimony from the following individuals on behalf of the Medical Executive Committee: Dr. George C. Hoffman; Dr. Stanley Snyder; Dr. Frank Gwathmey; Dr. James Stark; and Dr. Isabelle Richmond.

Testimony on behalf of Physician 392, was accepted from the following: Dr. Hellene Maragh; Dr. Robert Michael Matchett; Dr. Robert D. Brickman; and Dr. Charles Horton. Physician 392 also testified in her own behalf. Counsel for Physician 392 requested postponement of the proceedings to permit the attendance and testimony by Dr. Ron Levine and Dr. Liberson. After considering the purpose and anticipated testimony of Dr. Levine and Dr. Liberson as described by counsel for Physician 392, the Committee

concluded that the presence of those physicians as witnesses was not necessary to its deliberation nor to the fair consideration of the case presented on behalf of Physician 392, and that the presence of Dr. Levine could have been secured through proper scheduling.

Following the close of the hearing session on the evening of January 28, 1986, the Committee deliberated in executive session. In order to assure a timely and fair review of the Decision of the MEC, in order to avoid repetitive or redundant proofs, testimony or evidence, and in order to afford all participants in the hearing a reasonable opportunity to present relevant oral and documentary evidence, the Committee decided upon the following course of procedure for the hearing to be held January 29, 1986. Physician 392 would be permitted to make a summary presentation for thirty minutes duration, followed by questions from the Committee. Neither cross-examination of Physician 392, nor introduction of rebuttal testimony or evidence by the Medical Executive Committee representative would be permitted. Following questions by the Hearing Committee of Physician 392, closing argument by counsel for the MEC and counsel for Physician 392, in that order, would be permitted. Thereafter, the Hearing Committee would adjourn the hearing and deliberate on its Recommendation.

Legal counsel' for the participants were advised of the foregoing procedure by late morning on January 29, 1986. Legal counsel for each of the participants noted written objections to this procedure, which objections were considered by the Hearing Committee and were overruled. The Hearing Committee considered there would be sufficient information in the record at the close of the hearing to support its Recommendation to the MEC on the basis of those studies reviewed during the hearing.

On the final day of the hearing, the Hearing Committee considered a summary statement of Physician 392 and closing arguments of counsel for the Medical Executive Committee and for Physician 392. The Hearing Committee then adjourned the hearing and convened for deliberation in executive session.

Each member of the Hearing Committee was present at all times during the course of hearing, and during the Committee's deliberations, except for brief individual absences as permitted by the Chairman to allow the respective physician to attend to personal matters. Similarly, Dr. Terzis and her counsel were present at all times during the course of the hearing.

This report is tendered to the Medical Executive Committee in accordance with the Bylaws, and upon the unanimous vote of each of the members of the Hearing Committee. Enclosed herewith

as part of the hearing record are all exhibits offered by the participants. The Hearing Committee accepted into evidence all exhibits offered except a document submitted by counsel for Physician 392 purporting to be a transcript of the prior Medical Executive Committee proceedings. This document was neither accepted nor considered, and is inherently unreliable for lack of any designated author and may constitute a breach of confidentiality of Medical Executive Committee proceedings. Accordingly, it will not be part of the record of these proceedings.

II. Scope of Review

In accordance with Article X of the Bylaws and in compliance therewith, the Hearing Committee conducted a hearing to consider Physician 392's challenge to the Decision of the Medical Executive Committee. The Committee reviewed the Decision of the Medical Executive Committee and the evidence in the record to determine whether Physician 392 had made an appropriate showing that the charges or grounds of the Decision lack any factual basis or that such basis or any action based thereon is either arbitrary, unreasonable or capricious.

III. Recommendation

Based on the substantial factual evidence in the record, the Recommendation of the Hearing Committee with respect to the

Decision of the Medical Executive Committee dated November 22, 1985 is as follows:

Findings of the Medical Executive Committee

With respect to the Findings of the Medical Executive Committee, the Committee recommends that the Findings A, B and D be accepted as stated.

With respect to Finding C the Committee accepts that finding pertinent to the requirements imposed by Regulation 13 of the Bylaws. The Committee notes that Regulation 13, however, does not expressly require the attending physician to personally sign or countersign the medical record.

With respect to Finding E, the Committee considered only the evidence regarding Ad Hoc Study Nos. 40, 54 and 88. With respect to Study No. 40, the Committee considered there to be sufficient facts to conclude that proceeding with surgery and surgery itself were appropriate. With respect to Study No. 54, the Committee concluded that cancellation of surgery was appropriate, but noted that a timely consultation would have averted unnecessary anesthesia in this instance. With respect to Study No. 88, the Committee concluded that the surgery in this instance was inappropriate, that a timely and proper consultation was necessary, and further notes that Physician 392 made the decision

to proceed with surgery even after being advised of medical contraindications to surgery.

With respect to Finding F, the Committee considered Study Nos. 55, 88 and Medical Record No. 136345310 (hereafter designated Study No. 233), and concluded that in each instance it was inappropriate to proceed with surgery. Based on these cases alone, the Committee considered there to be adequate facts to support the findings of Paragraph F of the Decision, and determined that these cases were representative of the findings and concerns expressed by the Medical Executive Committee in its Decision.

With respect to Finding G, Physician 392 admitted the activity described in the incident reports designated at Finding G.1.. The Hearing Committee notes that Physician 392 stated that these practices have been corrected or resolved. No decision was reached by the Committee as to the veracity of Physician 392's statements to the MEC regarding these incident reports. With respect to Findings G.2., G.3. and G.4., the Committee considered each of the Studies addressed therein and concurs with the Findings of the Medical Executive Committee in each case.

Conclusions of the Medical Executive Committee

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Based upon a review of the Findings set forth above, the Committee considered the Conclusions reached by the Medical Executive Committee in its Decision and recommends acceptance of Conclusion 1.

With respect to Conclusion 2, the Committee recommends adoption of the following:

2.a) In the medical recordkeeping practices of Physician 392, that physician has failed to meet the standard of practice of this medical staff.

2.b) In Study Nos. 50, 88 and 233, the practice of Physician 392 was demonstrated by the evidence in the record of errors in clinical judgement to be below the standard of practice of the medical staff.

With respect to Conclusion 3, the Committee concurs with the Medical Executive Committee and finds that in the appearance of Physician 392 in prior proceedings, and in proceedings of the Hearing Committee, serious questions have been raised as to the veracity of Physician 392. (To this conclusion, two members of the Hearing Committee note their exception.)

The Committee also recommends and concurs with the Medical Executive Committee that the foregoing conclusions support corrective action under the Bylaws. The Committee determines that these conclusions support corrective action under the Bylaws Section IX.A., because the conduct of Physician 392 has been determined to be:

a) detrimental to the patient's safety or to the delivery of quality patient care;

b) disruptive to hospital operations; and,

c) below the standards of the medical staff in maintaining adequate medical records and in the clinical judgment exercised in Study Nos. 50, 88 and 233.

IV. Corrective Action by the Medical Executive Committee

With respect to the corrective action to be taken in this matter the Hearing Committee recommends as follows:

1) That within a period of 30 days of the effective date of a final decision, unaltered patient records from Physician 392's personal files shall be appended to the appropriate hospital charts with the dates of attachment noted by medical records personnel, and that the charts be otherwise attended, so that the hospital records are complete and conform to the rules and regulations; and, that Physician 392 shall demonstrate to the satisfaction of the Medical Executive Committee compliance with

the requirements of this paragraph within the time allotted.

“

2) That Physician 392 be placed on probation for a period of one year, during which time there shall be concurrent review of all medical records and practice patterns of Physician 392 to ascertain inclusion of the following items in each patient's hospital records:

- a) pertinent history and physical examination;
- b) plan of care;
- c) indications for surgery;
- d) complete operative permit;
- e) complete operative record;
- f) progress notes signed by Physician 392;
- g) discharge summary signed by Physician 392;
- h) evidence of continuing involvement of Physician 392 in patient care by signature or countersignature of Physician 392 in the hospital record;
- i) inclusion of any other pertinent documentation required and necessary for the care and treatment of patient.

3) That Physician 392 obtain appropriate and timely consultations from a member of the medical staff when indicated.

4) That Physician 392, within 30 days of the effective date of a final decision, be given two hours of instruction by the medical record librarian in hospital record keeping, and two hours

hours of pertinent basic operating room protocol instruction by the Operating Room Management Committee; and, that records of such completed instruction be forwarded to the Medical Executive Committee.

5) That in consideration of the Findings and Conclusions set forth above, upon a determination by the Medical Executive Committee that any of the terms of probation set forth herein have not been met by Physician 392, such determination shall be grounds for suspension of the medical staff privileges of Physician 392. Suspension of medical staff privileges shall be imposed for such breach of any one or more of the terms of probation without further recourse to the procedures of Article X of the Bylaws, upon acceptance by the Board of Directors of a recommendation for suspension by the Medical Executive Committee.

Respectfully submitted on behalf of Ad
Hoc Hearing Committee,



J. Parker Cross, M. D.

Chairman

Dated: January 31, 1986

BEFORE THE MEDICAL EXECUTIVE COMMITTEE
OF MEDICAL CENTER HOSPITALS

Decision of the
Medical Executive Committee
Regarding Physician 392

At its regularly scheduled meeting of February 3, 1986, the Medical Executive Committee considered the Report and Recommendation of the Ad Hoc Hearing Committee ["Hearing Committee"] regarding Physician 392. A copy of that Report is attached hereto and incorporated by reference herein.

The Hearing Committee was appointed to consider this matter at the request of Physician 392 following an initial decision of the Medical Executive Committee dated November 22, 1985. In accordance with the Bylaws, Rules and Regulations of the Medical Staff of Medical Center Hospitals [the "Bylaws"], the Medical Executive Committee has considered the Hearing Committee's Report and Recommendation, and the record of the proceedings, including all exhibits introduced at the hearing.

Based upon its review of the foregoing, the Medical Executive Committee, by unanimous vote, accepts the Findings and Conclusions of the Report and Recommendation of the Hearing Committees for the reasons set forth therein. The Medical Executive Committee, by unanimous vote, modifies the Corrective Action recommended by the Hearing Committee.

The final Findings, Conclusions and Corrective Action of the Medical Executive, Committee are set forth below.

FINDINGS OF THE MEDICAL EXECUTIVE COMMITTEE

- A. Inadequate histories and physicals were noted in a significant number of charts (see Table I). Specific deficient components were:
1. Absence of pertinent medical history and physical examination for neurological deficit;
 2. Absence of history of previous procedures, results, and/or complications;
 3. Absence of notation regarding significant pre-existing medical problem;
 4. Lack of detailed history of any pre-existing studies or evaluations which might have been significantly pertinent to that particular surgery; and
 5. Lack of indications for surgery and anticipated results.

- B. Informed consent for surgical procedures was found to be inadequate in a significant number of charts (see Table II) as manifested by:
1. Discrepancies between the procedure performed and the procedure listed on the operative consent;
 2. The absence of a consent form in the medical record;
 3. Absence of physician's signature; and
 4. Absence of witness's signature.
- C. There was a paucity of notes and/or countersignatures by the attending physician regarding the patient's medical status, both preoperatively and postoperatively. Many of the cases reviewed were of difficult, complicated problems, requiring sophisticated specialty care. In only 15 cases was there documentation in the progress notes that Physician 392 had indeed seen the patient outside of the immediate operative environment (See Table III.) The Committee notes that Regulation 13 of the Bylaws, however, does not expressly require the attending physician to personally sign or countersign the medical record.

- D. In a number of charts, operative notes were either absent, inadequate, or incomplete (See Table IV).
- E. Concerns were raised as to the appropriateness of surgery in Ad Hoc Study Nos. 40, 54, and 88. The Committee considered only the evidence regarding Ad Hoc Study Nos. 40, 54 and 88. With respect to Study No. 40, the Committee considered there to be sufficient facts to conclude that proceeding with surgery and surgery itself were appropriate. With respect to Study No. 54, the Committee concluded that the cancellation of surgery by Physician 392 was appropriate, but noted that a timely consultation would have averted unnecessary anesthesia in this instance. With respect to Study No. 88, the Committee concluded that the surgery in this instance was inappropriate, that a timely and proper consultation was necessary, and further notes that Physician 392 made the decision to proceed with surgery even after being advised of medical contraindications to surgery.
- F. Concerns were raised regarding the quality of patient care in the three charts. There were sufficient facts available regarding the charts designated below to support the conclusion that the care provided was less than the standard of practice in this hospital. Moreover, these charts contained information showing the need for cross-specialty consultation or alternative responses to preoperative laboratory

and radiologic findings. The Committee finds that in each of the following cases it was inappropriate to proceed with surgery:

1. Ad Hoc Study Number 50,
2. Ad Hoc Study Number 88,
3. Ad Hoc Study Number 233.

G. In the following cases, the explanations offered by Physician 392 were not supported and, in some cases, were directly contradicted by other physicians or records involved in the cases or by the statements of other responsible members of the Medical Staff:

- 1 Ad Hoc Study Number 54,
2. Ad Hoc Study Number 88,
3. Ad Hoc Study Number 233.

Conclusion of the Medical Executive Committee

”

The foregoing Findings support the following conclusions:

1. That the practice of Physician 392 fails to meet the Rules and Regulations of the Medical Staff set forth in Rules No. 13, 14, 16, and 17;
- 2.a) That in the medical recordkeeping practices of Physician 392, that physician has failed to meet the standard of practice of this medical staff.
- 2.b) That in Study Nos. 50, 88 and 233, the practice of Physician 392 was demonstrated to be below standard of practice of the Medical Staff by the evidence in the record of errors in clinical judgment.
3. That in the appearance and statements by Physician 392 in prior proceedings, and in proceedings of the Hearing Committee, serious questions have been raised as to the veracity of Physician 392.

The foregoing Conclusions support corrective action under the Bylaws. The Committee determines that these Conclusions

support corrective action under the Bylaws Section IX.A. because the conduct of Physician 392 has been determined to be:

- a) detrimental to the patient's safety or to the delivery of quality patient care;
- b) disruptive to hospital operations; and,
- c) below the standards of the Medical Staff in maintaining adequate medical records and in the clinical judgment exercised in Study Nos. 50, 88 and 233.

Corrective Action

Based on the foregoing Findings and Conclusions of the Committee, the following Corrective Action is imposed:

- 1) That for a period of 30 days from the effective date of a final decision, the Medical Staff privileges of Physician 392 be suspended, during which time unaltered patient records from Physician 392's personal files shall be appended to the appropriate hospital charts with the dates of attachment noted by medical records personnel, and that the charts be otherwise attended so that the hospital records are complete and conform to the rules and regulations; and, that Physician 392 shall demonstrate to

the satisfaction of the Medical Executive Committee compliance with the requirements of this paragraph within the time allotted.

2) That following satisfactory completion of the foregoing period of suspension, Physician 392 be placed on probation for a period of one year, during which time there shall be concurrent review of all medical records and practice patterns of Physician 392 to ascertain inclusion by Physician 392 of the following items in each patient's hospital records:

- a) pertinent history and physical examination;
- b) plan of care and expected outcome;
- c) indications for surgery;
- d) complete operative permit;
- e) complete operative record;
- f) progress notes signed by Physician 392;
- g) discharge summary signed by Physician 392;
- h) evidence of continuing involvement of Physician 392 in patient care by notes and signature or countersignature of Physician 392 in the hospital record; and
- i) inclusion of any other pertinent documentation required and necessary for the care and treatment of patient.

3) That Physician 392 obtain appropriate and timely consultations from a member of the Medical Staff when indicated.

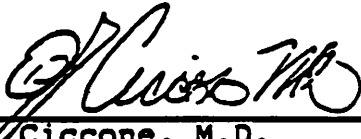
4) That within 30 days of the effective date of a final decision, Physician 392 be given two hours of instruction by the medical record librarian in hospital record keeping, and two hours of pertinent basic operating room protocol instruction by the Operating Room Management committee; and, that records of such completed instruction be forwarded to the Medical Executive Committee.

5) That in consideration of the Findings and Conclusions set forth above, upon a determination by the Medical Executive Committee that any of the terms of suspension or probation set forth herein have not been met by Physician 392, such determination shall be grounds for suspension of the Medical Staff privileges of Physician 392. Suspension of Medical Staff privileges shall be imposed for such breach of any one or more of the terms of suspension or probation without further recourse to the procedures of Article X of the Bylaws, upon acceptance by the Board of Directors of a recommendation for suspension by the Medical Executive Committee.

The effective date of a final decision shall be as determined by reference to Article X.F.2 and Article X.G.

In accordance with the Bylaws a copy of this Decision shall be delivered to Physician 392, to her counsel, and to the President of Medical Center Hospitals.

Medical Executive Committee
of Medical Center Hospitals

By 
Alvin J. Ciccone, M.D.
President of the Medical Staff

Date: 7 Feb 1986

0206b/gml14

TABLE I

INADEQUATE/ABSENT HISTORY AND PHYSICAL OR DOCUMENTATION OF PRIOR STUDIES (55 CHARTS)

<u>Ad Hoc Study Number</u>	<u>Medical Record Number</u>	<u>Comments</u>
6.	230178710	(probably inadequate history and physical for 4 1/2 hour procedure - no attending signature on history and physical) (10-10-84, no eye exam)
7.	442505644	(inadequate documentation of status of prior nerve grafts, aims of surgery; "EENT exam normal," 10 hour surgery)
8.	460925788	(3rd admission--no neurologic documentation - inadequate history and physical for 14 hour procedure; 4th admission--no documented history and physical) (EMG not documented)
9.	270262986	(no neurological exam - inadequate physical, no EMG, which hand? Surgery cancelled by pulmonary consultant)
10.	101501210	(history does not adequately document 1st procedure-inadequate)
15.	112046818	(inadequate neurological exam)
25.	094544105	(inadequate history and physical on both admissions)
27.	227080174	(4 admissions - 2/4 inadequate history and physicals)
28.	261759838	(inadequate history and physical)
29.	274744361	(inadequate history and physical)
30.	711006692	(inadequate history and physical)
31.	800142499	(inadequate history and physical)
32.	119381066	(inadequate history and physical)
33.	100125424	(history and physical poor and inadequate)
35.	230665237	(substandard - bad - history and physical)
36.	281767651	(history and physical inadequate)
37.	223561003	(history and physical inadequate)
38.	230807133	(history and physical inadequate)
39.	101584391	(history and physical inadequate)
40.	228204672	(history and physical inadequate)
41.	229124283	(no documentation of injury) (no outpatient studies on chart)
42.	229883234	(history and physical inadequate)
43.	242585461	(history and physical inadequate)
45.	338244393	(eventually done by infectious disease consultant)
51.	227505540	(inadequate physical)
54.	229825509	(Adm. #1: no pulses recorded; Adm. #2: no history and physical)
56.	151425469	(inadequate history and physical)
57.	265594537	(physical exam marginal) (EMGs and nerve conduction studies not in chart)

68. 800145558 (no history and physical)
 70. 142709349 (inadequate)
 89. 110540994 (no neurologic exam on chart)
 92. 214713356 (no neurovascular hand exam documented pre-op)
 94. 261835132 (bilateral brachial plexus injuries not documented by EMG)
 97. 250536760 (physical exam of arms and hand not adequate, inadequate neurological exam)
 99. 243108102 (neurologic exam not adequate - no documentation lower CN function)
 132. 236947121 (inadequate history and physical for surgery performed)
 145. 223769831 (inadequate; transfer note: not a complete H&P)
 146. 261835132 (inadequate)
 147. 227786333 (history poor - what were previous operations?)
 149. 010832134 (inadequate physical; checklist H&P for major reconstruction) (EMG and myelogram "done" but not in chart)
 158. 224980142 (inadequate physical; checklist H&P)
 164. 235645850 (no physical exam-describes injury, but no other physical)
 167. 622890853 (physical exam inadequate; checklist H&P)
 180. 225066176 (poor physical - no pulses recorded)
 184. 201484292 (inadequate physical - no neurovascular exam for brachial plexus case; poor description of deficits)
 187. 223767238 (poor physical - no pulses recorded)
 198. 237903360 (no documentation of neurologic function in brachial plexus)
 199. 388308960 (physical exam does not document post cutan n. status)
 204. 227849864 (physical exam marginal for an inpatient procedure - no M.D. signature)
 211. 229382277 (etiology of original problem not documented; diagnosis of reflex sympathetic dystrophy not considered; PE does not document status of ulnar nerve function) (no EMG or clinical data)
 213. 296287075 (PE does not adequately document nature and extent of injury - 1st admission--no documentation of right arm neurovascular function)
 216. 213528879 (inadequate exam of affected arm in brachial plexus - injury; no neurological exam or consult)
 220. 041500682 (no detailed neurological exam for brachial plexus case) (no patient PTT for myelogram)
 225. 711006692 (no EMG in chart; 12 hour operation; no record of post-op. visits by Physician 392)
 228. 153344694 (inadequate history and physical on patient with history of reticulum cell sarcoma - expected result?)

TABLE II

CONCERNS REGARDING CONSENT (42 CITES)Procedure performed different from that for which consent given (2 charts)

<u>Ad Hoc Study Number</u>	<u>Medical Record Number</u>	<u>Comments</u>
35.	230665237	(carpal tunnel release - but cubital tunnel also done - why not documented need for this and no consent)
96.	223444525	(permit for Guyon release; carpal tunnel release also performed)

Not in chart (2 charts)

<u>Ad Hoc Study Number</u>	<u>Medical Record Number</u>	<u>Comments</u>
93.	117013348	(incomplete chart? Where was surgery done?)
200.	230888761	

No M.D. signature (18 charts)

<u>Ad Hoc Study Number</u>	<u>Medical Record Number</u>	<u>Comments</u>
1.	229668735	signed 10-20-85 (1984 case)
8.	460925788	(orthopedics consent not signed by surgeon - Adm. #2) signed 10-20-85 (surgery May 84)
10.	101501210	signed 10-20-85 (August 1984 case)
17.	229826175	signed 10-20-85; insertion of CVP and A-line and neurovascular free flap left toe to third finger
21.	307429345	(7-18-84 admission) signed 10-20-85
27.	227080174	(Adm. #3: not signed by M.D.)
31.	800142499	(inadequately signed) copy of op note signed 10-20-85)
34.	229227805	June 1984 case; signed 10-20-85
39.	101584391	
41.	229124283	(also inadequate) October 1984 case; signed 10-20-85
72.	286446269	(No M.D. signature)
86.	149180439	August 1984 case; signed 10-20-85
91.	190422887	(signed 10-20-85)
96.	223444525	(Adm. #1: no M.D. signature)
98.	227126885	(incomplete) August 1984 case; signed 10-20-85
100.	526387701	(phone consent 6/11/82; No M.D. signature)

180. 225066176
205. 136502365

Does not specify procedure/body part or names wrong/body part or more procedures done than named on consent (6 charts)

<u>Ad Hoc Study Number</u>	<u>Medical Record Number</u>	<u>Comments</u>
41.	229124283	(inadequate consent - which side?)
57.	265594537	(which side)
74.	230769722	(inadequate - does not say which side)
81.	262027059	(inadequate - does not designate which arm injured)
89.	110540994	(exact procedure not specified; no M.D. signature) signature now; not on copy
158.	224980142	(vague)

No witness/M.D. signed as witness (9 charts)

<u>Ad Hoc Study Number</u>	<u>Medical Record Number</u>	<u>Comments</u>
7.	442505644	(no independent witness)
20.	262300832	(M.D. signed as witness)
57.	265594537	(M.D. signed as witness)
87.	245023800	(incomplete - no witness) (M.D. was witness)
88.	167409317	(same individual was witness and counselling M.D.) no M.D. on consent for CVP line
92.	214713356	(incomplete - same individual signed as counselling M.D. and witness)
96.	223444525	(Adm. #2 and Adm. #3: M.D. signed as witness)
97.	250536760	(M.D. and witness same)
211.	229382277	(M.D. signed as witness; no signature in M.D. blank)

Inadequate (4 charts)

<u>Ad Hoc Study Number</u>	<u>Medical Record Number</u>	<u>Comments</u>
24.	050508840	M.D. same as witness
29.	274744361	only Plas. Spec. consent; no M.D. signature on form
57.	265594537	(resection of median nerve with possible nerve graft)
70.	142709349	(hospital consent not adequate) see no M.D. signature

Inappropriately signed (1 chart)

<u>Ad Hoc</u> <u>Study</u> <u>Number</u>	<u>Medical</u> <u>Record</u> <u>Number</u>	<u>Comments</u>
25.	094544105'	1st Admission: Countersigned op note 10-20-85 and consent 10-20-85; no problem found on 2nd (top) admission

TABLE III

#392 NOTES/DOCUMENTATION PRESENT (15 CHARTS)

<u>Ad Hoc Study Number</u>	<u>Medical Record Number</u>	<u>Comments</u>
6.	230178710	(countersigned operative note)
14.	525239120	(signed history and physical)
113.	231722506	(signed operative permit)
117.	229825509	(10/83 admission - note)
118.	229984610	(10/21/83 signed discharge note; 10/21/82 signed history and physical; signed op note)
119.	230178710	(3/83 - history and physical and operative permit signed)
123.	570271513	(seen on post operative day #3 by #392)
124.	167568514	(dictated and signed operative note)
125.	206525016	(signed notes)
131.	525239120	(3/83 signed operative note; seen by #392)
135.	800111424	(signed operative note)
161.	225962394	(signed discharge note and operative note; operative permit acceptable; 2 preoperative notes and 3 postoperative note)
185.	231261494	(10/83 signed discharge note; signed operative note)
195.	450048153	(3/83 operative permit acceptable; operative note signed x 3; 4/84 - signed operative note and discharge note, also attending note present)
226.	800098892	(countersigned some progress notes; none from 7-16 through 8-6 when patient transferred to CHKD. Surgery 7-28, 8-6)

TABLE IV

CONCERNS REGARDING OPERATIVE NOTES (7 CHARTS)

Absent/Inadequate Operative Note (4 charts)

<u>Ad Hoc Study Number</u>	<u>Medical Record Number</u>	<u>Comments</u>
11.	223767238	(No op note on second admission)
31.	800142499	(Inadequate)
35.	230665237	(One-half of op note not dictated - part on cubital tunnel.)
90.	227040291	(Incomplete operative note)

Operative Note Not Properly Signed (3 charts)

<u>Ad Hoc Study Number</u>	<u>Medical Record Number</u>	<u>Comments</u>
19.	122264394	(op. note dictated by Dr. Levine not co-signed)
20.	262300832	(incorrectly signed)
25.	094544105	(one operative note not signed properly.)

VIRGINIA: IN THE CIRCUIT COURT FOR THE CITY OF NORFOLK

PHYSICIAN 392, a/k/a
JULIA K. TERZIS, M.D.,

Plaintiff,

v.

C86-496

MEDICAL CENTER HOSPITALS,
a Virginia Non-Stock Corporation,
Serve: David Bernd, President
18 Koger Executive Center
Suite 202
Norfolk, Virginia 23502

and

THE EXECUTIVE BOARD OF DIRECTORS
OF MEDICAL CENTER HOSPITALS,
Serve: Frank Kollmansperger, Chairman
1208 N. Princess Anne Road
Norfolk, Virginia

Defendants.

AMENDED BILL OF COMPLAINT FOR TEMPORARY INJUNCTION

TO THE HONORABLE JUDGES OF THE CIRCUIT COURT
FOR THE CITY OF NORFOLK:

Your plaintiff respectfully represents:

1. That the plaintiff is a Canadian citizen, and physician and surgeon duly licensed to practice medicine in the Commonwealth of Virginia, and is a resident of the City of Norfolk, Virginia; and that the defendants are MEDICAL CENTER HOSPITALS, a corporation organized pursuant to the Virginia Non-Stock Corporation Act and its EXECUTIVE BOARD OF DIRECTORS, empowered by Article VII, Section 6 of the Bylaws of Medical Center Hospitals to "terminate or suspend the appointment of a physician . . . or reduce, modify or condition the privileges granted." Said Bylaws

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of Medical Center Hospitals are attached hereto and incorporated herein by reference as Exhibit "1" to the Amended Bill of Complaint.

2. That your plaintiff practices micro-neurosurgery, which is a highly specialized and sophisticated branch of the medical arts and sciences. Your plaintiff is a nationally and internationally renowned practitioner, surgeon, scholar, author, lecturer and innovator in the field of micro-neurosurgery, and maintains a state-of-the-art, high technology diagnostic and operative facility at Norfolk General Hospital in order to provide each of her adult and pediatric patients with the full benefits of her knowledge and experience. Throughout her career, your plaintiff has succeeded in successfully treating a tremendous variety of unusual and previously incurable adult and pediatric neurological ailments and conditions and has thus actively extended the conceptual and practical parameters of modern neurology and micro-neurosurgery.

3. That your plaintiff has been fully privileged to practice medicine at Norfolk General Hospital since June of 1981, until March 30, 1986, at which time, by action of the Board of Directors of Medical Center Hospitals, Inc., her privileges were suspended for thirty days and Physician 392 was further put on "probation" for one year, the terms of which are so onerous as to make her practice difficult, if not impossible. This action of the Executive Board of Directors was communicated by letter to Julia K. Terzis dated March 25, 1986 over the signature of Frank Kollmansperger, Chairman, which letter is attached to the

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original Bill of Complaint filed herein as Exhibit "C" and is incorporated herein by reference.

4. That the arbitrary and capricious suspension and probation imposed on your plaintiff contrary to the Bylaws, Rules and Regulations of the Medical Staff of Medical Center Hospitals will have a profound effect and work an irreparable injury upon Physician 392 and her patients.

The plaintiff's business reputation and good name are impugned by the actions of the Board of Directors and other committees of Norfolk General Hospital, which actions are already the subject of rumor and innuendo in the medical community. The plaintiff's opportunity and right to practice her profession in the future are further imperiled by the fact that hospitals universally ask applicants for privileges whether they have been subject to suspension and/or probation and the action of the Board of Directors will therefore render the plaintiff unable to practice medicine in North America. A typical application for privileges is attached to the original Bill of Complaint as Exhibit "A" and is incorporated herein by reference.

Further, your plaintiff has surgery scheduled and patients due to be admitted to Norfolk General Hospital during the period of her suspension. The suspension will deny her admitting and operating privileges. Her procedures require her highly specialized facilities at Norfolk General Hospital, which facilities she has spent five years creating. Many of these patients, both adult and pediatric, are scheduled for the second stages of multiple-stage, year-long treatments. Depriving these

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patients of their treatments poses threats of additional muscle atrophy and other adverse effects and will interrupt their course of treatment to their detriment.

5. That a physician, accorded privileges at Norfolk General Hospital, as was your plaintiff, is guaranteed minimal due process and procedural fairness by the Bylaws of Medical Center Hospitals AND by the Bylaws of the Medical Staff of Medical Center Hospitals.

The Manual for Accreditation of Hospitals of the Joint Committee on Accreditation of Hospitals mandates "FAIR HEARING AND APPELLATE MECHANISMS" of accredited institutions. The Bylaws of Medical Center Hospitals, in Article VII, Section 6 ("Termination or modification of staff status") further provides that before the Executive Board may act to affect privilege, the practitioner shall be "afforded the protection of due process as outlined in the bylaws of the Medical Staff and approved by the Executive Board of Directors."

The contractual obligation to your plaintiff from Medical Center Hospitals and its Executive Board are further embodied in the Bylaws of the Medical Staff of Medical Center Hospitals, which specify certain procedural guarantees which were violated in the actions taken against your plaintiff since November of 1984. Those Bylaws provide that a request for "corrective action" [such as suspension and/or probation] must be made with reference "to SPECIFIC activities or conduct which constitute the grounds." [Article IX(A)(1)] The Bylaws require the notice of a hearing before the Medical Staff or an ad hoc committee to

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specify "the grounds [for adverse action] and the specific or representative charts being questioned" [X(B)(e)]. None of the procedural guarantees of the Bylaws requiring specific notice and an opportunity to defend were afforded your plaintiff. A copy of The Bylaws of the Medical Staff of Medical Center Hospitals is attached to the original Bill of Complaint as Exhibit "D" and is incorporated herein by reference.

6. That your plaintiff practiced uneventfully at Norfolk General Hospital until 1984, at which time she became subject to an extraordinary inquisition into her practice, which history is set out at length in a Written Statement in Support of an Appeal appended to the original Bill of Complaint as "Exhibit B" and incorporated herein by reference. The investigations, "interviews," hearings, and adjudications of the Committees and the Board of Medical Center Hospitals, their agents and staff, were conducted arbitrarily and capriciously and were otherwise not in accord with the guarantees provided your plaintiff in the Bylaws, Rules and Regulations of the Medical Staff of Medical Center Hospitals and The Bylaws of Medical Center Hospitals.

7. That throughout the process of investigation and prosecution of various committees and Boards of Norfolk General Hospital, they acted arbitrarily and capriciously and your plaintiff was routinely denied the rights afforded her to her by that institution's own Bylaws, to-wit:

(a) Denial of a fair hearing by the interrelationship of investigative, adjudicative and appellate bodies.

One physician, Dr. Hoffman, served on all bodies which considered

action against Physician 392 and served as prosecutor before the appellate body. Of the first ostensibly "appellate" body -- the Medical Executive Committee [MEC] -- a majority of nine members had already passed judgment on Physician 392 in an adjudicative setting as members of the Departmental Authorities Committee [DAC].

(b) Failure to give adequate notice and an opportunity to defend. Physician 392 was confronted initially with 233 charges derived from 211 charts. These charges were not only multiplicitous, but were also so vaguely formulated as to be impossible to defend. Working within time constraints, Physician 392 was given an opportunity at various hearings to defend against only seven specific cases, frequently without the assistance of counsel and denied the assistance of those Fellows and/or clerical assistants who assisted her in gathering appropriate charts.

Many of the "hearings" at which your plaintiff appeared were characterized as "interviews" and in the one hearing at which your plaintiff appeared with counsel, before an Ad Hoc Hearing Committee of the DAC, your plaintiff and her counsel were denied an opportunity to rebut the multiplicitous and nebulous charges levelled against her, in violation of the By-laws' explicit provision that the physician be afforded an opportunity to present FACTS in support of the assertion that the committee was without grounds. Your plaintiff has never been accorded a full and fair hearing on the charges against her, and never accorded an opportunity to present evidence in her defense.

(c) Failure to specify the standards by which your plaintiff would be judged. The various committees which have sat in judgment on your plaintiff have variously described the standards to be applied to her as the Rules and Regulation of Medical Center Hospitals or "medical practice as practiced at this institution." Many of the charges against your plaintiff have origins in medical record-keeping, for which no specific standard is set forth. Further, by the Bylaws and Rules and Regulations, two committees -- the Medical Records Review Committee and the Quality Evaluation Committee -- are charged with period review of hospital records and bringing lapses to the attention of the affected physician. Prior to her appearances before the DAC and MEC, your plaintiff was never apprised of any deficiencies in her record-keeping practice. Further, your plaintiff has long ago agreed to abide by the wishes of the Staff in record-keeping matters.

When faced by the deficiencies of the Rules and Regulations in setting specific standards for judgment of Physician 392's record-keeping practices, the members of the adjudicative and appellate bodies resorted to "actual practice" as the standard, at the same time they denied your plaintiff and her counsel access to random charts which would establish that standard.

(d) Denial of finality of adjudication in appearances before various committees. When first subject to a review of her practice by the Departments of Plastic Surgery and the Department Authorities Committee in November of 1984, your

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plaintiff was given an "admonishment" regarding several "relatively minor" lapses in OR protocol. Following investigation by the DAC, your plaintiff was informed by Dr. William Tynes, then President of the Medical Staff, by letter of April 8, 1985, that the DAC contemplated no further action after a review of cases brought to their attention. From May of 1985 to the present, however, your plaintiff has been subject to an inquisitorial process in which she has been faced by multiplicitous and nebulous charges of alleged wrongdoing based upon 211 medical charts. Having conceded that in matters of record-keeping her hospital charts did not meet the standards brought to her attention for the first time during these proceedings, your plaintiff has been repeatedly subject to resurrection of the same charges.

WHEREFORE, in order to prevent Medical Center Hospitals and its Executive Board from enacting and enforcing its arbitrary and capricious reduction of plaintiff's privileges and in order to ensure that the interests of the plaintiff's patients and the public be protected against disruption or loss of your plaintiff's valuable and unique medical care and service, that the due process afforded your plaintiff by her contract with Medical Center Hospitals, Inc. be preserved, that your plaintiff's renown and reputation and ability to practice her livelihood not be irreparably and detrimentally affected by this denial of due process, and that the plaintiff have an opportunity to challenge the accusations of wrongdoing and present evidence in her own behalf, your plaintiff prays that a temporary injunction be immediately granted:

CHARLAN. KNIGHT.
UDLEY & PINCUS
OF VIRGINIA

(1) Restraining and enjoining Medical Center Hospitals and its Executive Board of Directors and other Medical Staff of Norfolk General Hospital, and their agents, servants and employees from:

- (a) Any further investigation of your plaintiff;
- (b) Suspending or in any way modifying the hospital privileges of your plaintiff;
- (c) Preventing your plaintiff from admitting and treating surgical patients.

(2) Ordering:

- (a) Medical Center Hospitals and its Executive Board of Directors, their agents, servants and employees to dissolve any orders that may concern your plaintiff;
- (b) Medical Center Hospitals and its Executive Board of Directors to make its charges against your plaintiff specific and to detail each and all of the infractions of which the plaintiff is allegedly guilty, and to relate each such infraction to a particular chart or record;
- (c) Medical Center Hospitals and its Executive Board of Directors to form an ad hoc committee of knowledgeable and totally impartial physicians from an institution other than Norfolk General Hospital, where a fair and impartial hearing can no longer be afforded to your plaintiff, to review the charges promulgated against your plaintiff;
- (d) The presence of a court reporter at any proceedings against your plaintiff;

(e) That your plaintiff be afforded this Court's discovery and subpoena powers to produce medical records at any hearing, to discover the nature and motivation of the proceedings against your plaintiff to date, and to obtain the charts and medical records of other surgeons on the Medical Staff of Norfolk General Hospital so as to adduce the actual standard of care applicable to your plaintiff as far as the plaintiff's record-keeping is concerned;

(f) That of the several hundred charts of your plaintiff on which "charges" were originally formulated, Medical Center Hospitals and its Executive Board of Directors set forth its findings separately as to those charts in which it finds no deficiency, or for which satisfactory explanation has been provided to the DAC or MEC;

(g) That Medical Center Hospitals and its Executive Board of Directors afford the opportunity to Physician 392 to present evidence and to summons witnesses to rebut those charges which may remain;

(h) That the discovery and subpoena powers of this Court be further afforded to the plaintiff for the thirty (30) days during which this temporary injunction is in force, during which time the plaintiff may subpoena records of and depose, various Medical Staff in anticipation of a hearing on permanent injunction or other proceeding;

(i) Such other remedies as equity may deem meet.

PHYSICIAN 392, a/k/a JULIA K.
TERZIS, M.D.

By Walter J. Terzis
Of Counsel

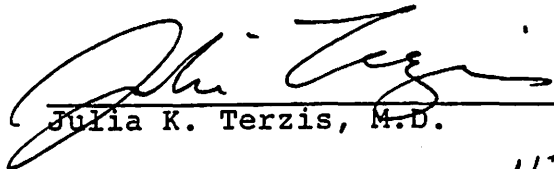
HARLAN, KNIGHT,
DUNN & PINCUS
NO. 1, R. VIRGINIA

Thomas J. Harlan, Jr.
Michael F. Bergan
HARLAN, KNIGHT, DUDLEY & PINCUS
1350 Sovran Center
One Commercial Place
Norfolk, VA 23510
(804) 625-7605

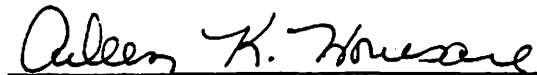
A F F I D A V I T

Commonwealth of Virginia, at large:

Appeared before me on this date JULIA K. TERZIS, M.D.
who made oath and stated that the matters and things alleged in
the foregoing Amended Bill of Complaint are true to the best of
her knowledge, information and belief.


Julia K. Terzis, M.D.

TAKEN, SUBSCRIBED and SWORN before me this 11th day
of April, 1986.


Notary Public

My Commission expires: 9/12/89.

[MFB1p]

HARLAN, KNIGHT,
& PINCUS
NORFOLK, VIRGINIA

CERTIFICATE OF SERVICE

I hereby certify that a true copy of the foregoing Amended Bill of Complaint was hand-delivered this 11th day of April, 1986 to John M. Franklin, Esquire, and was mailed this 11th day of April, 1986 to Gregory M. Luce, Esquire.

Thomas J. Zula ✓

[MFB1p]

HARLAN, KNIGHT,
DUNN & PINCUS
NO. 101 K. VIRGINIA

VIRGINIA: IN THE CIRCUIT COURT OF THE CITY OF NORFOLK

PHYSICIAN 392, a/k/a
JULIA K. TERZIS, M.D.

Plaintiff,

v.

CHANCERY NO.: C86-496

MEDICAL CENTER HOSPITALS and
BOARD OF DIRECTORS, MEDICAL
CENTER HOSPITALS,

Defendant.

MOTION TO ENLARGE INJUNCTIVE RELIEF

NOW COMES the plaintiff, by counsel, and moves this Court to enlarge the injunctive relief granted upon the prayer of this plaintiff on March 31, 1986. In support of her motion, the plaintiff states:

1. That on Thursday, April 3, during the period of injunction, the plaintiff admitted to surgery a 60 year old female patient, after a pre-operative consultation by Gordon Ryan, M.D., a consulting physician specializing in internal medicine, regularly relied on by the plaintiff.

2. That after surgery on or about April 10, 1986, in surgical ICU, this patient had difficulty clearing secretions and a pulmonary consult was requested by Dr. Ryan from the group which he customarily deals with, Drs. Donlan and Derring.

3. That Dr. Ryan was told that the physicians from whom he sought the pulmonary consult would "rather not become involved with Dr. Terzis' patients" and suggested that Dr. Terzis

obtain the consult from among the Staff at eastern Virginia Medical School.

4. That Dr. Ryan has subsequently declined to see patients of Dr. Terzis, for the stated reasons that he fears he will be unable to obtain "backup" from other specialists in the future.

5. That Dr. Ryan further stated that he declined to see patients of Dr. Julia Terzis because he has been informed that the charts of Dr. Terzis' patients are being scrutinized by reviewers, and that the chart of the patient referred to in paragraph 1 of this Motion had already been relieved by Kevin Murray, M.D., a member of the Medical Staff of Medical Center Hospitals and a specialist in internal medicine.

6. That Dr. Terzis was ultimately required to obtain the consult of Ignacio Ripoll, M.D., a pulmonary specialist at Eastern Virginia Medical School.

7. That the unmerited and highly irregular scrutiny of the medical records of Dr. Terzis' patients constitutes a form of harassment of your plaintiff which has had the effect of isolating her from the services of other members of the medical community upon whom she and her patients have relied; that the effective denial of consultation services would render your plaintiff unable to perform her usual work and pose a potential threat to those patients whom she continues to treat.

Wherefore, the plaintiff prays for relief from this Court in the enlargement of its order of March 31, 1986, to enjoin the Medical Staff, its members, employees, and agents from harassing the plaintiff by its continued irregular review of the medical records in a manner calculated to hamper the plaintiff's continued care of her patients.

PHYSICIAN 392, a/k/a
JULIA K. TERZIS, M.D.

By Michael F. Bergan
Of Counsel

NOTICE OF HEARING

TAKE NOTICE that the undersigned will move The Honorable Leonard B. Sachs of the Circuit Court of the City of Norfolk for an Order in accordance with the attached Motion and for leave to amend the plaintiff's Bill of Complaint in accordance with the Amended Bill lodged with the Clerk of this Court on April 15, 1986, at 10:00 a.m. or as soon thereafter as counsel may be heard.

PHYSICIAN 392, a/k/a
JULIA K. TERZIS, M.D.

By Michael F. Bergan
Of Counsel

Thomas J. Harlan, Jr., Esquire
Michael F. Bergan, Esquire
HARLAN, KNIGHT, DUDLEY & PINCUS
1350 Sovran Center
Norfolk, Virginia 23510
(804) 625-7605

HARLAN, KNIGHT,
DUDLEY & PINCUS
NORFOLK, VIRGINIA

CERTIFICATE OF SERVICE

I hereby certify that a true copy of the foregoing Motion and Notice was hand-delivered to John Franklin, Esquire, 520 First American Bank Building, Norfolk, Virginia 23510, and mailed to Gregory Luce, Esquire, 1701 Pennsylvania Avenue, N.W., Washington, D.C. 20006, counsel for Medical Center Hospitals, this ____ day of April, 1986.


Thomas J. Harlan, Jr.

VIRGINIA: IN THE CIRCUIT COURT OF THE CITY OF NORFOLK

PHYSICIAN 392, a/k/a JULIA K.
TERZIS, M.D.,

Plaintiff,

v.

CHANCERY NO. C86-496

MEDICAL CENTER HOSPITALS, etc.,

Defendants.

A F F I D A V I T

I, Julia K. Terzis, M.D., do hereby certify that I have been treating a 60 year old white female patient for almost three years. She had had a tumor removed from her cheek resulting in damage to certain cranial nerves which affected two things on her face: her eyelid and her cheek. Because she could not close her eyelid, this caused the eye to become susceptible to infections and possible loss of vision. The paralysis to her cheek after the tumor operation caused her to have difficulty managing her secretions inasmuch as the cheek is used to apply pressure to the mouth cavity during swallowing.

Approximately one year ago, I performed a "cross facial nerve graft", the first step in a two step procedure. The purpose of this operation was to supply nerves to the damaged cheek and the second step in the operation was now to supply muscles to that cheek to be innervated by the nerves which had been placed there a year before.

She was admitted to Norfolk General Hospital on or about Wednesday, April 2, 1986 for the second step in this two step procedure. As a consultant, I asked Dr. Gordon Ryan, a specialist in internal medicine, to see this lady patient of mine and to clear her for the surgical procedure which I intended to perform on Thursday, April 3, 1986. Dr. Ryan cleared her for surgery. In addition to Dr. Ryan, the anesthesiologist that I now use in all of my procedures is a Dr. Matchett who has privileges at the Norfolk General Hospital in anesthesiology as well as for post-operative ventilatory management in the intensive care center of patients at Norfolk General Hospital. He also examined this lady and cleared her for surgery.

The surgery took approximately 13 hours. The eyelid as well as the cheek of this lady were the subject of this second stage procedure operation. The surgery was uneventful and, following surgery she was placed in the surgical intensive care unit. Both Dr. Ryan and myself had anticipated that she would have difficulty managing secretions following this surgery and, as expected, on Thursday, April 10th while still in the ICU, seven days following her surgery, this patient continued to have problems with secretions which caused her blood oxygen values (PO_2) to be depressed. Dr. Ryan informed Dr. Marash, my microfellow, that he would call in a pulmonary specialist as a consultant. This was sometime in the morning of April the 10th. I was later informed at

6:25 p.m. by Dr. Ryan that he had attempted to obtain the services of a pulmonary consult but they had told him that they would "rather not become involved". Dr. Ryan further advised me that I should contact the Medical School's pulmonary people for this female patient.

As I was in surgery, at 6:25 p.m. I called and left a message at the Medical School for a pulmonary consult of this patient. When I finished my surgical procedure at approximately 9:30 p.m. on Thursday, April 10, 1986, I went to the ICU and found, to my relief, Dr. Ignacio Ripoll, a specialist in pulmonary diseases attending to my patient in the intensive care unit.

After this, Dr. Ryan informed me that since he could not get medical backups and also since "every single word" he writes in one of my patient's charts is "being scrutinized by reviewers" and that this particular chart on this particular patient had already been reviewed by a Dr. Kevin Murray, that it would be impossible for him to practice medicine under these circumstances. Dr. Ryan notified me that he would no longer take care of any of my patients in the future; of course, he would continue to minister to this particular female patient until she is discharged from the hospital.

I do not know why all of my charts, as they are being generated, are being "scrutinized" by members of the Medical Staff. I do not know why my medical consultants, such as

Dr. Ryan, cannot obtain medical specialists to see my patients. This is a matter of great urgency to me since it involves the health of my patients which the Board of Directors of this Hospital seem to be very concerned with.


JULIA K. TERZIS

COMMONWEALTH OF VIRGINIA

CITY OF NORFOLK

I Arleen K. Howsare, a Notary Public in and for the City and State aforesaid, do hereby certify that Julia K. Terzis came before me on this the 14th day of April, 1986, was sworn, and stated that the matters and things contained in this Affidavit are true to the best of her knowledge and belief.

9/12/89
My Commission Expires


Notary Public

1 VIRGINIA: IN THE CIRCUIT COURT OF THE CITY OF NORFOLK

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PHYSICIAN 392,

Plaintiff

-vs-

THE BOARD OF DIRECTORS OF
MEDICAL CENTER HOSPITALS, INC.,

Defendant

- - - - -

BEFORE: The Honorable Leonard B. Sachs,
Judge of the aforesaid Court

DATE: April 17, 1986, at 12:00 p.m.

PLACE: Norfolk, Virginia

APPEARANCES:

HARLAN, KNIGHT, DUDLEY & PINCUS,
By: Thomas J. Harlan, Jr. and
Michael F. Bergan,
Counsel for the Plaintiff

TAYLOR, WALKER & ADAMS
By: John Franklin, III,
Counsel for the Hospital

MILES & STOCKBRIDGE
By: Gregory M. Luce
Counsel for the Hospital

Reported by:
Catherine H. Leitz, CSR, RPR

1 THE COURT: Mr. Luce, you've got the rules and
2 I received a, not an amended but in lieu of an affidavit by
3 Doctor Terzis which does not substantially change the facts
4 which she set forth. I haven't measured it, but it seems to
5 be pretty similar to what I recall.

6 MR. HARLAN: Yes, sir. The only thing we've done
7 in that is change and added the Medical Center Hospital as a
8 technicality to the Board and I think some of the language in
9 it, the language is essentially the same, 99 percent.

10 THE COURT: All right.

11 MR. LUCE: Your Honor, I have reviewed and
12 compared it to the original one, and in the substance of the
13 allegations, I would agree with Mr. Harlan, is essentially the
14 same.

15 THE COURT: All right. Ready to go?

16 MR. LUCE: Your Honor, I'd like to, with the
17 Court's permission, outline how I thought I'd go about this
18 and see if that's an appropriate and effective way for the
19 Court to consider this issue.

20 THE COURT: Let me ask you. Something just
21 occurred to me. I sued Medical Center Hospitals one time,
22 albeit unsuccessfully, for the physicians in the Medical Tower
23 next to the hospital and where they appropriate or, I should
24 say, misappropriated the parking lot and I was retained to get
25 an injunction, which I did, and unfortunately while I was out

1 of town taking depositions somebody got it disenjoined. Does
2 that bother anybody here today, as a lawyer I had an adversary
3 interest?

4 MR. LUCE: Your Honor, it doesn't bother me and
5 Mr. McMillan has also given me his version of the events. I'm
6 sure that's all well behind us.

7 MR. HARLAN: Certainly doesn't bother the
8 plaintiffs.

9 THE COURT: He was certainly very gracious
10 because I lost.

11 MR. LUCE: I didn't want the Court to consider
12 that to be a background check by anybody.

13 THE COURT: You did your homework.

14 MR. LUCE: Trying to ascertain the status of this
15 matter, Your Honor, the Khoury case, the status of EVMA are
16 the two points the Court raised in our last prehearing
17 conference.

18 THE COURT: Let me ask, that was banter I'd
19 rather that not appear. Obviously I wouldn't say
20 misappropriated. I would have to be more careful. I
21 understand everybody was smiling and everybody understood the
22 context, but in cold print it's takes a whole different
23 feeling and meaning.

24 MR. LUCE: Just to make it clear, Your Honor,
25 we're not suggesting there is any basis for the Court to

1 recuse itself in this matter.

2 Your Honor, in the bill of complaint we have
3 suggested that the plaintiff has essentially sought two things.
4 It has sought to a virtual receivership of the medical staff
5 and that has been denied by plaintiff in their memorandum. My
6 allegation in the memorandum I submitted is essentially based
7 on the prayer for relief, which calls for the implementation
8 of procedures that are really not called for in the bylaws,
9 and so it's a different procedure from what's set forth in the
10 bylaws.

11 Today we have filed and bring on for hearing both
12 the demurrer and the dissolution of the injunction, and with
13 the Court's permission, I'd like to proceed first with the
14 demurrer. If matters of evidence come into question, it may
15 be the motion for dissolution may be an appropriate basis for
16 at least considering those, and in all candor, I think the
17 pleading itself contains sufficient documentation of the
18 circumstances now as replied to permit this Court to make a
19 ruling on the face of the bill.

20 The amended bill now does have very clearly
21 several of the documents that I felt were necessary to the
22 Court's disposition of the demurrer. First, it has the
23 decision of the Executive Board or board of directors. The
24 nomenclature is slightly different in the medical staff bylaws
25 than in the articles of incorporation, but it is the same body,

1 it is the board of directors of Medical Center Hospitals, and
2 it also has the medical staff bylaws as part of the pleading.

3 The case of Khoury has been the subject of a
4 great deal of attention, but before turning to that, Your
5 Honor, I'd like to very briefly outline what I think are some
6 corporate health care and hospital law principals for the
7 Court to consider.

8 The first is that the bylaws of the medical staff
9 should be considered a very distinct document from the bylaws
10 of Medical Center Hospitals. Now, the law in Virginia and in
11 most states is clear, that corporate bylaws and the articles
12 of incorporation constitute a form of contract between the
13 Commonwealth and the governing body of Medical Center
14 Hospitals and other corporations duly authorized under the
15 laws of Virginia. The enforcement of corporate bylaws is a
16 matter that is of extremely limited standing. Only limited
17 persons have a right to seek to enforce corporate bylaws.

18 The type of corporation we're dealing with here
19 is alleged to be and is accurately stated as a corporation
20 organized pursuant to the Virginia Incorporation Act and that
21 is correct. The corporation is also exempt from federal and
22 state taxation pursuant to the provisions of 501C3 of the
23 Internal Revenue Code.

24 It's clear, Your Honor, Medical Center Hospitals
25 is a private hospital, and I do not read the bill of complaint

1 either as originally submitted or as amended, nor do I see any
2 indication in the memoranda submitted in response to our
3 motion and demurrer, to contain any allegations that we are a
4 public entity. In fact, Your Honor, public entities couldn't
5 be exempt from taxation pursuant to 501.

6 MR. HARLAN: We will stipulate it's not a public
7 entity. It's a private hospital.

8 MR. LUCE: Now, Your Honor, given that, I think
9 the next issue for the Court to look at, then, is what are the
10 bylaws of the medical staff and what are the bylaws of the
11 corporation and what is their relationship. The bylaws of the
12 medical staff, Your Honor, are the means by which this
13 hospital has delegated to the medical staff the task of
14 organizing itself, and on at least an initial level, policing
15 itself in the care of patients that those physicians who are
16 members of that medical staff provide to patients admitted to
17 the hospital.

18 There are different kinds of relationships
19 between physicians and hospitals that I think the Court should
20 be sure to segregate in considering this case. The basic
21 membership in the medical staff, regardless of whether it's
22 affiliate or active or courtesy, is a limited right to admit
23 and treat patients within that hospital. Depending on the
24 nature of the privileges granted and the type of procedures
25 allowed to be performed, that outlines what the hospital is

1 willing to allow physicians to do within the four walls of the
2 hospital.

3 Now, the bylaws themselves of the Medical Center
4 Hospital medical staff make it clear that the intent is that
5 the bylaws are to create this organization called a medical
6 staff. The clear weight of authority is that a medical staff
7 of a hospital is not a legally cognizable entity. It is not
8 an unincorporated association which may sue and be sued. It
9 is not a group of physicians who are in any type of
10 partnership. And it is clear, I submit, by majority of law in
11 the state, in the country, that there is no contract created
12 by the bylaws.

13 Now, the bylaws of the medical staff exist not
14 only because the Executive Board delegates this task of
15 credentialing and policing the admission and care of patients
16 in hospitals, but also because those bylaws must be adopted in
17 substantial conformity to the basic requirements of the Joint
18 Commission on Accreditation of Hospitals.

19 THE COURT: Say that again, please.

20 MR. LUCE: The bylaws of the medical staff, which
21 are styled the bylaws, rules and regulations of the medical
22 staff, are adopted by the governing body, in this case,
23 Medical Center Hospital's Executive Board, in conformity to
24 the requirements of the Joint Commission on the Accreditation
25 of Hospitals.

1 Now, JCAH, if I may use the abbreviation, is a
2 private body whose accreditation has been accepted by the
3 Commonwealth of Virginia and by the Department of Health and
4 Human Services of the United States Government as a, one of
5 two ways in meeting the qualifications of a hospital, to
6 participate as a provider for receipt and payment under the
7 Medicare program and the Medicaid program. The other way that
8 you can do that is simply to be properly licensed through the
9 state and the state can have its own and, in fact, does in
10 almost every state have its own separate licensing agency.

11 The Virginia regulations are also applicable to
12 the hospital governing its size, mostly governs the physical
13 plant, but there are certain other physical requirements
14 imposed on hospitals pursuant to those regulations. The
15 hospital in question, Medical Center Hospitals, is accredited
16 and has continuously been accredited by the Joint Commission
17 and is licensed and has been continuously licensed by the
18 Department of Health of the Commonwealth of Virginia. Its
19 bylaws have been reviewed by the Joint Commission, and I
20 believe Your Honor would have to accept that these bylaws do
21 meet the Joint Commission's standards on the necessary
22 elements of a bylaw.

23 Now, the question, Your Honor, I think, is
24 implicit is what is the effect of these bylaws on the
25 corporation itself. The bylaws of the medical staff are the

1 conditions under which physicians may treat their patients at
2 the hospital. They do not constitute a contract for a variety
3 of reasons that we've stated in our brief, but the elemental
4 reason, the one that I think has been overlooked, is that the
5 corporate bylaws plainly state that the corporation reserves
6 to itself the right, notwithstanding any provisions of the
7 bylaws, to suspend the privileges of any physician in the
8 event it deems it necessary to do so for the protection and
9 care of its patients. And, Your Honor, you will find that in
10 the Medical Center bylaws at article seven, section six.

11 Now, Your Honor, the clear implication is that
12 the Medical Center Hospitals are required to abide by the
13 bylaws by certain agencies. They're required to abide by the
14 bylaws by the Joint Commission if they want to maintain their
15 accreditation. They're required to abide by their corporate
16 bylaws by act of the General Assembly. The Virginia Non-stock
17 Corporation Act provides that the corporate board of directors
18 can be held accountable for their actions. And I'll have the
19 corporate cite in just a second, but the corporate bylaws
20 clearly don't create a contract and yet it is only the
21 corporate bylaws that are binding on the defendant in this
22 case.

23 THE COURT: You say neither the corporate bylaws
24 nor the bylaws of the medical staff create a contract.

25 MR. LUCE: Well, let me -- they don't create a

1 contract with members of the medical staff; that's correct.

2 THE COURT: So then neither set of bylaws --

3 MR. LUCE: That's correct, Your Honor. Your
4 Honor, the statute I was referring to is Section 13.1-915
5 which addresses the involuntary termination of corporate
6 existence, and the applicable provisions state that the
7 corporation, existence of a corporation may be terminated
8 involuntarily by order of the Commission, meaning the State
9 Corporation Commission, when it finds that the corporation has
10 continued to exceed or abuse the authority conferred upon it
11 by law or has failed to maintain a registered office or
12 registered agent of the Commonwealth as required by law, and
13 it goes on to some other matters.

14 But, Your Honor, it wouldn't be accurate to say
15 that a non-stock corporation is free to ignore its own
16 corporate bylaws. It wouldn't be accurate to state that, and,
17 in fact, the State Corporation Commission, at least, and
18 probably the Attorney General, would have some authority to
19 require a corporation to meet its bylaws or be essentially
20 dissolved.

21 Now, we bring this up in advance, Your Honor,
22 because I think it's important to understanding the Khoury
23 case. Now, the Khoury case, it's been suggested, is no longer
24 good law. It's been suggested that the Khoury case is
25 outdated, and even the cases that I have cited are not

1 accurate in their portrayal.

2 THE COURT: Is that suggested by this reply brief?

3 MR. LUCE: It is, Your Honor.

4 MR. HARLAN: Never suggested the Khoury case is
5 outdated. We said Mr. Luce has simply absolutely misapplied
6 it.

7 THE COURT: Let's not have the comments.

8 MR. HARLAN: I'd like to defend my position, Your
9 Honor.

10 THE COURT: We have to proceed in an orderly way
11 because tensions are very high in this thing and it doesn't do
12 any of us any good to have free flow.

13 MR. LUCE: Now, Your Honor, the Virginia law is
14 not unique in this case. Virginia law, under Khoury, is the
15 majority rule in this country and I say that without any
16 hesitation whatsoever. The Khoury case has been cited by the
17 District of Columbia and numerous jurisdictions have picked it
18 up since. By the way, Your Honor, I have tore apart every
19 case that I could find through Shephards or West law that has
20 ever cited the Khoury case and reviewed those.

21 THE COURT: Favorably.

22 MR. LUCE: No, Your Honor. Every case and it's
23 available to the Court.

24 THE COURT: That may be more about Khoury than I
25 want to know.

1 MR. LUCE: It was all a lot more than I wanted to
2 know in 24 hours, Your Honor, but I found it very interesting
3 because I think what the --

4 THE COURT: That's K H O U R Y for the court
5 reporter.

6 MR. LUCE: The next thing about Khoury, Your Honor,
7 you have to understand it in a continuing legal opinion
8 regarding this entire subject in the late fifties and early
9 sixties, as the Court is well aware, there was a series of
10 attempts usually by black physicians to gain privileges at
11 hospitals in the Commonwealth of Virginia and other states in
12 which they had previously been banned. And the traditional
13 suits filed before the United States Civil Rights Act in 1963
14 did not prevail. They didn't prevail ever. They didn't
15 prevail under generally accepted principals of corporate law.
16 And those are cited in the beginning of our brief.

17 Now, the question is, is Khoury good law anymore
18 on those principals of corporate law? Your Honor, what I
19 think the Court should bear in mind is that Khoury was
20 essentially made inapposite or not controlling by a number of
21 circuits, including the Fourth Circuit Court of Appeals, which
22 held that the receipt of Hill-Burton funds, which were
23 necessary to the construction of the hospital, necessarily
24 created a sufficient state nexus that the hospital was imbued
25 with certain of the state action characteristics, and one

1 state action could be found the provisions of 42 USC 1983, and
2 the general protections of the Fourteenth Amendment and the
3 Fifth Amendment through the Fourteenth Amendment applied.

4 Now, it's been suggested in the reply brief, well,
5 that's blowing smoke, it's just not the matter. Well, it is
6 the matter, Your Honor, for after Khoury there were a number
7 of other cases in which Khoury was discussed by the federal
8 district courts. And until the Simpkins versus Moses H. Cone,
9 decided by the Fourth Circuit Court, held virtually the --

10 THE COURT: That is C O N E.

11 MR. LUCE: C O N E, Cone, Your Honor. Moses H.
12 Cone. I'm not going to go through the cites, Your Honor.

13 THE COURT: Like cone mills?

14 MR. LUCE: I don't know, Your Honor.

15 THE COURT: Down in Greensboro, North Carolina.

16 MR. LUCE: In Greensboro, North Carolina, yes.

17 MR. HARLAN: Could we have that cite, please?

18 MR. LUCE: It is cited at some length in both
19 Ahmed, which is a type of leave which was attached to our case.
20 I mean, it's the basic law of the Fourth Circuit.

21 THE COURT: Fourth Circuit. Simpkins versus --

22 MR. LUCE: Moses H. Cone.

23 THE COURT: This a Memorial Hospital?

24 MR. LUCE: I believe it is, Your Honor.

25 THE COURT: It's a hospital. Okay. I'm aware of

1 it. We can find it.

2 MR. LUCE: I can find the cites. In Simpkins,
3 the Fourth Circuit held, and the Fourth Circuit was the last
4 court to change its position on this view that Hill-Burton
5 funds were sufficient to trigger state action nexus. Once
6 Simpkins made that decision, it just didn't matter under
7 Khoury anymore whether or not a plaintiff had a right to
8 independently compel a governing body to admit a qualified
9 member to the medical staff because the standard was no longer
10 whether or not there was an intrusion on the authority
11 delegated by the charter of that corporation on the authority
12 delegated by the authority to the governing body.

13 Instead, one would simply bring a civil rights
14 case, and typically you would bring that in federal court,
15 there being a market level of success in the federal courts
16 and virtually no success in the state courts during this
17 period of time.

18 Now, what happened, Your Honor, was that all of
19 the circuits did not all agree the mere receipt of Hill-Burton
20 funds was sufficient. Some circuits held the mere receipt of
21 Medicare or Medicaid funds was sufficient. Fourth Circuit was
22 not among those.

23 In Trigger (phonetics) versus Libby Convalescent,
24 the Court held mere receipt of Medicare was not a sufficient
25 nexus. But in Simpkins it was very clear that receipt of

1 Hill-Burton funds for the construction of the hospital
2 triggered state action. And if Simpkins was the law today,
3 Medical Center Hospitals would have had a corresponding due
4 process obligation, constitutional due process obligation in
5 the matters pertaining to medical staff discipline.

6 But in 1978 the Fourth Circuit decided the
7 Modaber case, now Modaber versus Culpepper Memorial Hospital,
8 was the first explicit recognition by the Fourth Circuit that
9 the ruling of the United States Supreme Court 1975 in the
10 Edison Power case, Jackson versus Edison, Metropolitan Edison,
11 I believe, was controlling on its rulings in the past. And
12 what Jackson was, was that a state authorized utility which
13 existed as a private company and had a tremendous amount of
14 state involvement.

15 THE COURT: Style of this case again, Jackson --

16 MR. LUCE: Jackson, Your Honor, is also cited in
17 the Modaber case, and I can get the cite if the Court desires.

18 THE COURT: Is Modaber a U.S. or state?

19 MR. LUCE: Modaber is United States Fourth Circuit.
20 And Modaber --

21 THE COURT: And Jackson?

22 MR. LUCE: Jackson is United States Supreme Court.
23 Jackson versus Metropolitan Edison, 419 US 345.

24 THE COURT: 419 US what?

25 MR. LUCE: 345, 1974.

1 THE COURT: What does that say, Jackson?

2 MR. LUCE: What Jackson said was that to determine
3 whether or not the defendant's termination of plaintiff's
4 privileges is state action, we must inquire -- I'm quoting
5 from Modaber quoting Jackson -- we must inquire whether there
6 is a sufficiently close nexus between the state and the
7 challenged action of the regulated entity that the action of
8 the latter may fairly be treated as that of the state itself.
9 And in Metropolitan Edison, the Court held that --

10 THE COURT: Nexus between the action. That's --

11 MR. LUCE: The nexus between the state and the
12 challenged action.

13 THE COURT: Yes, but the action and not the nexus
14 between the state and the entity. It's the action of the
15 entity.

16 MR. LUCE: Well, yes, Your Honor, that's the way
17 the quote reads here.

18 THE COURT: All right.

19 MR. LUCE: Now, the Modaber case, as the Fourth
20 Circuit case says, the case before us squarely presents the
21 question we reserved in another case, Doe versus Charles Mary
22 Medical Center, and we find our former position, the mere
23 receipt of Hill-Burton funds makes the recipient of state
24 action is inconsistent with Jackson versus Metropolitan Edison,
25 which is controlling on us. And then in the footnote they

1 said the other circuits are in accord. Well, the other
2 circuits were in accord long before the United States Fourth
3 Circuit was, for that matter, but be that as it may, with
4 Modaber there was a change in the manner in which a physician
5 who had been denied privileges at a private hospital could
6 challenge that denial.

7 Now, Your Honor, the other case, and I did not
8 cite this in my brief and I will give the cite now, is Smith
9 versus Hampton Training School for Nurses, which, as most
10 people down here know, is the corporate name for Hampton
11 General Hospital. The cite on that is 243 F.Sup. 403.

12 THE COURT: 243 F. Sup?

13 MR. LUCE: Yes, Your Honor, 403.

14 THE COURT: That's about what, 1962?

15 MR. LUCE: 1965 case, Your Honor. Now, that at
16 page 406 the federal district court in Newport News, Judge
17 Hoffman, ruled as follows: I think this -- I quote this case
18 because I think it's the best expression of what this
19 transition from Simpkins to Modaber meant. It says, prior to
20 Simpkins, the Supreme Court of Appeals of Virginia decided
21 Khoury versus Community Memorial Hospital. And they note that
22 prior to the date on which the presently alleged cause of
23 action arose, which was Khoury --

24 THE COURT: Excuse me. Mr. Frank, you want to
25 return at 2:00?

1 (Interruption in the proceedings.)

2

3 MR. LUCE: So it says, prior to Simpkins, the
4 court of appeals in Khoury decided Khoury expressly holding
5 that a privately owned hospital was not an instrumentality of
6 government for the administration of any public duty, although
7 the service it performs is in the public interest. And it
8 goes on to state, while the Khoury case must now be reexamined
9 in light of the later decision in Simpkins, it is unquestioned
10 that at the time of these causes of action now asserted by the
11 plaintiff arose, the state and federal law was clear and
12 plaintiffs had no cause of action.

13 That's what Khoury says, there is no cause of
14 action. But after Simpkins there was a cause of action and it
15 was founded essentially in the United States Civil Rights Act.

16 Now, what has happened since then is, of course,
17 that Simpkins is no longer good law. Where are we? We're
18 back in 1962 with Khoury. And that is exactly what this
19 Federal District Court has held in the Ahmed case, which was
20 attached to our pleading. And this Court has held essentially
21 the same in Carter.

22 Now, an additional case, Your Honor, that
23 addresses this same point -- these are all Virginia cases,
24 Your Honor -- is the Greenspan case. Greenspan is a federal
25 district court opinion which is cited in our brief in support

1 of the memorandum for, of motion for dissolution. The cite on
2 that, Your Honor, is 485 F. Sup. 311. It's a 1980 case.
3 Greenspan makes it clear that the plaintiffs, in that instance
4 members purportedly of a medical staff of a privately owned
5 and maintained End Stage Renal Dialysis Facility, those
6 plaintiffs claimed that they had rights under the Constitution
7 of Virginia and the Constitution of the United States, and the
8 Court made it clear they have no such rights. That's at 314
9 of the opinion, Your Honor. They also held that despite then
10 HEW control over the ESRD facility. That's End Stage Renal
11 Disease Facility.

12 THE COURT: End what?

13 MR. LUCE: End Stage. That even that federal
14 control and funding fell short of the requisite state action.
15 And it also speaks further in there, Your Honor, of the
16 essential proposition that absent the protections of the Civil
17 Rights Act, there is no cause of action to compel a hospital,
18 a private hospital to appoint someone to medical staff, nor is
19 there a cause of action for judicial review for dismissal from
20 that medical staff.

21 Now, as I mentioned in the brief, that seems like
22 a harsh result. I think that in many instances it may well be
23 a harsh result. The question is whether or not it is what the
24 law provides and whether or not it is in the public interest.

25 Khoury is a case that has been continuously cited

1 in the Commonwealth of Virginia and in other jurisdictions as
2 sound law. Khoury is not as suggested by the reply memoranda
3 of the defendant, of the plaintiffs, limited to an application
4 for privileges. Khoury has been limited in its application,
5 however, Your Honor, by the Code of Virginia at 32.1, 134.1,
6 now 134.

7 THE COURT: Yes.

8 MR. LUCE: Now, 134.1 provides, as we know, that
9 in the instances in which a hospital fails to act on
10 application within 60 days or in which it suspends or
11 otherwise diminishes the privileges previously granted, that
12 the decision of the governing body must be based on certain
13 recognized and acceptable provisions, and there are certain
14 prohibited practices.

15 134.1, however, is not meaningless as the
16 plaintiff has suggested. 134.1 does not mean you can come up
17 with all the good reasons that might be close to what the
18 statute allows and simply evade any kind of judicial review.
19 But I think, Your Honor, that you have to take a look at what
20 the Ahmed case says and recognize that it was clearly designed
21 to limit judicial intervention to those instances in which a
22 governing body either gave no reason or gave an impermissible
23 reason for exclusion from a medical staff, regardless of
24 whether it was appointment, reappointment, suspension or
25 revocation.

1 THE COURT: Let me ask you about that staff
2 privileges act section you just cited. The 60 days, I've read
3 and reread that section quite a few times, and I can't tell
4 for sure yet, although maybe more reading will bring me more
5 light, I can't tell yet whether or not that 60 days applies
6 not only to request for privileges as well as to action taken
7 to limit or deprive privileges.

8 MR. LUCE: Your Honor, I think it's clear, it
9 applies to the application for privileges. I know that it
10 does in part because the intent of the statute was to
11 challenge the practice frankly that hospitals were being
12 advised to follow, which was they might be able to get you if
13 you deny them for an impermissible reason, but no one has any
14 right or standing to compel a hospital to act, and so what
15 happened was, nobody acted. You'd submit an application and
16 it would sit and the doctor would call up and have you acted
17 on my application. Oh, it's still being looked at, and he'd
18 call up again in a couple months, well, we're still trying to
19 get all the sources, and this could go on forever. That kind
20 of practice clearly had an inhibiting effect on the ability of
21 a physician to relocate their practice in a meaningful and
22 reasonable way.

23 THE COURT: I'll consider it in light of your
24 interpretation. I didn't mean to sidetrack you.

25 MR. LUCE: It doesn't, Your Honor, because it

1 brings this to -- really, I think that's not anecdotal.
2 That's what happens if you don't have a statute like 134.1 and
3 someone doesn't want to have someone appointed to the medical
4 staff, but the importance of 134.1, I think, has to be
5 considered in the context in which it was originally enacted.

6 THE COURT: Says here -- bear with me a minute.
7 Statute says, and this is quote, it shall be an improper
8 practice for the governing body of a hospital which has 25
9 beds or more and which is required by state law to be licensed
10 to refuse or fail to act within 60 days of a completed
11 application for staff membership or professional privileges or
12 deny or withhold from a duly licensed physician staff
13 membership or professional privileges or to exclude or expel a
14 physician from staff membership in such hospital or curtail,
15 terminate or diminish in any way a physician's professional
16 privileges in such hospital.

17 MR. LUCE: Yes, sir.

18 THE COURT: It goes on to say, if you don't do
19 that, it's an improper practice, which that's the language of
20 the statute, improper practice. It doesn't say what you get
21 for improper practices, but it's denominated an improper
22 practice.

23 MR. LUCE: That's correct, Your Honor. I think,
24 Your Honor, the critical point is, you see --

25 THE COURT: But this is all the disjunctive.

1 MR. LUCE: It is within the context of the
2 comments.

3 THE COURT: It's all in the alternative to deny
4 them privileges, to take away privileges, to limit privileges,
5 and it all has to be done within 60 days, and of course, that
6 gives me some concern here. So I'll ask you to think about
7 that as we go through.

8 MR. LUCE: I think, Your Honor, that the
9 appropriate answer would be, and I have not researched, but
10 I'm familiar with from previous matters and I believe to be
11 correct in this representation, that if you will note, there
12 appears a comma at a critical juncture which I think limits
13 the application of the within 60 days provision.

14 THE COURT: Let me find that because that would
15 be important.

16 MR. LUCE: The place where the comma is is one of
17 the more arcane elements of statutory construction.

18 THE COURT: That's why a lot of people give up
19 the law.

20 MR. LUCE: Yes, Your Honor. I would hate to be
21 held to the same standard in my own writings, but I think the
22 statute, if you look at it, Your Honor, is it stops on the
23 60-day modifier in, I think, a logical place. It says to act
24 within 60 days. Then when does the time period stop? Of a
25 completed application for staff membership or professional

1 privileges. That, I think, has to be read essentially as one
2 because they could give you membership and not give you the
3 privileges they wanted or whatever. Deny or withhold from a
4 duly licensed physician staff membership or professional
5 privileges. I think that's virtually redundant language,
6 frankly.

7 Now, back in such hospital, comma, I think is why
8 I represented initially, Your Honor, that I think that the 60
9 days was designed to attack a rather pernicious practice of
10 simply not acting on applications.

11 THE COURT: Then read on, or to exclude. So
12 you've got to go back and have a point of reference.

13 MR. LUCE: It shall be an improper practice. It
14 shall be an improper practice to, one, fail to act within 60
15 60 on an application for membership or privileges; two, to
16 exclude or expel a physician.

17 THE COURT: In writing.

18 MR. LUCE: Yes, Your Honor.

19 THE COURT: You say in writing. In writing
20 applies to both application and refusal.

21 MR. LUCE: Yes, Your Honor.

22 THE COURT: Okay. That's a good interpretation
23 for you, but I'm not sure the statute that's clear, but go
24 ahead.

25 MR. LUCE: Your Honor, I'm not going to suggest

1 the statute is all that clear, but I do think that comma is
2 pretty important as far as where the 60 days goes. If we're
3 into a problem about 60 days, we have, to some extent,
4 irreconcilable conflict with not only this hospital's medical
5 staff's bylaws but other hospitals.

6 THE COURT: When do we have that, if you read it
7 as I suggest.

8 MR. LUCE: As I understand it, Your Honor, there
9 might be some concern on the part of the Court that there had
10 to be an action within 60 days to exclude or expel a physician,
11 but if you took that opinion, you wouldn't know when the 60
12 days started. You know it starts from an application.

13 THE COURT: It's not a great statute.

14 MR. LUCE: Your Honor?

15 THE COURT: It's not a great statute.

16 MR. LUCE: It's not, Your Honor, but does the
17 Court have with it the Chippenham case?

18 THE COURT: I have it marked and on my desk.

19 MR. LUCE: Your Honor, I have a copy.

20 THE COURT: Whereabouts?

21 MR. LUCE: Your Honor, the original wording of
22 the statute appears --

23 THE COURT: This is the one they had to change.

24 MR. HARLAN: Page 69.

25 THE COURT: Because of two things, yeah.

1 MR. LUCE: Yes, Your Honor. If you look at page
2 68 and 69, you'll see the wording of the statute, and I think
3 that it's important for a couple reasons. First of all, Your
4 Honor, the reply brief suggests that the Commissioner of
5 Health testified before the General Assembly and that became
6 part of the legislative history.

7 THE COURT: Yes.

8 MR. LUCE: That's inaccurate. It's very clear
9 from the opinion that the Commissioner of Health, at that time
10 Mr. Shinehold (phonetics), had not testified before the
11 General Assembly, but, in fact, testified in the trial court.
12 The other thing that's important is that the reply brief
13 suggested there weren't some major changes in this statute. I
14 disagree with that. This statute was drafted as part of the
15 Virginia Certificate in Need law and it was an add-on by the
16 House.

17 THE COURT: Stop me if I'm wrong. All I see that
18 happened is they took that out of the certificate of need
19 paragraph to comply, to go away from article four, section
20 whatever of the Virginia Constitution that says, you can't
21 have more than one purpose in a statute, and you broke it out
22 and made it an independent section of the code. I don't think
23 they changed any of the language, did they?

24 MR. LUCE: Yes, they did, Your Honor.

25 THE COURT: Did they? I looked at it but didn't

1 go word for word.

2 MR. LUCE: I did, Your Honor, and I'm familiar
3 with the statute, and I think if you read this statute, it's
4 clear in its original format, not necessarily about the 60
5 days.

6 THE COURT: I tell you what, I'm going to get you
7 to read the statute that existed in Chippenham, which is the
8 predecessor of 32.1-134.1, if you will, read it starting at
9 the bottom of page 68 so I'll follow along here and we'll see
10 where the changes are.

11 MR. HARLAN: I can do it easier than that, Your
12 Honor. We have it highlighted, the two changes that were made.

13 THE COURT: I'll accept that in a moment.

14 MR. LUCE: Actually, Your Honor --

15 THE COURT: Let me see the changes.

16 MR. HARLAN: Let me show it to counsel first.
17 The blue and the yellow, the yellow has been deleted and the
18 blue is now in the affirmative.

19 MR. LUCE: Now, Your Honor, as you can see, this
20 statute was a typical agency organic statute that allowed the
21 agency to take disciplinary action in the form of suspension
22 or revocation of a hospital license. And it was designed to
23 not impair or affect any other right or remedy of the state.

24 Now, after the Chippenham ruling by the Supreme
25 Court, the General Assembly put the matter back in. They

1 obviously had to revise the statute and they had to do so in a
2 manner that would pass constitutional mustard. So they put in
3 a little different section entitled 32.1 and they deleted the
4 references to the suspension or revocation of license, in fact,
5 said it expressly would not to avoid constitutional problems.

6 Now, Your Honor, I think that it's important to
7 understand, first of all, that the allegation is that this,
8 that was legislative intent for this bill to provide for the
9 free relocation of a physician's practice and the bindings of
10 its care and so forth, as Doctor Shinehold's testimony was not
11 part of the legislative history. That is very clear in this
12 opinion. It's clear both in the express statement that it was
13 Doctor Shinehold's testimony in the case, and it's also clear
14 when you look at the footnote that appears at page 72, which
15 shows that, in fact, the bill was amended on the House side
16 when it was originally introduced. Didn't even have this
17 provision in it.

18 Now, Your Honor, why go into all that? Well, the
19 reason I suggest that it's important for the Court to note
20 these distinctions is this, that the statute at 134.1 was
21 clearly a compromise bill. It was a compromise bill that said
22 that the Court should at least be able to have some authority
23 to enjoin the failure of a hospital acting on applications,
24 that pernicious practice that everybody knew went on. The
25 other practice that was being addressed here was the decision

1 privileges are refused, period, because the other thing the
2 hospital did was they just denied it without reason the
3 application. Now, they can't do that anymore. They have to
4 state a reason.

5 Now, I think, Your Honor, that this statute is
6 not rendered meaningless, but I could think that it is not
7 enforceable beyond its bear terms here for a number of reasons.
8 Number one, the General Assembly easily could have included
9 more than what's included here, and number two, the General
10 Assembly recognized that, well, we're not going to say you
11 can't do anything else, but we're not going to expressly grant
12 injunctive jurisdiction to the courts to review these
13 decisions. So this statute does not impair other causes of
14 action that may or may not exist.

15 Typically defamation is one that often comes up
16 in these kinds of instances. It wouldn't impair the ability
17 of a physician if he were defamed to bring a defamation action.
18 It's an extreme. The limited application -- this is just my
19 own view about it. This is what the federal district has said.
20 The application of 134.1, I submit, Your Honor, is the
21 greatest extent of this Court's jurisdiction under the bill of
22 complaint as filed. And under the bill of complaint as filed
23 on its face, a phrase that counsel seems to take some
24 objection to, but I was taught that's how you judge these
25 things for a demurrer, on its face it states she was denied

1 certain rights. The bill doesn't cite 134.1, but I mean, you
2 know, so what. It's there and the Court can use it.

3 And if you look at the decision of the Board, you
4 don't have a one line ruling here that simply copies 134.1.
5 You have an explanatory decision that states reasons, that
6 states the basis upon which this Board accepted the
7 recommendation of the Medical Executive Committee and it lists
8 case names and the circumstances. The allegations of the
9 medical staff, the Board felt satisfied, were established.

10 Now, Your Honor, I think under 134.1 this bill
11 clearly fails to stand a claim. And I think it has to be
12 dismissed. And I think that the Khoury case is still very
13 clearly good law.

14 Now, I want to go back, Your Honor, to where I
15 started out. And that is, what is the authority of the Board?
16 Where does the Board derive its authority and to what extent
17 has it limited its authority in its relationships with its
18 medical staff. Respondent's reply brief suggests that I have
19 misapplied and misconstrued and by slight of hand have
20 misrepresented to this Court the holding of a number of cases.
21 Among those cases is Bello. Bello is a Massachusetts case.

22 Now, Your Honor, I think it's merely a matter of
23 the pressure of time and not any other purpose or reason that
24 counsel has made those allegations. And this is not an easy
25 area. The cases are sort of all over the place, but it's

1 pretty clear, Your Honor, that there are three lines of cases
2 in this country. There is the Khoury line, which is what I
3 call the non-intervention line. There is the modified Khoury
4 line, which the Shulman case discusses. The modified Khoury
5 line, that is, a hospital is, can still be held accountable
6 for its medical staff disciplinary actions to the extent that
7 its bylaws for that medical staff or its corporate bylaws
8 presumably establish steps in the procedure. That's what I
9 would call modified Khoury or step two.

10 Then there is the third case, which is really
11 represented almost only in any real sense by the New Jersey
12 courts, although other courts have modified a little bit about
13 what New Jersey held, and New Jersey has always held that
14 position, and it's even noted as far back as the 1960s and
15 Shulman has somewhat of an iconoclastic position in this
16 respect. Of those three lines of cases, Shulman is not a
17 modified Khoury case and Bello is not a modified Khoury case.

18 I learn something all the time when I'm dealing
19 with counsel as excellent as Mr. Harlan and I found I
20 committed an adumbration in my pleading and I never adumbrated
21 before, Your Honor, and I went to find out what I had done.
22 What it says was, I had foreshadowed or I had sketchily
23 described the holding of some cases.

24 MR. HARLAN: Trading in a cloud, Your Honor, a
25 mist of fog, if you will.

1 THE COURT: That was your term.

2 MR. LUCE: That wasn't in my dictionary, but I
3 think that what it is, it's a peculiar deletion in the rule.

4 Now, the Shulman case is the one in question and
5 I looked up Shulman for where my error had been. And the
6 petitioner's memoranda at six says that the Shulman case held
7 that the holding of absolute discretion of a private hospital
8 authority was subject to exception. In a case in which there
9 is a failure to conform to procedural requirements set forth
10 in its constitution, bylaws or rules and regulations. In that
11 event the extent of judicial review is to require compliance
12 with the prescribed procedure. In the instant case, the
13 bylaws, which are a part of the record, don't provide any
14 specific procedure.

15 Now, Your Honor, there is three words that are
16 deleted from this citation that are a curious adumbration to
17 me. They are, the only possible exception. And if you read
18 the opinion and you turn the page, you find that the court
19 says, some courts have held that that is the standard. That's
20 modified Khoury. Shulman didn't hold that, didn't need to.
21 Even as stated in their brief, these bylaws didn't recover any
22 kind of procedure like that.

23 Shulman is not a modified Khoury case. It has
24 been cited by the courts. I don't dispute that as modified
25 Khoury but it is not. It's been cited for both propositions.

1 In fact, eight years later in Shulman, very persistent fellow,
2 the Court itself stated not in its conclusion of law but in
3 its discussion that it thought that's the way the Court held.
4 Is this arcane, Your Honor? I don't think so. I don't think
5 so. Not because counsel have rather casually suggested I
6 misrepresented the cases. That's argument. I understand that.
7 I think it's important because it reflects the state of the
8 law today.

9 The state of the law today is that hospitals have
10 a lot of obligations that are created by a lot of different
11 sources. The question before this Court is, of all the
12 obligations a hospital has, to the Joint Commission to
13 maintain accreditation, to the Department of Health in
14 Virginia to maintain licensure, to the Department of Health
15 and Human Services to make sure it gets paid for Medicare and
16 so forth, how many of those afford a private right of action?
17 And finally is there a private right of action provided by the
18 bylaws?

19 Well, Your Honor, let's take a look at that in
20 one final case that it's been suggested I've misdescribed.
21 The Bello case that I started out with is an important case.
22 First of all, it's a case that I cited that's apparently not
23 of such antiquity that it's still worth discussing, and the
24 Bello case contains some language that I think is partly a
25 source of a lot of confusion, confusion in the reply brief by

1 the plaintiff and a confusion on a lot of the Court's
2 thinkings.

3 The Bello case discussed whether or not a
4 physician had standing to enforce the bylaw provisions of the
5 hospital. And what the Court held there was, that under the
6 Massachusetts law there's a limitation on those persons who
7 can enforce the bylaw provisions.

8 Now, bear in mind that there are two terms that
9 come up in the Bello case that I think have been misunderstood
10 in the reply brief and probably in other courts' rulings.
11 First is, what is the member of a hospital? And secondly,
12 what bylaws are we talking about? The reply brief suggests
13 that Bello, it stands for the proposition that -- and I will
14 quote from page three of the reply memoranda. The holding of
15 Bello, properly stated, is that such physicians are without
16 standing to seek an injunction. The court in Bello explicitly
17 recognized that Massachusetts law entertains challenge to the
18 hospital bylaws by members, underlined, quote, and that
19 contractual rights arise when such application is accepted by
20 the corporation.

21 Well, Your Honor, I don't have any problem with
22 the Bello case because the bylaws in question are the
23 corporate bylaws and the member in question is not a member of
24 the medical staff. It's a member of a non-stock corporation.
25 Bello is Khoury. Bello states that.

1 However, the case that is cited by the physician,
2 Duby versus Barton, a Massachusetts case, involves challenges
3 to the hospital's bylaws brought by members of the hospital
4 corporation. The physicians are not members of the hospital
5 corporation. They have cited no case and we can find none
6 which supports the proposition that an applicant denied
7 membership in a corporation has a right to challenge the
8 corporation's compliance with its own bylaws.

9 THE COURT: Do you distinguish between that and
10 one who is a member of the staff?

11 MR. LUCE: Yes, Your Honor, because they're not
12 talking about membership on the medical staff. They're
13 talking about membership in the corporation, and membership in
14 the corporation is a defined term.

15 THE COURT: How are you ever a member of a
16 non-stock corporation?

17 MR. LUCE: Your Honor, that is exactly what the,
18 as stated in the beginning, this is a non-stock member
19 corporation organized under the laws of Virginia, and member
20 is a defined term.

21 THE COURT: Defined how?

22 MR. LUCE: I'm going to read that for you, Your
23 Honor. I'm reading from Section 13.1 and it's 803 definition
24 section of the Virginia Non-stock Corporation Act. Member is
25 defined as, means one, having membership rights in a

1 corporation in accordance with the provisions of its articles
2 of incorporation or bylaws. And articles of incorporation --

3 THE COURT: What's that definition section, 13.1
4 what?

5 MR. LUCE: Dash 803, Your Honor.

6 THE COURT: All right.

7 MR. LUCE: Now, the bylaws they're talking about
8 here are the corporate bylaws, Medical Center Hospitals'
9 bylaws, not medical staff.

10 THE COURT: Let me see that.

11 MR. HARLAN: We've given you a copy of the Bello
12 case for clarity.

13 MR. LUCE: Do you want to see Bello or --

14 THE COURT: No, no, just the definition section.
15 All right. Here you are.

16 MR. LUCE: Your Honor, in this case, Medical
17 Center Hospitals by law has only one member, Alliance Health
18 System.

19 THE COURT: What is that member?

20 MR. LUCE: Alliance Health System, which is
21 essentially the holding company of Medical Center Hospitals
22 and some other entities within that Alliance system. And as a
23 member corporation, it has the authority to appoint the
24 Executive Board and it has oversight authority and in some
25 instances --

1 THE COURT: Do you have the articles of
2 incorporation and bylaws of the hospital here today?

3 MR. LUCE: I have the bylaws, Your Honor, and I
4 believe I have the articles of incorporation. I have a copy
5 of the bylaws for you.

6 Do you have a copy of these?

7 MR. HARLAN: Let me see if we have the same copy.

8 MR. LUCE: They are appended to our motion for
9 dissolution.

10 MR. HARLAN: Excuse me. Does the Court have a
11 copy of the petition filed by Mr. Luce because I think there
12 is a copy attached to that petition.

13 MR. LUCE: The Court does have a copy.

14 MR. HARLAN: It would be a part of the court file,
15 would it not, the petition?

16 MR. LUCE: I think it's also our --

17 MR. FRANKLIN:: It's appended to the brief as an
18 exhibit.

19 THE COURT: That's all right.

20 MR. HARLAN: Could we have that formally marked
21 as an exhibit?

22 THE COURT: Are the articles of incorporation
23 attached anywhere?

24 MR. LUCE: I'm not sure they are, Your Honor. I
25 think the Court can take judicial notice of them and I can

1 have a copy for the Court. I have it here somewhere, Your
2 Honor, but I've got a lot of papers, as the Court knows.

3 MR. HARLAN: I have no objection to stipulating
4 and offering the articles of incorporation, Your Honor, if
5 you'd like to have a copy. We've obtained a copy from the
6 State Corporation Commission.

7 THE COURT: The articles of incorporation?

8 MR. HARLAN: Yes.

9 THE COURT: Let me take a look.

10 MR. HARLAN: And I'd also at this time like to
11 introduce them as well as the bylaws of the Medical Center
12 Hospitals.

13 THE COURT: I'll take in the bylaws of Medical
14 Center Hospitals -- defendant's one or plaintiff's one?

15 MR. LUCE: Put them in as defendant's, if you
16 like, Your Honor.

17 THE COURT: I'll put them in as defendant's,
18 since it's your portion of the argument. So then as exhibit
19 two is admitted the articles of incorporation. All right.
20 D-2.

21
22 (Whereupon, the articles of incorporation were
23 marked as Defendant's Exhibit No. 2.)
24

25 MR. LUCE: Your Honor, I think it's important to

1 note that Bello also raises another question that doesn't
2 raise -- it resolves a number of questions, and one of them is
3 that Bello refers also to the authority of the Attorney
4 General in the exercise of its supervisory powers over public
5 charities, and in the Massachusetts courts they've held that
6 it's the exclusive function of the Attorney General to correct
7 abuses of administration in public charity in the institution
8 of proper proceedings under that statute, his duty to see that
9 public interest is protected and proceed in the prosecution or
10 decline to proceed or as may require.

11 Your Honor, to be honest, I have not had an
12 opportunity to determine whether that falls within the
13 Virginia Attorney General's power. I don't think the Patri
14 (phonetics) Doctrine comes in. There are lots of lawyers
15 with lots of clever ideas that might attack, but what we're
16 talking about here is this Court's review of a final decision
17 by this hospital's governing body, and the members of the
18 corporation that can enforce those bylaws are and have a
19 contract, if it can be called a contract at all, are the
20 members of the corporation.

21 THE COURT: How much longer will you be?

22 MR. LUCE: Your Honor, let me check my notes, but
23 I believe that really -- I guess the last thing I would say,
24 Your Honor, is that it is clear, and I'd ask the Court to note
25 in section six of article seven of the Medical Center bylaws --

1 THE COURT: Say it again.

2 MR. LUCE: Medical Center bylaws article seven,
3 section six.

4 THE COURT: Yes.

5 MR. LUCE: That the hospital governing body, the
6 Executive Board reserved to itself the authority to suspend in
7 any case in which it felt it needed to do so,
8 notwithstanding the bylaws of the medical staff. So even if
9 there was some kind of contract created, I don't submit there
10 was, but even if there were, that contract would not be a
11 valid contract because one party would always have the
12 unilateral authority to simply walk away from it, and I don't
13 think that constitutes a contract.

14 THE COURT: All right.

15 MR. LUCE: Let me, if I might, just one final
16 point because --

17 THE COURT: What do you say to the proposition
18 that once they get -- that may be true, but if they have
19 alternative methods for depriving the doctor of privileges
20 once they get on track, and instead of the summary method of
21 power that the Executive Board has, then is there any
22 suggestion that the mere fact that the summary power of the
23 Executive Board nullifies and overrides any defects that might
24 occur in the procedures followed by the other route, which is
25 route B, we'll call it?

1 MR. LUCE: Excellent point, Your Honor, one that
2 Mr. Franklin and I have discussed and I'm glad the Court
3 brought that up because I neglected to include it in my
4 outline. The question there, I guess, is really in judicial
5 terms would be, was the procedural error prejudicial error so
6 that the decision of the body was tainted, that it couldn't
7 have reached a fair decision because it didn't adhere to the
8 proper procedure for reaching those decisions.

9 Your Honor, I think that in the case of a state
10 agency, the procedural errors that might occur, and they
11 always occur, but the procedural errors that might occur have
12 to be established to be prejudicial error. That's clear.
13 That's provided in the Virginia APA, 99-614:7. And in a
14 hospital governing body there is no such standard. That's
15 exactly why they wrote that that way and that's why I tell
16 hospitals to write them that way.

17 This is the scenario. This does not reflect on
18 this case, purely hypothetical. A physician goes up through
19 the proceedings of the hospital's bylaws and it's determined
20 that there is just no doubt that that physician has killed a
21 patient, take the extreme, but the hospital has a summary
22 suspension procedure and used it but didn't use it quite right,
23 didn't give the right notice and suspended them and everything
24 and the physician was given this appeal within ten days,
25 decided that and established that the hospital didn't follow

1 its bylaws. But they also decided that the physician was a
2 risk to patient health and safety.

3 That's why that provision exists, Your Honor, and
4 that provision is controlling, and it has to be because the
5 hospital is not nor is it required to be an administrative
6 agency. It is required to make good qualified decisions about
7 the safety of patient care and to assure that patient care is
8 provided in a safe fashion and generally for the well-being of
9 patients and in an organized conduction of the affairs of the
10 hospital.

11 And Your Honor can see in the Cristhill
12 (phonetics) case where a hospital uses summary suspension
13 procedure and the Fourth Circuit said, we're not sure you did
14 it right, you're supposed to give ten days, and they used a
15 lot of stuff they wouldn't use now simply because it's been
16 reversed. But the fact is, a hospital has got to be able to
17 make the right decision about these things.

18 Now, the bylaws do provide in the standard of
19 review before you go before the governing body is, can you
20 assure there was a material error in the procedure, that
21 something wasn't fair, and I think that what I'm saying to the
22 Court is that the board, the governing body of a hospital is
23 imbued with the authority to make those decisions. They're
24 supposed to know, just as this Court is supposed to know, in
25 appropriate cases whether or not the result that's been

1 suggested by an agency is, in fact, the real facts, are those
2 the things that justify the decision.

3 Your Honor, I think what we're talking about is
4 the difference between this Court being the final arbiter of
5 the administrative agency clearly and the governing body being
6 the final authority of its medical staff decision.

7 THE COURT: That's what Marberry Madison
8 (phonetics) was all about, judicial review.

9 MR. LUCE: It was, Your Honor, and it was also
10 within the course of the constitutional framework, and here we
11 don't have a constitutional framework. We have a corporate
12 framework, and the corporate framework under the Virginia law
13 is clear that the state will not interfere in deliberations of
14 the governing body.

15 THE COURT: Virginia law says, for instance, no
16 court shall override a judicial review of the ABC Board.

17 MR. LUCE: A lot of people found that a pretty
18 harsh result. It's been modified some. Now there is still
19 some appeal, but it's limited, but I saw they did lose their
20 last case in the court of appeals.

21 Thank you, Your Honor. Give me just a minute.

22 MR. HARLAN: Can we take a five minute recess,
23 Your Honor.

24

25 (Whereupon, a lunch break was taken.)

AFTERNOON SESSION

THE COURT: Okay. Mr. Harlan. You're on.

MR. HARLAN: All right, sir. If I may, because I realize that the argument of these cases can tax even the most patient of soles.

THE COURT: Which you know I'm not.

MR. HARLAN: I have drawn an outline. The word, and we will promise Mr. Luce to talk in monosyllabic phrases from now on, but adumbrate is certainly an adjective that is quite apropos.

If I can just begin to clear away the chaff and get away down to the kernels, this is a rough outline of what we're trying to discuss. If there is a state action or state run hospital, which this is not, it is known as a public hospital and the employees have a full Fourteenth Amendment United States constitutional due process. That is not involved here.

If there is no state action and it is a private hospital, which this is, there are two aspects that can apply. First of all, it is no Fourteenth Amendment due process that's involved. That is not being argued. But if there are bylaws and if there are constitutional provisions, the due process, which for want of a better word, just so you and I understand each other, it is limited to a contractual due process which

1 comes out of the bylaws. That is the case at bar.

2 Now, further, to distinguish and clear away some
3 of the chaff, there are two separate bodies of law. They are
4 as distant and separate as in the landlord-tenant situation
5 where the four walls are being rented and one body of law
6 applies and the common entranceway another entirely different
7 law applies. The law that applies to applicants, those who
8 come up to the hospital and say, may I become a member of your
9 staff, is one body of law. The basic tenant is it is at will,
10 doctor, I don't like the color of your eyes, application
11 denied.

12 With respect to existing staff, those who are
13 already on the staff, such as Doctor Terzis, this is the law
14 that applies. The existing staff has a contractual right by
15 signing the application with the hospital so that the hospital
16 is mandated to go through the provisions minimally of their
17 bylaws and thereby afford the physician what I am calling
18 contractual due process.

19 Now, we're saying that this limited area of
20 contractual due process, for a member of the existing staff,
21 is subject to judicial review on two basic premises. Number
22 one, general equitable principals, which this Court has
23 inherently in its powers to review to see whether or not the
24 tenets of the contract had been abided by. That's number one.

25 Number two, Section 13.1-134.1, that's number two,

1 and that is the area in which Doctor Terzis is proceeding and
2 to talk about state action, talk about the Khoury.

3 THE COURT: When you speak of contractual due
4 process, would another word be procedural due process?

5 MR. HARLAN: No, sir. When I say contractual due
6 process, it is a restricted due process and it may not exist
7 in some hospitals, to be sure, because if the hospital didn't
8 have --

9 THE COURT: I don't know the term contractual due
10 process.

11 MR. HARLAN: It might be -- it's my term for the
12 purposes of trying to explain. What I'm saying is, suppose
13 you went to a hospital and made an application to join its
14 medical staff and they had no bylaws and they just reviewed
15 and said come on aboard. Then if there is nothing by which
16 the hospital had agreed to perpetuate your employment, they
17 could terminate you at will. But if there are bylaws in the
18 hospital and if the applicant has agreed to abide by those
19 bylaws, almost universally the modern courts that have
20 addressed the problem have said that this due process, as
21 narrow as it might be, must be accorded contractually to the
22 applicant who is a member of the existing staff.

23 Now, so that's -- so all of the rest of this that
24 has been discussed in their case is inapropos, and let me give
25 you an example. The Khoury case, Doctor Khoury was not a

1 member of the existing staff. Doctor Khoury had made an
2 application. He was there on a temporary basis, subject to
3 the permanent giving of his staff privileges, at which time
4 they terminated Doctor Khoury because he accused the
5 radiologist or impliedly accused the radiologist of dropping
6 his patient on the floor and breaking his back.

7 Khoury is totally inapposite to this case. It
8 does not apply. It is good law, to be sure, but it doesn't
9 apply. It's like the landlord tenant situation that applies
10 to the four walls of the apartment rented and not to the
11 common entranceways. We're talking about existing staff
12 limited to contractual due process.

13 Now, if I may, Judge, let's, if I can, lead the
14 Court down the procession through which Doctor Terzis and
15 others have journeyed into getting their privileges granted at
16 the Medical Center Hospitals.

17 On the medical, the bylaws rules and regulations
18 of the staff, sir, I have a paper clip in place, if you'd be
19 kind enough --

20 THE COURT: Somebody got my copy of it.

21 MR. HARLAN: Did you-all --

22 THE COURT: That's okay. Go ahead.

23 MR. HARLAN: Here it is. Right here, 13.1-134.1.
24 Now, Judge, this is a typical application, and I draw your
25 attention, first of all, to the first page of the application

1 where you fill out your education, so sort, so forth and so on,
2 and the second page of the application, if you look down in
3 the lower left-hand corner, Roman numeral 13. If the answer
4 to any of the following questions is yes, please give details
5 on a separate sheet of paper; has your license to practice
6 medicine ever been limited, suspended or revoked; have you
7 been refused membership on a hospital staff; has your request
8 for any specific clinical privileges ever been denied or
9 granted with stated limitations; have your privileges at any
10 hospital ever been suspended, admonished, revoked or renewed,
11 et cetera.

12 Now, Roman numeral fifteen, what the applicant
13 whose signature is on the very next page signs is this, I
14 fully understand that any misstatements or omissions from this
15 application constitute cause for denial of appointment, so
16 forth and so on, but here is the salient paragraph as
17 paragraph number two, three, and four.

18 THE COURT: Don't read it to me. Just cite it to
19 me because I'm looking right at it.

20 MR. HARLAN: All right. She agrees to read and
21 abide by the bylaws, rules and regulations of the medical
22 staff of the Medical Center Hospitals. That's this book, Your
23 Honor, right here that you're reading from. She also
24 acknowledges that she's familiar with the principals and
25 standards of the JCAH and she agrees to be bound by the terms

1 of the bylaws, rules and regulations and the principals of the
2 JCAH. Okay. And she further agrees, and the last sentence of
3 that first paragraph, to abide by such hospital and staff
4 rules and regulations that may be from time to time enacted.
5 Now, that is the salient paragraph for purposes of this case.
6 That's the beginning.

7 Now, this application is then taken, according to
8 the bylaws of the medical staff, and processed, and she is
9 given membership in the medical staff. I used it existing
10 staff. She becomes a member of the medical staff and so
11 became a member of the medical staff since 1981.

12 Now, we have given to the Court a list of cases
13 in our memoranda in opposition beginning at page three and
14 attached to your memoranda Xeroxed copies of them, which case
15 after case after case after case talk about this narrow window.

16 The narrow window is one, not if you're applying
17 for staff as Doctor Khoury did, but if you're a member of the
18 staff, and if there are bylaws, there exists then and there a
19 contract between the hospital on the one hand and the member
20 of the medical staff, such as Doctor Terzis on the other.
21 Doctor Terzis agrees to abide by the bylaws, and the hospital,
22 by case law, agrees that the bylaws will prevail in the event
23 that she is being charged with anything that may affect her
24 privileges. They will give her whatever minimal due process,
25 or I've used the word contractual due process, that exists in

1 the bylaws.

2 Now, what you have also in front of you is the
3 bylaws of the hospital. Where's our copy of that? Do you
4 have it? Bear with me, Judge. There's a lot of papers in
5 this case. Here we are. That's this document, sir.

6 THE COURT: That's D1.

7 MR. HARLAN: Now, the bylaws of the Medical
8 Center Hospitals specifically, if you'll turn to section,
9 excuse me, article Roman numeral seven, section six. First,
10 section one, section one, article Roman numeral section one.
11 Authority, Executive Board in this paragraph delegates to the
12 medical staff the authority to evaluate the professional
13 competency of its members, doctors, and applicants for medical
14 staff privileges subject to conditions set forth in conditions
15 two through nine below.

16 It goes on to say, the medical staff is to
17 maintain standards of medical care appropriate for large
18 regional hospitals and says the Executive Board also expects
19 the medical staff to review the medical care provided and so
20 forth.

21 Then, number two tells what the medical staff
22 consists of. All physicians, dentists, affiliate medical
23 staff, so forth, and three, how the medical staff shall
24 organize itself. This is the constitution, if you will, that
25 gives the medical staff its mandate. The medical staff shall

1 be organized in accordance with the bylaws adopted by it and
2 approved by the Executive Board. So the Executive Board, in
3 order for the bylaws to be valid, must approve them.

4 Now, if the Court would be kind enough to turn to
5 section six, it talks about termination or modification of the
6 staff's status. And if you'll drop down to the middle of that
7 paragraph.

8 THE COURT: Before any such action?

9 MR. HARLAN: Yes. If you'll read that, before
10 any such action is taken by the Executive Board, the
11 practitioner mandatorily shall be given written notice of the
12 proposed termination or modification of staff status and
13 advised that he will be afforded the protection of due process
14 as outlined by the bylaws and approved by the Executive Board.

15 Now, here is a little bit of circuitous reasoning,
16 if you will. The Executive Board is granting to the medical
17 staff the ability to generate bylaws and then after they
18 generate them the Executive Board ratifies their validity. So
19 in this case they have ratified it, and whether the term due
20 process in this particular language is more expansive in the
21 Fourteenth Amendment sense or whether it is as the medical
22 staff approved, it is probably irrelevant for this point, but
23 nevertheless, this is where the medical staff gets its power
24 to --

25 THE COURT: Define for me, will you please, or

1 illustrate for me or illuminate for me what is the due process
2 of which they speak, the due process as outlined in the bylaws
3 of the medical staff.

4 MR. HARLAN: All right, sir.

5 Now, the due process in the bylaws of the medical
6 staff begins under the concept of corrective action. And if
7 you look at page 45, Your Honor please, article nine, and just
8 bear with me, and if you will go through the entire article
9 nine, I will tell you that this is what it will talk about.
10 It divides corrective action into two basic methods, number
11 one, I'll call it normal corrective action, and, number two,
12 summary. I'll point that out to you.

13 THE COURT: That's Roman numeral nine?

14 MR. HARLAN: Yes, sir. Now, normal corrective
15 action contemplates -- let me first start with a summary
16 corrective action. Summary corrective action is spelled out
17 at page 48, subparagraph C. It tells what the grounds are and,
18 in essence, it is an impaired physician or an unfrocked
19 physician, something that can immediately jeopardize the
20 patient care.

21 And summary suspension means one, under the terms
22 of this, the physician's privileges on the existing staff be
23 summarily suspended and that a hearing follows the suspension.
24 Now, that was not the case here. I'm just pointing out two of
25 the powers.

1 Now, if the Court will go back to page 45, under
2 the normal corrective action, paragraph B, it talks about the
3 procedure for corrective action. And, in essence, a charge
4 against a physician must, for a review, a request for any
5 corrective action under this article may be made by any
6 officer of the medical staff, and it outlines the various
7 people that can make it. All such requests shall be in
8 writing and addressed to the president.

9 Now, when the president then puts the charges
10 before the Departmental Authorities Committee, which we
11 referred to as the DAC, and the Departmental Authorities
12 Committee can investigate it. I'll refer to that as, DAC as
13 step one, and they have no power to act per se but they make
14 recommendations only to the Medical Executive Committee.

15 Two, the Medical Executive Committee also has the
16 ability to request the physician be present to answer the
17 charges, and they can, they are a superior committee in terms
18 of the way the bylaws are structured and they can adopt in
19 full the recommendations of the DAC. They can modify,
20 eliminate and so forth, but then they make a recommendation to
21 the Executive Board.

22 Now, it is -- let me just back up a minute. The
23 charges which are supposed to be in writing at this time
24 should have been delivered to the physician. The physician
25 then goes to the DAC and faces the charges. Okay. After that

1 hearing they make a recommendation of the MEC. She can or he
2 can at the DAC level see what the recommendations are and say,
3 okay, I don't further wish to contest this. And if that
4 physician doesn't wish to contest the charges or the
5 recommendations at this point, then the recommendations would
6 be passed through swiftly and be approved by the Board.

7 If, on the other hand, the physician contests the
8 recommendations as made to the MEC, she can request or she can
9 be invited to appear before or she is invited to appear before
10 the MEC.

11 At the MEC level the same thing can happen. The
12 MEC can throw out the DAC's recommendations, adopt them. They
13 can even add charges, as they did in this case, or appear to
14 be able to add charges, and she is given the opportunity to be
15 present.

16 Now, at neither of these two committee hearings,
17 the DAC nor the MEC, are you allowed to have any concept of
18 due process. As a matter of fact, they say no attorney shall
19 be present. If you read, if you read on, shall not constitute
20 a hearing. It's a non-hearing, if you will. Shall be
21 preliminary in nature. None of the procedural rules provided
22 by these bylaws with respect to the hearing shall apply thereto.
23 A record of such interview shall be made, is called an
24 interview with the physician by the DAC, and included with its
25 report to the Medical Executive Committee. Then 10 days after

1 they've got to make a report to the MEC.

2 Almost similar rules to this with the MEC. The
3 appearance shall not constitute a hearing, shall be
4 preliminary in nature. None of the procedural rules provided
5 by these bylaws and so forth shall apply and a record shall be
6 made. Action of the Medical Executive Committee may be to
7 accept, modify, correct, to issue a warning, a letter of
8 admonition, a letter of reprimand, to impose terms of
9 probation or requirement for consultation, to recommend
10 reduction, suspension or revocation of privileges.

11 Now,, keep in mind, both of these boards have
12 only the right to recommend and only would that recommended
13 right turn into fact as if the physician acquiesced and then
14 it is subsequently stamped with approval, but if the physician
15 doesn't acquiesce, then here at this juncture, when the MEC
16 recommends to the Executive Board, at that point in time the
17 physician following these rules under Roman numeral ten now,
18 Your Honor, hearing an appellate review procedure, page 53,
19 at that point in time the physician can notice her appeal or
20 his appeal.

21 Now, we're now where the MEC has recommended to
22 the Executive Board and at this juncture an appeal. Now,
23 when this happens, the following are the protocols of Roman
24 numeral ten, the Medical Executive Committee appoints a
25 chairman and up to seven total members of what they call it an

1 Ad Hoc Committee or an appellate Ad Hoc Committee, if you will.
2 Okay. This committee we have been referring to in this
3 proceeding as Doctor Parker Cross's committee. And for the
4 first time she or the doctor is allowed to have a lawyer
5 present.

6 The doctor is mandated by, in number ten, to be
7 able to put on evidence in her behalf, to cross-examine
8 witnesses, to call witnesses on her behalf, although they have
9 no provision to order witnesses to be present. And the
10 conduct of the hearing is set forth at page 56 to 57. The
11 personal appearance of the doctor requesting this is mandatory.
12 If she doesn't appear, her appeal is waived. The chairman
13 presides and he will rule on the matters of law and evidence
14 to assure all participants in the hearing a reasonable
15 opportunity to present relevant oral and documentary evidence
16 and maintain decorum.

17 Paragraph six -- I'm reading from the top of page
18 58, Your Honor. The hearing need not be conducted strictly
19 according to the rules of law relating to examination of
20 witnesses. Any relevant matters upon which responsible
21 persons rely on the conduct of serious affairs shall be
22 considered. Each party is entitled to submit memoranda.

23 Now, the key thing here, page 58, paragraph seven,
24 when the Medical Executive Committee, when its recommendation
25 has prompted the hearing, shall appoint one of its members,

1 some other member of the medical staff or an attorney -- in
2 this case the attorney that was appointed to represent it at
3 the hearing -- there were two attorneys at this particular
4 hearing. Mr. Luce sat alongside Doctor Cross and Mr. Franklin
5 sat alongside Doctor George Hoffman, who is a member of the
6 Medical Executive Committee and acted in sort of a
7 prosecutorial role in the fact he read the charges.

8 The Medical Executive Committee's representative
9 shall speak first presenting his evidence in support of its
10 adverse recommendation or decision. The affected practitioner
11 shall thereafter be responsible for supporting his challenge
12 to the adverse recommendation or decision by an appropriate
13 showing that the charges or grounds involved lack any factual
14 basis or that such basis or any action based thereon is either
15 arbitrary, unreasonable or capricious.

16 If you'll drop down to page 59, paragraph ten,
17 the hearing committee shall make a written report based on
18 substantial factual evidence.

19 Now, one of the contentions that Doctor Terzis
20 has maintained and signed an affidavit to this effect both in
21 her bill of complaint and amended complaint was she was denied
22 the right to put on evidence out of the 142 charges which she
23 was then faced with at this then Ad Hoc Committee. They heard
24 four cases, four cases, and out of the four cases we notified
25 them between day one and day two that two of her witnesses,

1 one was in Canada, the other was taken away on an emergency
2 because his wife was dying in Florida and that we were on the
3 second day of the hearing. We didn't think that they would
4 reach the point where they had gotten through 142 charges and
5 they didn't. They went through four.

6 So the second day we're invited by Doctor Cross
7 to put on evidence and we started putting on evidence. And we
8 reached midnight. The court reporter said, I can't go any
9 further. Fine, we'll set a new day. The new day happened to
10 be Wednesday. 11:30 in the morning I got a telephone call
11 from Mr. Luce. He says, Mr. Harlan, we're going to go today
12 at 4:30 p.m. I said, wait a minute, this is Doctor Terzis'
13 big day. She's got patients all over the world coming in. We
14 told you that. Can't you do it on Friday or can't you do it
15 on Saturday? The committee is going to meet, Mr. Harlan,
16 whether you're there or not, and by the way, you're not
17 putting on anymore evidence, number one. Number two, Doctor
18 Terzis will be given 30 minutes.

19 THE COURT: This is really an evidentiary hearing
20 and we're really here on a demurrer today.

21 MR. HARLAN: All right. We'll proceed. The
22 recommendation of the Ad Hoc Committee goes back to the
23 Medical Executive Committee, and the Medical Executive
24 Committee by the rule ten is allowed to accept it, reject it
25 and reinstate its own first recommendation. And then it goes

1 to the Executive Board. Then we got notified as to what their
2 actions were and we then can ask to be present before the
3 Executive Board.

4 Now, the Executive Board takes the transcript
5 from the so-called trial below, is supposed to read it. We're
6 allowed to put a memoranda before the Executive Board. We
7 have attached that to a copy of our bill of complaint, have we
8 not, which seriatim outlines what happened. It's part of the
9 verified testimony of Doctor Terzis or in affidavit form, and
10 we're given fifteen minutes to argue before the Executive
11 Board, which we were, and the Executive Board in this case
12 upheld the actions of all the committees.

13 Now, that is basically where the bylaws set forth
14 the appeal to the board of directors, at page 60 and 61, and
15 it -- there is a misprint apparently at page 65. If it is, it
16 says, this decision, meaning the one by the Executive Board,
17 shall be made immediately effective in final and shall be
18 subject to further hearing or appellate review. They claim
19 it's a misprint, but these are the bylaws that were
20 promulgated by the medical staff since 1984. The action took
21 place in 1986 and no attempt has been made, as far as I'm
22 aware of, to send an errata sheet around which says it shall
23 be subject to further hearing and appellate review. We are
24 here in this Court for further hearing and appellate review.

25 Now, Judge, the cases, and I don't want to stand

1 up here and read case after case after case, but I do ask you,
2 because we have carefully Xeroxed the earlier cases. Some of
3 these cases are 1965 cases, '62 cases cited by the defendants.
4 There has been a change in the thinking in the United States
5 and it is reflected in this area in terms of the existing
6 staff, and time after time again the courts that are called
7 upon to review this have stated that indeed the court has,
8 we're not practicing medicine say the courts. That was one of
9 the reluctances. This is one of the things Mr. Luce first
10 stated, that Medical Center Hospital was upset because this
11 Court is telling them how to practice medicine.

12 This is the most -- I'm going to try to use a
13 monosyllabic word. Unnecessary. That's a little more.
14 Unnecessary statement to make. What I'm trying to say is,
15 traditionally, in every single case the Court doesn't know how
16 to run General Motors, but they get involved in disputes over
17 labor in terms of whether due process has been handled.
18 You're not telling them how to run their hospital in terms of
19 medically how to run it. You're telling them or this Court is
20 telling them or will hopefully be telling them --

21 THE COURT: Let me ask you a question.

22 MR. HARLAN: Yes, sir.

23 THE COURT: When you're arguing contractual due
24 process, are you not just, in fact, arguing contractual rights,
25 which is the --

1 MR. HARLAN: Yes.

2 THE COURT: Which is the third part of the, the
3 third leg on that stool that we have there, which is, which
4 was put forth in Khoury. Khoury had, I think, three legs and
5 one they dealt with and one they didn't and one they reserved
6 on. They assumed a contract for the purposes of their
7 decision. Then they reserved in Khoury whether or not there
8 were any contractual rights available to the --

9 MR. HARLAN: Yes, and they found there were none.

10 THE COURT: They didn't say that. They said he
11 had never joined the staff, although I recall that was a tough
12 decision in my opinion. They said he had never joined the
13 staff, and probably Frank Slayton was the one that got this
14 thing passed, put in staff privileges after he got from South
15 Boston. He probably saw to it that they had a little
16 something in there for the boys, but -- am I right, Mr. Luce?
17 You know whether or not Frank Slayton sponsored that
18 legislation?

19 MR. LUCE: I don't know.

20 THE COURT: Be interesting to know, wouldn't it.

21 MR. LUCE: Yes, sir.

22 MR. HARLAN: I think the case in this case is
23 right along with what you're talking about, page 243. The
24 Supreme Court is sitting up there --

25 THE COURT: Said he wasn't a vested member, so to

1 speak. Therefore, they didn't have to reach that point.

2 MR. HARLAN: That's right. That's it in a
3 nutshell. In other words, along the lines of what you're
4 saying, right out of 243 of the Khoury case, page 243,
5 paragraph two, the head note two, the chancellor, therefore,
6 had before him two completely different versions of the same
7 conversation, one by Doctor Khoury, one by the Board member,
8 Doctor Lacy, either of which could be credible and upon which
9 he could make a finding of fact. That factual issue has been
10 resolved by the chancellor against Doctor Khoury. So there
11 was no contract. And that therefore since there was no
12 contract and since he was not a member of the existing staff,
13 he was an applicant at will and could be terminated at will
14 and was.

15 THE COURT: Now, you spoke early on at the outset
16 in the petition for temporary injunctive relief of an
17 incestuous relationship. I suppose that's descriptive, but we
18 all know what you mean anyway. But do you feel that in any
19 way is part of your due process problem?

20 MR. HARLAN: Your Honor please, what, to answer
21 your question is this, we now stand in a temporary injunctive
22 relief, the Court treating as true the affidavit, realizing
23 that there could have been irreparable harm to Doctor Terzis
24 and has allowed us to proceed or will hopefully allow us to
25 proceed to develop this evidence. What we are saying

1 correctly, Your Honor -- you are correct -- is what I'm saying
2 is that she is given by the bylaws a right of review by two
3 separate committees. That is their own bylaws.

4 The contracts in Virginia of adhesion are those
5 which are drafted, and like insurance contracts, we go by it,
6 we can't alter it as opposed to the free will between you and
7 I in drafting a contract. A contract of adhesion, such as the
8 bylaws, Doctor Terzis had to adhere to its terms without
9 modifying them. She has no right to modify them, and
10 therefore the courts universally treat these contracts of
11 adhesion, including the Virginia Supreme Court, strictly
12 against those who create them, the bylaws being the contract.

13 Now, to answer your question, the Medical
14 Executive Committee is comprised of fifteen members or was
15 comprised of fifteen members who heard Doctor Terzis' matter,
16 nine of whom formally heard the charges two weeks before and
17 made recommendations as to the DAC. Nine out of fifteen is
18 not only a majority, it's a plurality. The same people are
19 hearing it, and implied, not implied but stated in the bylaws
20 is that she should be given a fair hearing.

21 So we are, will argue when we develop this
22 evidence for the Court later that certainly this is one aspect
23 of the failure of the Medical Center Hospitals to comply with
24 its limited contractual due process implied in its bylaws with
25 the chancellor interpreting the bylaws in terms of, and I

1 would argue, strict construction against the hospital because
2 it's a contract of adhesion. So to answer your question, that
3 is part of it.

4 The second, most important part of it is in front
5 of the Doctor Parker Cross committee, the appellate committee,
6 we were --

7 THE COURT: Is that the MEC?

8 MR. HARLAN: Judge, here is what happened. We go,
9 she goes alone before the DAC. She goes alone before the MEC.
10 They make a recommendation to the Executive Board.

11 THE COURT: Which is the Parker Cross committee,
12 the Executive Board?

13 MR. HARLAN: It's appointed by the Executive Board,
14 gives us a hearing with a lawyer and reports back to the
15 Executive Board.

16 THE COURT: All right.

17 MR. HARLAN: That's where the article ten applies,
18 Parker Cross committee. We were facing 142 charges. We had
19 been presented four charges against us with evidence. The
20 rest were just read. There was no evidence presented in the
21 other charges. They were just read, four charges. We put on
22 partial evidence.

23 We have got a letter which we complained bitterly
24 of to Doctor Cross because the second day of the hearing --
25 first day was their charges put on against us. Second day

1 said, go on, Mr. Harlan, put on evidence. I started. I get
2 by four cases, responding to the same four cases. The court
3 reporter at 11:30 p.m. said, I can't go any further. It was
4 snowing outside or threatening and we terminated the hearing.
5 I went up to Doctor Cross and suggested in the presence of Mr.
6 Luce that we plan for Monday and Tuesday night. Wednesday was
7 a bad day, could we do this on Saturday. It was taken under
8 advisement. Now, it was that committee hearing where we were
9 serially cut off from producing any other evidence.

10 Now, for your information, the DAC, we've got a
11 clandestine transcript, if we're allowed to introduce it later.
12 But there is an official transcript of the MEC, an official
13 one. I have it right here.

14 THE COURT: Official transcript of what now?

15 MR. HARLAND: Of the proceedings before the
16 Medical Executive Committee, and in no way, no way did the
17 Medical Executive Committee go through at that time 170
18 charges.

19 Here is what happened. There was 211 charges at
20 this level.

21 THE COURT: DAC?

22 MR. HARLAN: DAC. There was 172 charges at the
23 MEC. And when it finally got over to the Ad Hoc Committee,
24 out of the MEC, it was 142 charges. Allow me, plus or minus
25 one or two. So we were facing before Doctor Cross's committee

1 142 separate charges and all they did was have a man come in,
2 Doctor Hoffman came in and read the charges of the MEC. I was
3 told, well, go ahead, Harlan, have at him, cross-examine him.
4 I said, what, cross-examine the prosecutor? Well, Mr. Harlan,
5 what do you want to do.

6 Anyway, the first day, in essence, they put on
7 four cases. They brought evidence of four cases. They brought
8 four witnesses I was allowed to cross-examine limitedly.

9 THE COURT: Again, we're getting into an
10 evidentiary hearing. You're illustrating your due process
11 point. I grab the grasp of it.

12 MR. HARLAN: My due process point is we're
13 seriously prevented from presenting evidence, which
14 there is another aspect of this the Court has to be
15 appreciative of. There has been absolutely no other case in
16 the history of Medical Center Hospitals in which one physician
17 stood trial for 142 charges arising all at one time in 1986 or
18 1985 for four and-a-half years of practice at the same
19 hospital. And she was allowed a period of two weeks to
20 prepare for her defense. That's another element of the due
21 process.

22 Now, I think the Court correctly has summarized
23 Khoury. He is not in the class of the existing staff. He was
24 treated as an applicant by the Court and that's the reason.

25 Now, what we have done is have gone through West

1 law, the law library and have pulled out every modern case
2 that we possibly can and I have listed it in the brief.

3 THE COURT: I used to think at one time West law
4 would be a boon for judges.

5 MR. HARLAN: Now, I just read some of the ones.

6 THE COURT: If they would give me an optical
7 scanner and a computer so that I could feed them through and
8 key in key words so I could match up all those decisions
9 through a computer, which, by the way, I asked to get on the
10 use of computers in the practice of law committee with the
11 Virginia State Bar because some day it will come to that.
12 Some day we'll have computers sitting right up here but --

13 MR. HARLAN: I hope you've read the article in
14 the American Bar Association, that Wyoming article. What's
15 his name, Jerry Spence, lamenting the fact we lawyers do not
16 think in terms of the case in the principal and the human
17 element. What's going on, we're getting sunk ever deeper in
18 this morass and swamp of paperwork and stilted reasoning. In
19 any event, Judge --

20 THE COURT: Right on, Jerry.

21 MR. HARLAN: That's right. Mann versus Southside
22 Hospital, 1959 case cited by Medical Center Hospitals for the
23 principal of unfettered discretion of hospital authority,
24 again, was an applicant case, and they make the comments by
25 the court. The case actually states that in this case of

1 private institutions where up here private hospitals, private
2 hospitals in the absence of any contractual relationship or
3 agreement to the contrary, then the member of the staff can be
4 summarily dismissed at will. For example, if there is no
5 bylaws, if Terzis has come to the hospital --

6 THE COURT: I have your point quite clearly. Let
7 me ask you a question to get back to one I raised the other
8 day. What is the role and position of Medical Center
9 Hospitals under the EVMA umbrella and what is the EVMA, public
10 or private?

11 MR. HARLAN: The Eastern Virginia Medical
12 Authority is created, is a creature of statutory enactment by
13 the legislature. It is authority empowered to create a
14 medical school and a graduate school of medicine and --

15 THE COURT: Condemn land.

16 MR. HARLAN: Yes. Very much, exactly like the
17 Norfolk Redevelopment and Housing Authority, except for a
18 different reason. And it is a State institution, I believe
19 I'm correct. It doesn't affect this case directly, but that's
20 correct. They condemn land, they raise funds, they build
21 medical schools. They hire teachers.

22 For example, we came over here the other day and
23 I told you in the affidavit she had to go to the medical
24 school to get a pulmonary expert. The medical school also
25 hires permanent staff members apart from the community out

1 here and the medical community is loath to use a salaried
2 physician when they can go in and get their own consultative
3 fees. So a physician is not encouraged, if you will, to use
4 the medical school salaried physicians when we have all these
5 good men in true out in the medical community.

6 Now, Eastern Virginia Medical School has a
7 contract with the Medical Center Hospitals. And it is a
8 reciprocal type of agreement. The hospital will allow
9 residents in medicine to practice in its four walls under the
10 supervision of so-called attendings and be taught by the
11 medical staff clinical surgery and other things. And I think
12 the way that it goes is that the Eastern Virginia Medical
13 School pays the salary of the residents directly.

14 THE COURT: I'm not interested in the school.
15 I'm interested in the Authority.

16 MR. HARLAN: Well, the Authority is out here.

17 THE COURT: It's the umbrella.

18 MR. HARLAN: It's the umbrella, in essence, and
19 from it are the two schools, Eastern Virginia Graduate School
20 of Medicine.

21 THE COURT: How about the hospital?

22 MR. HARLAN: Hospital is simply a part, different
23 entirely, but it has a contractual agreement with EVMA.

24 THE COURT: You've answered my question.

25 MR. HARLAN: One other side thing, if I might tell

1 you, because this is involved and will be involved in this
2 case. Doctor Terzis has a contract with the Eastern Virginia
3 Medical Authority to operate a microneurosurgical laboratory
4 with funds that are coming, I believe, from private sector. I
5 think Mr. Hofheimer donated two million dollars in the
6 beginning and so forth. Hiring her as director of the
7 facility, paying her a salary to operate that and she does
8 that for two days a week contractually.

9 Now, who comes there, medical students come there
10 and also residents in microsurgery come there for training.
11 The clinicians in the hospital, such as Doctor Terzis,
12 existing staff surgeons also by filing their application for
13 staff privileges and becoming a member of a teaching hospital
14 staff also agree to teach resident surgeons who are paid by
15 State Authority, residents. So there is a nexus there. But I
16 haven't been able to develop or certainly do not have the
17 evidence at this time to develop any state action which would
18 trigger in the full Fourteenth Amendment rights and --

19 MR. LUCE: Your Honor, that was stipulated.

20 THE COURT: He's responded to my question.
21 That's all. He says he doesn't have anything.

22 MR. HARLAN: I do not have anything and --

23 THE COURT: He hasn't violated the stipulation.

24 MR. HARLAN: And the stipulation was, we stipulate
25 our argument is addressed not to state action. However, as in

1 any case, during the course of discovery if new evidence is
2 adduced, I certainly would ask the Court to allow me to amend
3 my complaint to amplify it, if in the very unlikely situation
4 I feel that there may be a possibility of state action.

5 Now, to this end --

6 THE COURT: You've answered my question. I just
7 didn't know really the relationship between EVMA and all these
8 other people.

9 MR. HARLAN: Now, going down through these cases,
10 all I can tell you is, very clearly over and over again in
11 each one of these cases that there is the issue of if there is
12 an existing staff doctor, if there are bylaws, the bylaws form
13 a contract and the application and the hospital is bound to
14 administer that contract.

15 Now, let me just turn to one other interesting
16 thing that Mr. Luce mentioned over here. If you'll be kind
17 enough to turn to D2, this exhibit, which is the bylaws of the
18 Medical Center Hospitals as opposed to the staff.

19 THE COURT: I have it.

20 MR. HARLAN: Section six, Mr. Luce pointed out to
21 the Court that after the Medical Center Hospitals' Executive
22 Committee has delegated to the medical staff the ability to
23 draft bylaws, he will be afforded the protection of due
24 process as outlined in the bylaws and so forth. Then he
25 argues, -- final sentence is this. Anything hereinabove to

1 the contrary notwithstanding, the Executive Board may modify
2 or suspend all privileges or practice of a practitioner if it
3 deems such suspension is necessary or desirable to the
4 maintenance of the quality of medical care of the hospital.

5 Now, they didn't do that, number one. Number two,
6 if they did it, I think they would be perpetrating a fraud on
7 Doctor Terzis because she never acknowledged, nor was she
8 aware of, nor is any other physician to my knowledge, unless
9 they're particularly sophisticated, aware that there is this
10 provision in the Medical Center Hospitals.

11 THE COURT: What does it say?

12 MR. HARLAN: All right. Anything hereinabove to
13 the contrary notwithstanding, the Executive Board may modify
14 or suspend all privileges of practice of a practitioner if it
15 deems such suspension necessary or desirable to the
16 maintenance of the quality of the medical care of the hospital.
17 In other words, they have to give her a hearing, they don't
18 have to do anything, and I'm merely saying to the Court they
19 did not do that. They did give her a hearing and at the very
20 least they should be estopped now to even urge this situation
21 upon the Court. And secondly, if they were to implement the
22 situation upon the Court on Doctor Terzis, it would be a rank
23 fraud to Doctor Terzis. And we have authority for that.

24 There are two cases in Virginia. Bear with me,
25 please, Your Honor. Let me give you the facts in one case

1 and I'll give you the name in just a minute, please.

2 A lady was a sales representative of a
3 corporation and she was not particularly happy with the job or
4 they weren't happy with her in the job. So the corporation
5 came to her and said, look, if you resign your position as
6 sales rep we'll give you another job over here with another
7 division and you can do, get your life in order and then find
8 out where you want to branch out to. So she resigned, and
9 when she went over to the new division, they didn't hire her,
10 and the Court said, it's a fraud, and that's what I would
11 submit would happen here.

12 Here is Terzis. She signed an application,
13 agrees to be bound by the bylaws of the medical staff, doesn't
14 even know the existence of this, that is, when I say this, the
15 bylaws of the hospital, and I think we're perpetrating for
16 what has she done. She has acted on her unilateral contract
17 with the hospital. She has provided care to the hospital in
18 terms of plastic and microsurgical reconstruction to its
19 patients. She has provided income to the hospital by placing
20 her patients in the hospital. She has taught residents in the
21 hospital and allowed them to learn her rather unique knowledge
22 of microsurgical surgery. She has staffed the hospital on
23 weekends to cover for emergencies. She has attended the
24 emergency room patients enabling them to minister to the
25 community's needs on nights and weekends for when citizens of

1 the City of Norfolk and surrounding places get into automobile
2 accidents or get very ill in the emergency room.

3 Her skills have been brought there. So she has
4 acted in reliance upon her application, and I would suggest to
5 you that if this hospital were to take upon itself -- let's
6 say that Doctor X in there said, we're not going to give you
7 the procedural due process, we're going to summarily suspend
8 you, bang, that there would be a good cause of action against
9 the hospital for fraud. And in any event, the case which I'm
10 citing to the Court is Sealand Service, Incorporated versus
11 Nancy O'Neal, 224 Virginia 343. I have a copy.

12 THE COURT: 224 what? Hand it up. I could use
13 that.

14 MR. HARLAN: Now, there is also --

15 THE COURT: It's easier to put in the file.
16 Anybody mind that it comes prehighlighted?

17 MR. LUCE: No, Your Honor.

18 MR. HARLAN: There is also a case that has just
19 come out. Where's that article that came out of the Virginia
20 Trial Lawyers magazine?

21 THE COURT: Judge Williams' case.

22 MR. HARLAN: United States District Court, the
23 Western District of Virginia, Daniel Thompson, plaintiff
24 versus American Motor Inns, memoranda of opinion.

25 THE COURT: That's Glen Williams' opinion?

1 MR. HARLAN: Yes, sir, and this is it printed in
2 there. In this particular case --

3 THE COURT: Did you give me that in any of your
4 papers you handed me today?

5 MR. BERGAN: Your Honor, it is an attachment on
6 demurrer.

7 THE COURT: I skimmed through it pretty quickly,
8 but I thought I saw that.

9 MR. HARLAN: There is also the case of Hercules
10 Powder Company. This is one of the cases cited by an article
11 appearing in the Virginia Trial Lawyers magazine by a lady
12 lawyer, Hercules versus Brookfield, 189 Virginia 531, where
13 the defendant operated a plant under a contract with the
14 United States Government and provided a termination pay plan
15 for its employees approved by the governor's contracting
16 officer. They dismissed the employee and the employee sued,
17 and they said, we don't -- I'm paraphrasing -- they don't owe
18 you any due process. And the Court found they had issued a
19 handbook to its employee and that that handbook constituted a
20 contract.

21 THE COURT: Do I have that one too, Mr. Bergan?

22 MR. BERGAN: It is not attached.

23 MR. HARLAN: This is a Virginia case. Again,
24 this is --

25 THE COURT: Prehighlighted.

1 MR. HARLAN: Prehighlighted. That's the handbook.
2 Now, the Board versus Chippenham Hospital I'd like to point
3 out to the Court because it was, the Court was commenting on
4 the difference between that and the statute. Do you have the
5 statute laying up here? Here it is. If the Court had the
6 copy of the Chippenham Hospital case -- I think we tendered it
7 to it -- the original statute which was ruled by the Board
8 versus Chippenham Hospital, 219 Virginia 65, as being unconstitutional
9 on technical grounds, that the title of the statute didn't
10 reflect.

11 THE COURT: Had more than two objects in the
12 statute.

13 MR. HARLAN: Correct. So they kicked it out, but
14 at that point in time the statute was, gave the hospital
15 rights, and I read to you this. The present statute gives the
16 physician rights and I'll read to you that. This is the last
17 part of the statute. The provisions of this section -- and
18 I'm reading from Chippenham Hospital -- will not impair or
19 affect any other right or remedy of the State. If the license
20 is suspended or revoked on any above grounds, the hospital may
21 appeal the decision of the Board.

22 Now, the new statute, which is almost verbatim
23 except for the last paragraph, says, any physician licensed in
24 the State to practice medicine -- keeping the word any
25 physician it has now changed the emphasis -- who is aggrieved

1 by any violation of this section that will have the right to
2 seek an injunction from the circuit court of the city or
3 county in which the hospital alleged to have violated this
4 section is located prohibiting any such further violation, the
5 provisions of this section, and this is a brand new addition,
6 the provisions of this section shall not be deemed to impair
7 or affect any other right or remedy.

8 All right. Now, here is where we get to this
9 point. We are bringing this on general equitable principals
10 and this statute by its very terms allows us to do so, the
11 court interpreting the contract or the bylaws and whether or
12 not the contractual obligations of the hospital have been
13 maintained or disposed of or administered to Doctor Terzis in
14 a manner consistent with those, what I call contractual due
15 process within the bylaws.

16 Now, the second thing, and this is what baffles
17 me and this is where the word adumbrate comes in. According
18 to Mr. Luce -- I will call it a loose interpretation, if you
19 will -- he says, Your Honor, that all that the hospital has to
20 do to comport with this is to get rid of the doctor and the
21 doctor assigned a reason in writing for getting rid of the
22 doctor, and that's all we have, and if they've done that,
23 we've got to appeal.

24 Well, even though he didn't read to the Court in
25 the first part of his brief when he cites the statute, he does

1 say --

2 THE COURT: You take the contrary view.

3 MR. HARLAN: Yes.

4 THE COURT: Thank you. I have it.

5 MR. HARLAN: Thank you.

6 Without further laboring through this, I would
7 respectfully suggest, Your Honor, that under the general
8 equitable principals of this Court you have the right to
9 interpret the contract in this injunctive procedure. You have
10 issued a temporary injunction. You've allowed us to adduce
11 evidence to show you or attempt to show you that the contract
12 itself, that is to say, the bylaws and article ten provision
13 or article nine provision --

14 THE COURT: You have two points, one, that the
15 proceedings are inherently and per se unconstitutional and in
16 violation of due process because of what you have referred to
17 as the incestuous relationship between the parties.

18 MR. HARLAN: Under the contractual --

19 THE COURT: Yes. And I cited to you a case and I
20 have forgotten the name of it now. My memory was better that
21 day, but we're going to adjourn here in a moment and I'll go
22 in and find it. It's in re: somebody, and the facts of it
23 were that a -- Mr. Luce probably knows it because he dealt in
24 administrative law at length. It was a case in the Supreme
25 Court of the United States, probably in the middle forties,

1 very early fifties, where in the aircraft industry a man who
2 or company which was cited for violations of the FAA
3 regulations or the CAB regulations, I forget which, appealed
4 their case, and the investigator who pursued and investigated
5 and acted as prosecutor, low and behold, by the time the thing
6 got to the board, this guy was now on the board. So the
7 Supreme Court said that you cannot have the same persons
8 reviewing in a judicial capacity those things which they
9 pursued as in a prosecutorial or investigative capacity.

10 MR. HARLAN: That's precisely the point, but I
11 want to make this very, very clear. We're not trying to come
12 up here and say in violation. It is within the framework at
13 this time, not to mislead the Court, of the contract.
14 Precisely, and we have cases in here that interpret that as
15 well. As a matter of fact --

16 MR. BERGAN: The case is Applebaum in California
17 which, has been appended to the Court.

18 THE COURT: Is with your memorandum?

19 MR. BERGAN: Yes.

20 MR. HARLAN: Judge, I think that --

21 THE COURT: Counsel, if you will, why don't you
22 join me in chambers for a few minutes on an informal chat to
23 look for that case to see whether it's applicable to this.
24 Also, I'm going to take a few moments to read these things. I
25 have a pretty good grasp.

1 MR. LUCE: Judge, could I have about five minutes
2 of the Court's time?

3 THE COURT: To respond?

4 MR. LUCE: Yes.

5 THE COURT: Sure.

6 MR. LUCE: I will be very brief.

7 MR. HARLAN: By the way, here's Bello.

8 MR. BERGAN: It's already been provided to the
9 Court.

10 THE COURT: All right. Mr. Luce.

11 MR. LUCE: Your Honor, I'm not sure, just to pick
12 up with the last point when we were talking about Chauncy, I
13 don't think that it's --

14 THE COURT: It's some name.

15 MR. LUCE: Withrow v. Larkin is the leading case
16 on the point.

17 THE COURT: I'll find it.

18 MR. LUCE: My understanding is Withrow v. Larkin
19 allows that combination, and, in fact, we haven't cited it
20 because we haven't gone into it in that length in the argument,
21 but in a nutshell, if Mr. Harlan wants to make that claim,
22 that all he can do to make that claim is to reject the
23 contract that he says was created because all of the
24 appointments and all of the combinations of functions that he
25 challenges are exactly in accordance with the provisions of

1 the bylaws.

2 And if we have failed to meet the provisions of
3 those bylaws and you determined that a contract is created,
4 then they, rhetorically there may be some basis for relief.
5 But what they can't do is to argue that the bylaws are
6 defective and the bylaws are a contract because they either
7 have to accept the terms of the contract and seek specific
8 performance, which is what Mr. Harlan is doing when he says,
9 well, the Court is an independent authority to examine this
10 limited contractual due process that he calls it, or else the
11 Court would have to say, no, the combination of functions
12 that's alleged here and if proven would be a denial of what?
13 It's not a denial of due process because due process doesn't
14 apply. We're not a public hospital. So is it a denial of the
15 contract terms? No, that's what the contract terms state.
16 So, in fact, Your Honor, they have a completely inconsistent
17 pleading and that has been part of the problem.

18 THE COURT: Do you think the Virginia
19 Constitution limits the due process under article one, section
20 ten or eleven, I forget which, to state action?

21 MR. LUCE: Absolutely, Your Honor. I think it's
22 clear. Archer v. Mayes says, it's clear the actual protection
23 clause of the Fourteenth Amendment is the same scope as the
24 Virginia Constitution.

25 THE COURT: They're different, though, because

1 the Fourteenth Amendment to the United States Constitution
2 says no state shall, et cetera, et cetera.

3 MR. LUCE: That's true, and I picked up on that
4 concern of the Court's in the transcript. That's why Archer
5 v. Mayes is included in our brief. That's the only case that
6 speaks to this. It's clear. Well, I know the Court is
7 familiar with this, but most of us from Virginia do know that
8 the Virginia Constitution Bill of Rights was the original
9 amendment to the Constitution and it was constitutional in
10 Virginia. It was always intended to protect the rights of
11 citizens against the state.

12 There is no question in my mind, Your Honor.
13 There must be state action in order to seek the protections of
14 article one, section eleven of the Virginia Constitution.

15 THE COURT: Then you say state action.

16 MR. LUCE: That's right and we don't have --

17 THE COURT: Shall (phonetics) versus Kramer says
18 seeking the enforcement of the Court is a state action, but
19 you're not?

20 MR. HARLAN: Judge, so I'm not sitting here and
21 misleading the Court, and with regard to the Court's --

22 THE COURT: I'll give you a moment.

23 MR. HARLAN: I'm trying to concur with him on
24 that.

25 THE COURT: He didn't raise that. I did. I

1 guess he's trying to tell you, don't worry about it, it's not
2 his position.

3 MR. LUCE: Your Honor, I'm absolutely convinced,
4 there is no cause of action against a private hospital under
5 that provision because it is not engaged in any kind of state
6 conduct. It says that no person shall be deprived of life,
7 liberty or property except by due process of law.

8 Well, we're not, at the very most, we're dealing,
9 and I don't accept it, but at the very most we're dealing with
10 the contractual right Mr. Harlan says is created.

11 THE COURT: That's his case. He has eliminated
12 everything but the contractual right.

13 MR. LUCE: I agree, Your Honor. I agree. And
14 that's what brings me to -- I'm not going to go back through
15 what I think are rather gross misrepresentations or confusions
16 about what happened. I ask the Court to consider our motion
17 for dissolution of the injunction because in the motion we
18 view, outline each of the steps taken and show where those
19 steps are dictated by the bylaws. The reason the attachments
20 are so thick is they're each of the reports.

21 Now, Your Honor, Mr. Harlan has alleged a
22 contract. That's clear from the face of the pleading. Now, I
23 think it's equally clear that the contract, if one exists at
24 all, is apparently one that's imposed by operation of law
25 because there is certainly no intent on Medical Center

1 Hospitals' part to make it a contract, and I believe that the
2 Court should carefully consider whether or not it's going to
3 take the position that a contract is created upon the
4 appointment to the medical staff.

5 Now, Mr. Harlan has suggested that the
6 overwhelming weight of modern authority is to the effect that
7 a contract is created by the bylaws. Your Honor, I simply
8 disagree, and the cases we have cited in our brief are on
9 point.

10 The 1981 decision of the Maryland Court of
11 Special Appeals is absolutely aberrational. It cites
12 basically cases in New York and New Jersey, if I remember
13 correctly, one from New Hampshire, I believe, in which it
14 states it's generally accepted that a contract is created by
15 the bylaws. It is not.

16 The Court of Special Appeals in Maryland is at
17 odds with the Levin case, and the Levin case, as the Court may
18 be aware, is a court of appeals case. Now, the Court of
19 Special Appeals is that intermediate court that we now have in
20 the form of a court of appeals in Virginia and there is no
21 Supreme Court authority in Maryland for that proposition.
22 The circumstances of that case did not require the Court to
23 really focus that heavily on it.

24 THE COURT: Let me ask you a bottom line. Is it
25 your position that the physician who is granted staff

1 privileges and who's accepted by the Board and is in all
2 respects a qualified accepted staff member owes certain
3 responsibilities and duties to the hospital but the hospital
4 owes none to him?

5 MR. LUCE: Your Honor, let me answer that in this
6 direct way.

7 THE COURT: Please do.

8 MR. LUCE: I believe that there is clearly a
9 relationship created. I do not believe that relationship is
10 created on the basis of a contract. I don't believe it's a
11 contract because the hospital -- for what purpose has the
12 hospital allowed the physician to come in? Well, the hospital
13 exists as an institution.

14 THE COURT: For what purpose does the hospital
15 exist? It doesn't exist for lawyers to practice there.

16 MR. LUCE: It clearly doesn't, Your Honor. It
17 exists to allow for the treatment and care of patients. It
18 doesn't engage in the practice of medicine.

19 THE COURT: The hospital does not treat and care
20 for patients.

21 MR. LUCE: Yes, it does, Your Honor.

22 THE COURT: No, it doesn't.

23 MR. LUCE: Your Honor, I think it does, through
24 its nurses, through its employees. Now, that is, in fact,
25 exactly what the Court, the Supreme Court of Virginia has held

1 in the Stuart Circle case. It held a hospital does provide
2 care and treatment for its patients, but it does not practice
3 medicine. By its very nature, a corporation can't practice
4 medicine is the typical reason that people cite Stuart Circle
5 Hospital. The hospital does provide care. It provides a form
6 of care and, in fact, it provides people to assist the
7 physician in the care of their patients.

8 An example would be if the physician comes in the
9 OR and there are no nurses available for him. Can the
10 physician sue the hospital because he's had to delay surgery?
11 Clearly not. But the hospital failed to provide a nurse and
12 they're supposed to. There is no basis, no contractual
13 obligation to be there, but the physician won't be able to do
14 it, but he has no right to sue for specific performance to be
15 allowed to practice in that way. If he wants to schedule a
16 case for surgery and the OR's been booked, he has no right to
17 sue the hospital to make sure he can schedule surgery when he
18 wants to. In fact, many times hospitals would like to see
19 that because they can get a certificate of need for what they
20 need, but I think the circumstances with the relationship --

21 THE COURT: What is a contract?

22 MR. LUCE: Your Honor, if I remember correctly,
23 it's a mutual agreement between parties for a consideration.
24 And there is no mutuality here.

25 THE COURT: Is there a unilateral contract here?

1 MR. LUCE: There may be a unilateral contract in
2 the sense that physician comes in and says, I want to practice
3 here, and the hospital says, if you want to practice here,
4 these are the terms and conditions.

5 THE COURT: What does the hospital owe to the
6 doctor under the bylaws?

7 MR. LUCE: Owe to the doctor? It doesn't owe
8 anything to the doctor under the bylaws, nothing. I know that
9 might seem like a strange response, Your Honor, but if you
10 look at it --

11 THE COURT: I'm not challenging you, but I'm just
12 looking for the bylaws because I want to take a look.

13 MR. LUCE: Which bylaws, Your Honor?

14 THE COURT: Both.

15 I'm ready to rule.

16 MR. LUCE: Your Honor, if there are any questions.
17 One last thing, I didn't raise it because I didn't see -- if
18 the Court needs to see anything about EVMA, Mr. McMillan has
19 been kind enough to provide me with a copy.

20 THE COURT: Mr. Harlan explained to me it's not
21 really a player in this game.

22 I know what I'm going to rule, but I just want to
23 make a coherent statement with it, if you'll give me a moment
24 to gather my thoughts.

25 The bylaws of the medical staff provide for -- I

1 forget in which section -- for due process requirement.

2 MR. HARLAN: Roman numeral ten, Your Honor, page
3 53.

4 THE COURT: I have it written down here.

5 MR. LUCE: The only reference to due process
6 appears at article seven, section six of the Medical Center
7 corporate bylaws.

8 THE COURT: Article ten speaks in paragraph two --
9 make it A2 -- says, all hearing and appellate reviews shall be
10 in accordance with the procedural safeguards set forth in this
11 article ten to assure that the affected practitioner is
12 accorded all rights to which he is entitled, and then the
13 procedures are set forth there in article ten, and it is the
14 opinion of the Court that when you speak of procedural safeguards,
15 you are really speaking of due process.

16 Then in the bylaws of the Medical Center
17 Hospitals, article Roman numeral seven, section Arabic number
18 six, it is written that before any such action, referring to
19 termination or modification, which is the caption of section
20 six, is taken by the Executive Board, the practitioner shall
21 be given written notice, and paraphrasing and then going on
22 down to say, and he will be afforded the protection of due
23 process as outlined in the bylaws of the medical staff and approved
24 by the executive board of directors, and that's article ten,
25 as I read it, if I'm not mistaken, meaning article ten, Roman

1 numeral ten of the bylaws and rules and regulations of the
2 medical staff.

3 Now, they do have a summary method for
4 disposition, but I'm going to hold that like the old time
5 election of remedies for a lawyer or a litigant, when you
6 elect which way to proceed, then you must proceed that way,
7 and if you elect to proceed through the hearing route rather
8 than by summary disposition, you must comply with the
9 procedural safeguards, as they refer to it, or the due process
10 safeguards as it is set forth in the bylaws of the Medical
11 Center.

12 My note here as I went along listening to the
13 argument is, if you're on the track, you have to stay on the
14 track, you can't shift your methodology at the end. And this,
15 to me, really is procedural due process, although Mr. Harlan
16 calls it contractual due process, but it also is in accordance
17 with the bylaws.

18 Then we get to the ultimate question, and that is
19 that which is reserved under Khoury, does the doctor have a
20 contractual right by reason of her having accepted the rules
21 and regulations of the medical staff and of the hospital, and
22 the Court finds and holds that they have mutual rights and
23 obligations and that there's a contractual relationship
24 between the parties. The hospital must accord procedural due
25 process to the physician before it terminates her and the

1 doctor must comply with the other rules and regulations of the
2 hospital.

3 Accordingly, the demurrer is overruled. The
4 exception of the defendant is noted.

5 MR. LUCE: Your Honor, that being the case, and
6 not wishing to overstate the Court's ruling but also knowing
7 that we have much work ahead of us, the Court, as I understand
8 it --

9 THE COURT: I might not tell and perhaps I
10 shouldn't, but it certainly would be easier for me to sustain
11 the demurrer, I suspect.

12 MR. LUCE: Your Honor, I suspect the Court has to
13 reach the ruling that it feels appropriate. I was merely
14 going to say, as I understand it, the Court has determined
15 there's a contractual relationship, the terms of which are
16 determined by the bylaws of the medical staff.

17 THE COURT: And it's also implicit in the law of
18 Virginia, and the Hercules Powder Company implies that, but I
19 think it is -- I haven't read Judge Williams' opinion yet, but
20 he and I agree.

21 MR. LUCE: That being the case, then, Your Honor,
22 it would seem that --

23 THE COURT: I don't consider this an employment
24 contract and so I distinguish it from Judge Williams' case.
25 But there is a contractual relationship which I spelled out,

1 what the doctor owes to the hospital, what the hospital owes
2 to the doctor.

3 MR. LUCE: Your Honor, that being the case, then
4 it would seem that the nature of this Court's function is
5 determining whether or not the contract terms were met, not
6 whether or not the terms of that contract are appropriate, and
7 so we have two basic issues here, Your Honor, that I think
8 need to be clarified. One is, what will be the standards of
9 review, and I would submit under the Court's ruling the
10 standard of review is to look at what transpired. That is the
11 record of the facts. That is the case.

12 THE COURT: All I've decided today is, that the
13 factual evidence will be gathered and presented as to whether
14 or not the hospital -- what I'm signifying to you is, and I
15 don't want to be limited by it, but it's my preliminary
16 feeling, unless I'm persuaded to the contrary, it is my
17 preliminary feeling that all we will concern ourselves with at
18 the outset is whether or not, two things, Doctor Terzis did,
19 in fact, violate the rules and regulations of the hospital and
20 then whether or not she was handled in accordance with their
21 own rules and regulations and bylaws.

22 Now, I'm not going to make medical decisions.
23 It's just a matter of proof like any other case, whether or
24 not someone was negligent. It's just like anything else. It
25 comes to the Court for decision and that's all we can do.

1 MR. LUCE: Your Honor, as I understand it, then,
2 it's absolutely no limit to the discovery. We're going to retry
3 this case in the course of the discovery. That's what will
4 happen.

5 THE COURT: It probably won't take long if you
6 only handled four cases at the hospital. It's just a factual
7 matter.

8 MR. LUCE: Your Honor, the problem with that is,
9 if there is a contract --

10 MR. HARLAN: Your Honor, you made your ruling.
11 Mr. Luce is continuing with the argument.

12 THE COURT: I can defend myself.

13 MR. LUCE: The question there is, we have, moving
14 on, I'm not arguing with the Court's ruling, but I'm trying to
15 now understand what it will do, as I understand what that
16 means, is that this case is going to be retried in this Court
17 and that Mr. Harlan is going to be able to not only pursue a
18 claim that we didn't follow our bylaws but also that those
19 bylaws are defective in his view.

20 THE COURT: It may be. Right. You see, if you
21 can't come in here and substantiate -- or let's put it this
22 way. He's attacking the action. So if he can come in here
23 and substantiate that the action of the Board was a pretense
24 because it was not founded in fact, then that is a denial of
25 her contractual rights and I'll have to decide that just like

1 any other case. And if he proves that the bylaws were not
2 followed, then he can prove his case.

3 I will not suggest that I am a doctor any more
4 than I am an engineer and we sit here all year long and decide
5 product liability cases and medical malpractice cases and
6 maritime law cases, and I'm not a sea captain, but these are
7 things where we are guided by expert witnesses who give their
8 opinions on these things as they go along, and I see this as a
9 very narrow factual issue. I don't see it as complex as you do
10 if, in fact, there were only four charges that form the basis
11 of this action. If it's longer, woe is me, but there it is.

12 MR. LUCE: Your Honor, that's going to take a
13 long time. We're going to, you know, wait on some of the
14 technical challenges, but I have to at this point move that
15 there be a considerable bond posted during the term of the
16 temporary injunction because, Your Honor, this case is going
17 to take a year at least. I know it will.

18 THE COURT: What should the bond be?

19 MR. LUCE: I think the bond should be equivalent
20 to the hospital's liability for malpractice, which under the
21 statute is \$750,000, a million dollars.

22 THE COURT: They haven't been sued.

23 MR. LUCE: They have not been sued; however,
24 they're being compelled to maintain a physician on the medical
25 staff which requires corrective action which corrective can't

1 be imposed.

2 THE COURT: I'll require a bond of --

3 MR. HARLAN: Can I be heard first?

4 THE COURT: Yes.

5 MR. HARLAN: Respectfully, they had summary
6 disposition. They could have gotten out of this like that.
7 There is nothing like this --

8 THE COURT: I have to provide for a bond. I'll
9 continue the injunction until further order of the Court.
10 I'll set a bond of which will be in the amount of -- it's only
11 for cost of court. That's about all that's involved here at
12 this time. There is no suit at the hospital. Simply to be
13 reinstated, not reinstated, would be retained on the rolls. I
14 would require a bond of a thousand dollars for which the
15 doctor can give personal recognizance for cost of court,
16 taxable court costs. That's all I see at the moment. If
17 somebody tells me I'm wrong and furnishes authority to
18 demonstrate, I'll be glad to listen.

19 MR. LUCE: Your Honor, I would say I believe that
20 for an injunction bond as opposed to an appellate bond that
21 the bond is entitled to cover the risk that's imposed on the
22 party.

23 THE COURT: You're not being prevented from doing
24 anything except discharging this lady who's the petitioner in
25 this case, and so therefore you're -- it's not like enjoining

1 the construction of a building or something where there is
2 some commercial loss.

3 MR. LUCE: Your Honor, we can't even make her
4 complete her medical records.

5 THE COURT: I think you can. I told you the last
6 time, I'm not going to try this case on a day by day basis.
7 If you find that this lady is not doing what you think is
8 expected of her, bearing in mind I don't want her harassed,
9 but neither do I want her thinking that she's laughing up her
10 sleeve because she's still here. I just want her treated like
11 any physician that you would treat on the staff, period.
12 That's all.

13 And if she doesn't live up to it and you have new
14 charges, go right ahead with it. I'm not going to stop you
15 forever. Then he'll have to come over here and try to enjoin
16 that or whatever, but we'll take it on a case by case basis.
17 I can't tell you any other way. I'm only dealing on what has
18 been. I can't deal with what will be in terms of how she will
19 chart patients or treat patients. We'll have to wait and see
20 how that turns out. Perhaps that's too pragmatic for you.
21 It's not very academic. It's not very neat, but life is not
22 always neat.

23 MR. LUCE: Your Honor, I understand that, but,
24 Your Honor, we're going to be engaged in --

25 THE COURT: You're in a war.

1 MR. LUCE: Your Honor, I'm used to that. That's
2 what I do.

3 THE COURT: We all are.

4 MR. LUCE: And the Court arbitrates, but the
5 circumstances of this case, I think, are unique. First of all,
6 I think the Court's ruling is unique among all of the cases.

7 THE COURT: I've been told that's my style.

8 MR. LUCE: Your Honor, the concern that I have is
9 that this is a --

10 THE COURT: Mr. Luce, I have no problem with my
11 ruling.

12 MR. LUCE: I understand, Your Honor. I'm going
13 down the line to discovery.

14 THE COURT: You're just thinking out loud. I
15 know.

16 MR. LUCE: We have the motion for dissolution.

17 THE COURT: I've extended it until further order.

18 MR. LUCE: Your Honor, we then go to the
19 discovery.

20 THE COURT: And I note your objection on that.

21 MR. LUCE: Thank you, Your Honor. The discovery
22 proceedings, as I understand it, the Court is not in what I
23 describe as even the limited review to determine whether or
24 not it met its bylaws. This is a redetermination of whether
25 or not there was a violation of the medical staff bylaws, and

1 more to the point, the hospital never had to show violation of
2 the bylaws in order to impose disciplinary action. That is
3 the problem.

4 THE COURT: I may have lost sight of it in the
5 two or three weeks since this thing was filed, but isn't that
6 really the essence of his complaint, that they they didn't do
7 what they were supposed to do in accordance with the bylaws?

8 MR. LUCE: No, Your Honor, it is not. The essence
9 of the complaint is the conduction of this investigation and
10 this hearing was not in accordance with what Mr. Harlan
11 thought it ought to be.

12 If you look at the request for relief, Your Honor,
13 you'll see this is not a request to compel this hospital to
14 obey its bylaws. It is to enjoin the hospital to conduct a
15 new kind of proceeding in accordance with Mr. Harlan's notion.

16 THE COURT: I'll be right with you.

17 Paragraph four, that the suspension, probation
18 imposed on your plaintiff contrary to the bylaws, rules and
19 regulations will have a profound effect. Paragraph five, that
20 a physician accorded privileges at Norfolk General as was your
21 plaintiff is guaranteed minimal due process and procedural
22 fairness by the bylaws. That the plaintiff, paragraph seven,
23 that the plaintiff is denied the rights afforded to her by the
24 bylaws. She is denied a fair hearing, failure to give
25 adequate notice, failure to specify the standards by which she

1 would be judged, et cetera. Many more. And so --

2 MR. LUCE: Your Honor, the prayer for relief says
3 that not only do they want to enjoin the hospital from taking
4 the disciplinary action and from further investigation, they
5 want to order that the hospital dissolve orders 2A at 2B,
6 that the Medical Center Hospitals make its charges specific
7 and detail. Now, all this assumes that we didn't do that,
8 Your Honor.

9 THE COURT: All I've ordered so far is, I have
10 not granted relief. Please do not misunderstand that and I
11 don't want that little lady sitting on the front row to
12 misunderstand it. All I've done is said there's a cause of
13 action here which may or may not be proven by the evidence.
14 But the plaintiff or complainant has a right to try. It's
15 very simple. You have taken the position by your demurrer
16 that there is no cause of action, no legal right to proceed.
17 I have taken a contrary view, and until an appellate court
18 reverses me, that is the posture of the case.

19 So all we're doing now is going to have a hearing
20 to determine whether or not Mr. Harlan can back up his
21 allegations with facts, and if he is, then and only then will
22 I determine what relief or remedy she is entitled to.

23 MR. LUCE: I understand that point. But, Your
24 Honor, the concern I have is, we're going to now embark on
25 what can only be described as a virtually punitive method of

1 discovery in which every member of the medical staff that had
2 anything to do with this case are going to be deposed, records
3 are going to be en masse are going to be required to be
4 produced and there's a record in this case, Your Honor.

5 THE COURT: If you feel that there is an overreaching
6 or an abuse of discovery, you are an articulate advocate and
7 you will be at my door for injunctive relief of your own, and
8 I will be as receptive to you as I have been so far to Mr.
9 Harlan. Mr. Harlan practices what I have told him in other
10 cases as aggressive advocacy and that's okay. He gives his
11 clients a hundred percent. Probably very few lawyers in his
12 position in the medical community would have taken this case.
13 So that tells you his courage, but I feel that I am quite
14 competent to decide whether or not he has been guilty of
15 overreaching.

16 MR. LUCE: Your Honor, I didn't ever intend to
17 question that.

18 THE COURT: I will. So you're conjuring up all
19 sorts of things, all of which can be dealt with by coming to
20 the Court for relief.

21 MR. LUCE: One final question, Your Honor. I'm
22 sorry, but I'd like to know whether or not the Court intends
23 to deal with the discovery on an expedited basis because that
24 is a major factor.

25 THE COURT: I don't, now that I've overruled the

1 demurrer, I don't see the great need for it on an expedited
2 basis in the technical narrow sense of expedited. She has her
3 injunction. She is, until further order of the Court, an
4 authorized member of the staff because I have held in abeyance
5 the dismissal or the sanctions, not a dismissal but suspension,
6 and so I fully expect, as I put in one letter, that I know
7 that counsel are energetic. I expected to go forward
8 expeditiously. This is one case I'm sure will not be allowed
9 to lag, but I really wouldn't want anybody to feel this was
10 the most important case and the only case the Court has to
11 deal with. I think it's an important case. It's terribly
12 important, if for no other reason you say I have decided it
13 uniquely. So therefore I think that makes it important, but I
14 think it's also important that if I am to decide the case on
15 the facts, now having determined there's a cause of action, it
16 ought to be properly developed, but I don't see any need to do
17 it in 30 days, just to put your mind at rest.

18 MR. LUCE: We'll go under the normal rules under
19 part four.

20 THE COURT: I would say so.

21 MR. HARLAN: Let me get a word in.

22 MR. FRANKLIN: Let me ask -- are you standing up?
23 Did you have a question, Judge?

24 MR. HARLAN: Judge, the posture of the Court was
25 that the case had taken X number of months, year and-a-half to

1 produce against Doctor Terzis and you would allow the
2 promulgation of discovery on an unhurried --

3 THE COURT: I'll call it orderly process.

4 MR. HARLAN: Yes, sir. The question is this, we
5 have notice of depositions set for tomorrow of two people and
6 we have received absolutely nothing from them, although the
7 Court had said in terms of certain exhibits --

8 THE COURT: I have some here in the file.
9 They've come in. Some exhibits are here.

10 MR. HARLAN: But may we proceed with discovery?

11 MR. FRANKLIN: Your Honor, might I add, may we
12 start with filing an answer, and I think the Court has already
13 said those depositions are not going to take place tomorrow.
14 We have advised those people based on the Court's statement on
15 Tuesday.

16 THE COURT: Are either of those litigants leaving
17 town?

18 MR. FRANKLIN: No, sir.

19 THE COURT: I'll quash those.

20 MR. HARLAN: Which litigants?

21 THE COURT: The witnesses.

22 MR. HARLAN: My problem is this, Judge, what
23 happens to lawyers as times goes on, we never get down off --
24 we waited for their demurrer at leisure. Now, we're going to
25 have to wait for a --

1 THE COURT: Let me ask something of both counsel.
2 Remove the sniping. It doesn't make it any easier.

3 MR. HARLAN: All right, sir. Snipe is removed.
4 Would you be kind enough to order them to file the responsive
5 pleadings within five days and thereafter we can proceed with
6 timely discovery.

7 THE COURT: You keep pressing me, each one of you,
8 for time.

9 MR. HARLAN: I'm trying to get away in June is
10 all I'm saying.

11 THE COURT: It will be here when you get back. I
12 don't want it to interfere with your vacation. I don't mean
13 that facetiously. It's going to be handled like any other
14 case. It's just going to be developed. I don't expect it to
15 take two years, but I think Mr. Luce is probably not far off
16 the mark when he speaks of a year.

17 MR. HARLAN: In other words --

18 THE COURT: Could I see counsel in chambers,
19 please? We're doing housekeeping now.

20
21
22 (Whereupon, this hearing was concluded.)
23
24
25

VIRGINIA:

IN THE CIRCUIT COURT OF THE CITY OF NORFOLK, on the
17th day of April, in the year 1986

17 APR 1986

PHYSICIAN 392 a/k/a
JULIA K. TERZIS, M.D.

PLAINTIFF

VS CHANCERY NO. C86-496

MEDICAL CENTER HOSPITALS, a Virginia Non-Stock Corporation
and
THE EXECUTIVE BOARD OF DIRECTORS OF MEDICAL
CENTER HOSPITALS

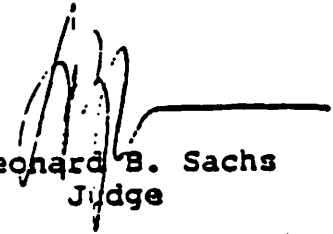
DEFENDANTS

COURT ORDER

This day came all the parties, by counsel, to be heard on a Demurrer and Motion to Dissolve the Injunction Order heretofore entered on the 31st day of March, 1986 and the arguments to Dissolve the Injunction and the Demurrer were heard and determined by the Court.

Thereupon, at the conclusion of all the evidence and arguments of the parties, by counsel, the Court overrules the Demurrer and denies the Motion to Dissolve the Injunction.

The Court Orders that the Injunction will continue until further Order of this Court and that the Plaintiff post a bond in the sum of One Thousand Dollars and No Cents (\$1,000.00) with personal recognizance.


Leonard B. Sachs
Judge

A COPY, TESTE: WILLIAM T. RYAN, CLERK
BY:  , D.C.

INJUNCTION BOND

CASE NUMBER: C-86-496

Know all Men by these Presents, That we Julia K. Terzis, M.D.

are held and firmly bound unto the Commonwealth of Virginia in the just and full sum of ONE THOUSAND
----- Dollars (\$1,000.00 (Personal Recognizance)), to the payment whereof, well and
truly to be made we bind ourselves, and each of us and each of our heirs, executors and administrators,
successors, or assigns jointly and severally, firmly by these presents, and we waive any claim or right to
discharge any liability to the Commonwealth, arising under this bond, with coupons detached from bonds
of the State of Virginia, and I
also waive the benefit of my Homestead Exemption as to this debt, obligation and
contract.

The Condition of the above Obligation is such, That, whereas, in a certain suit in
chancery, pending in the Circuit Court of the City of Norfolk, between

JULIA K. TERZIS, M.D.

plaintiff, and MEDICAL CENTER HOSPITALS and BOARD OF DIRECTORS, MEDICAL
CENTER HOSPITALS

and defendant, an injunction has been awarded to the said plaintiff, to enjoin and restrain the defendant
Medical Center Hospitals and Board of Directors, Medical Center Hospitals
from suspending, or otherwise affecting the plaintiff's privileges

Now, if the said plaintiff shall pay.....
all such costs as shall be awarded against her, and all such damages as shall be incurred, in case
the said injunction shall be dissolved, then the above obligation to be void; otherwise to remain in full
force and virtue.

 [SEAL]
JULIA K. TERZIS, M.D.

.....[SEAL]

.....[SEAL]

VIRGINIA:

IN THE CLERK'S OFFICE OF THE CIRCUIT COURT of the City of Norfolk, on the 29th

April, 1936.

1936. The said Court do hereby certify that the within and foregoing

ASSIGNMENTS OF ERROR

I.

In renewing and extending the Order of Temporary Injunction until further order, the Circuit Court erroneously concluded that it had jurisdiction to review the merits of the decision of the governing body of MCH and to determine whether or not MCH followed its Medical Staff Bylaws and Corporate Bylaws in disciplining Dr. Terzis..

II.

In overruling MCH's Demurrer and its Motion for Dissolution, and in renewing and extending the Order of Temporary Injunction indefinitely, the Circuit Court erroneously held as a matter of law that there is a contractual relationship between Dr. Terzis and MCH, the terms of which are determined by MCH's Medical Staff Bylaws and Corporate Bylaws, and that MCH breached that contract.

III.

In granting Dr. Terzis' request for a continuing injunction, the Circuit Court erred in concluding that Dr. Terzis had standing to challenge MCH's adherence to its corporate bylaws in imposing disciplinary actions upon her.

IV:

In granting Dr. Terzis' request for a continuing injunction, the Circuit Court erred in concluding that a thirty-day suspension from MCH's Medical Staff, followed by a one-year period of probation, would cause Dr. Terzis irreparable harm and erred in failing to consider the injury which a continuing injunction would cause to MCH and the public at large.