NORTH CAROLINA

FRANKLIN COUNTY

IN THE GENERAL COURT OF JUSTICE
SUPERIOR COURT DIVISION
FILE NO. 03-CVS-271

JOAN M. FAULKNER and
JOHN FAULKNER,

Plaintiffs,

v.

HEALTH MANAGEMENT ASSOCIATES, INC.; LOUISBURG H.M.A., INC., d/b/a/ FRANKLIN REGIONAL MEDICAL CENTER; LEMUEL G. YERBY, III, M.D.; and TRIANGLE SURGICAL ASSOCIATES, P.A.,

Defendants.

PLAINTIFFS' MEMORANDUM IN OPPOSITION TO HMA'S MOTION FOR PARTIAL SUMMARY JUDGMENT ON PUNITIVE DAMAGES

PROCEDURAL HISTORY

Plaintiff Joan Faulkner was severely burned in an operating room fire on June 25, 2002 at Franklin Regional Medical Center ("FRMC") in Louisburg. On April 7, 2003, Mrs. Faulkner and her husband John Faulkner filed this medical malpractice action, seeking compensatory damages from defendant Health Management Associates, Inc. ("HMA"), a Florida-based company that owns and operates FRMC, defendant Louisburg HMA, Inc., the HMA subsidiary that employs Kevin Henson, the anesthesia provider, defendant Lemuel G. Yerby, II, M.D., ("Dr. Yerby") the surgeon who performed the operation, and defendant Triangle Surgical Associates, P.A., Dr. Yerby's surgical group.[1]

[1] Plaintiffs also sued Dr. Steven Schwam, an anesthesiologist who was present during part of the operation. On September 30, 2004, plaintiffs dismissed their claims against Dr. Schwam.

The parties engaged in extensive discovery. When HMA refused to respond to plaintiffs' initial discovery requests, plaintiffs filed a motion to compel discovery, which was granted by Judge Kenneth Titus. Exhibit 1. One part of Judge Titus' order required HMA to produce information about operating room fires at other HMA hospitals. (Interrogatory No. 8 and Request for Production Nos. 30, 31 and 32). When HMA failed to comply with Judge Titus' order, plaintiffs filed a motion for sanctions, which was granted by Judge Howard Manning, Jr. Exhibit 2.

Under the court's compulsion, HMA disclosed in interrogatory answers that two patients were burned in operating room fires in HMA hospitals in South Carolina and Georgia in 1999 and 2000. Exhibit 3. HMA falsely described the patients' burns as "superficial." Id. The Georgia patient, described by HMA as having suffered "only superficial burns to the left eyelid and cheek," id., in fact sustained extensive, disfiguring burns from above the eye down to his upper lip. Exhibits 4, 5 (photos of Georgia patient); Exhibit 6 at 103. Similarly, HMA's interrogatory answer misstated the extent of the South Carolina patient's injuries. In a deposition in that case, the South Carolina surgeon described the fire: "She had flames coming out of her nostrils. . . . It was a terrifying event." Exhibit 7 at 45, 50. According to the surgeon, the patient had "second degree" burns, "deeper . . . than we had initially appreciated." Id. at 54.

After plaintiffs learned about the South Carolina and Georgia fires, they sought to depose HMA officials in Florida. HMA tried to block the depositions by filing a motion for protective order, which was denied by Judge Leon Stanback. Exhibit 8.

In the depositions of senior HMA officers in Florida, plaintiffs learned that HMA took no remedial action after the South Carolina and Georgia fires to protect other patients in HMA hospitals. Based on that information, plaintiffs moved to amend their complaint to add a claim for punitive damages against HMA. HMA filed a lengthy brief in opposition. Judge Ronald Stephens granted the motion to amend (Exhibit 9), and plaintiffs filed their Second Amended Complaint on November 2, 2004.

In the Florida depositions, HMA officials testified that key decision-makers Page Vaughan and Anthony Barber were not employed by defendant Health Management Associates, Inc., but instead by "Hospital Management Associates, Inc.," an HMA subsidiary not named as a defendant, and not mentioned in any prior testimony or in any documents produced in discovery. Compare Exhibit 10 at 89 (HMA Vice President Timothy Parry testifies that Vaughan's employer is "Hospital Management Associates, Inc.") with Exhibit 11 at 4, 14 (Page Vaughan testifies that he is employed by "Health Management Associates" and has never been employed by or heard of an entity called "Hospital Management Associates"); compare Exhibit 12 at 4-5 (Anthony Barber testifies that he is employed by "Hospital Management Associates") with Exhibit 12 at 45-46 (Barber identifies himself in correspondence with Dr. Faulkner as employed by "Health Management Associates, Inc."). To verify the identity of the employer, plaintiffs requested HMA to produce the personnel files of Vaughan and Barber. When HMA refused, plaintiffs filed another motion to compel discovery. On November 22, 2004, Judge Stafford Bullock ordered HMA to produce the personnel files for an *in camera* inspection. Exhibit 13. Judge Robert Hobgood conducted the inspection on December

20, 2004. On January 3, 2005, Judge Hobgood issued an order finding that the personnel files "conclusively" establish that Vaughan and Barber were both employed by defendant HMA, and were not employed by "Hospital Management Associates." Exhibit 14.

On August 5, 2005, HMA moved for partial summary judgment on the issue of punitive damages.

STATEMENT OF FACTS

I. The Fire at FRMC and HMA's Response

A. Mrs. Faulkner Is Burned in an Operating Room Fire at FRMC

On June 25, 2002, Mrs. Faulkner, age 43, entered Franklin Regional Medical Center ("FRMC") in Louisburg for a biopsy of a lymph node in her neck. The outpatient surgery was expected to last about one hour. Dr. Yerby performed the operation. Kevin Henson, a nurse anesthetist employed by FRMC, provided anesthesia. During the operation, Henson administered supplemental oxygen to Mrs. Faulkner by nasal cannula and face mask. Yerby used an electrosurgical unit (ESU) in performing the operation. While Yerby was using the ESU, a flash fire ignited under the surgical drapes, severely burning Mrs. Faulkner's face, neck and upper chest. After the fire was extinguished, Mrs. Faulkner was transferred to the post-anesthesia recovery area and then taken by ambulance to the Burn Center at the University of North Carolina in Chapel Hill. She remained in the Burn Center for 19 days. Despite reconstructive surgery, Mrs. Faulkner is permanently scarred and disfigured. See Second Affidavit of John Faulkner (photographs of Mrs. Faulkner before and after fire).

B. HMA Destroys the Evidence

An FRMC policy spells out specific procedures to be followed in the event of an operating room fire. Exhibit 15. The policy states: "It is essential that all equipment involved in the fire . . . be preserved for examination by an authority attempting to determine the cause. . . ." Id. at D. According to the hospital policy, "The area involved, with all involved items in place, should be closed off and secured, for later examination by responsible authority." Id. at G(d).

Cynthia Pulley, FRMC's Director of Risk Management and Quality, arrived in the operating room a few minutes after the fire was extinguished, before Mrs. Faulkner was transferred to the recovery room. Exhibit 16 at 5, 16-17. Pulley observed that the materials burned in the fire had been thrown in "one big mass" on the floor. Id. at 25. In violation of hospital policies, Pulley permitted hospital staff to place the burned items, including the surgical drapes, towels and face mask, in a bag with contaminated trash and to take the bag to a dumpster. Id. at 19-20, 27. Pulley never retrieved the burned items. Id. at 27.

In discovery, plaintiffs asked the HMA defendants to produce "All items burned or partially burned in Joan Faulkner's operation on June 25, 2002, including, but not limited to, surgical drapes, surgical gloves, nasal cannula and face mask." Exhibit 17 (Request for Production No. 26). The HMA defendants responded: "No items were retained from the fire. The materials involved in the fire were either destroyed or disposed of by the cleaning crew." Id.

C. HMA Breaks its Promise to the Faulkners

At the time of the fire, Dr. Faulkner, a family practice physician, was employed by HMA as Medical Director of the Perry-Medders Medical Group in Louisburg, and was a member of the medical staff at FRMC. Exhibit 18 (Affidavit of John Faulkner at ¶ 2). HMA owns and operates FRMC and Perry-Medders. Id. at ¶ 3.

One week after Mrs. Faulkner was burned, Dr. Faulkner met with three HMA officers: FRMC Executive Director Tom Dunning, FRMC Chief Operating Officer Scott McIntyre, and HMA Regional Vice President Page Vaughan. Dunning said that an outside agency was performing an independent investigation of the cause of the fire. Dr. Faulkner requested that he and Mrs. Faulkner be provided with a copy of the entire written investigative report. In response, Dunning said that the Faulkners would be given a copy of the full report. Id. at ¶ 4.

In July 2002, Cynthia Pulley, FRMC's risk manager, informed Dr. Faulkner that "ECRI" was the outside agency that had been retained to investigate the cause of the fire. Id. at ¶ 5. Pulley told Dr. Faulkner that he could expect to see the ECRI report if it was not damaging to the hospital, but if the report was damaging to the hospital, he should not expect to see any of it. Id. at ¶ 6.

On several occasions in July and August 2002, Dr. Faulkner asked Dunning and Pulley for a copy of the ECRI report. At first they told Dr. Faulkner that the report had not been completed. Later they told him that the report had been completed, but that the Faulkners would not be provided a copy of the report or informed of its contents. Id. at ¶ 7; see HMA Answer to Second Amended Complaint, ¶ 24.

D. <u>HMA Fires Dr. Faulkner</u>

According to Ginger Ellis, clinic administrator of the Perry-Medders Medical Group, Dr. Faulkner was a productive physician who exceeded HMA's productivity goals. Exhibit 19 at 4-5, 19-20. Ellis always heard good comments from Dr. Faulkner's patients. Id. at 20. Dr. Faulkner had positive interactions with clinic staff and with Ellis. Id. at 20. Betty Burnette, a veteran nurse manager at the hospital, described Dr. Faulkner in her deposition: "He was a wonderful doctor and patients loved him. . . . Not anyone more caring or good to his patients." Exhibit 20 at 16-17.

When Mrs. Faulkner was burned, HMA and Perry-Medders gave Dr. Faulkner a leave of absence to care for his wife and their five children. Exhibit 19 at 38-39; Exhibit 21 at 68-69, 73-74. On August 30 and September 3, 2002, Cynthia Pulley, FRMC's Director of Risk Management, received calls from ECRI reporting that Dr. Faulkner had called ECRI asking for information about its investigation. Exhibit 22 (Exhibit 8 to Pulley II); Exhibit 23 at 57-63. HMA responded swiftly: on September 11, 2002, without any prior notice, Tony Barber, HMA's Director of Physician Practice Management, sent Dr. Faulkner a letter by certified mail terminating his employment and ordering him to vacate the premises immediately. Exhibit 24. On the following day, Barber came to the PMMG clinic in Louisburg and informed Ellis, the clinic administrator, that HMA had terminated Dr. Faulkner's employment. Exhibit 19 at 13, 42-43. Ellis had received no advance notice that Dr. Faulkner was to be fired, and had not requested that he be terminated. Id. at 42. Ellis was "surprised" to hear the news. Id. Barber told Ellis that the firing was "without cause." Id. at 43.

On the same day, Barber summoned Dunning to the clinic, informed him that Dr. Faulkner had been terminated, and gave him a copy of the termination letter. Exhibit 21 at 80-83. Dunning, who had not known that Dr. Faulkner's employment was in jeopardy, was "shocked" by the news that he had been fired. Id. at 80-81.

II. The ECRI Report

On March 14, 2003, through their attorney, the Faulkners wrote Timothy R. Parry, Senior Vice President and General Counsel of HMA, to request again a copy of the ECRI report, and asked Parry to respond by March 28, 2003. Exhibit 18 at ¶ 8; Exhibit 25. No one responded to the letter. Exhibit 18 at ¶ 8.

The Faulkners filed suit on April 7, 2003. In depositions of hospital employees, they learned that Albert DeRichemond, a senior ECRI engineer, had investigated the fire at FRMC. HMA successfully resisted producing DeRichemond's report until HMA named him as an expert witness. At DeRichemond's deposition on September 15, 2004, HMA finally produced the report it had promised the Faulkners more than two years before. Exhibit 26 at 6.

ECRI, formerly known as the Emergency Care Research Institute, is a nonprofit health services research agency established in 1955. Since the 1970's, ECRI has investigated surgical fires, researched their causes, participated in the development of fire-related safety standards, and published frequently on the issue.

Two days after the fire at FRMC, HMA's liability insurer contracted with ECRI to conduct an investigation. Id. at 45. DeRichemond, who has investigated scores of surgical fires, id. at 16, interviewed all members of the surgical team, reviewed the

medical records and examined the ESU and exemplars of devices used in Mrs. Faulkner's operation. On September 18, 2002, he sent his report to HMA's attorney. Exhibit 27.

In his report, DeRichemond described the sequence of events immediately before and after the fire. Mrs. Faulkner was receiving supplemental oxygen at a rate of 2 liters per minute. Dr. Yerby was dissecting the lymph node with an electrosurgical unit (ESU).[2] Suddenly "sparks and a flash were noted at the surgical site, and a fire erupted with a whooshing noise and light under the drapes. . . . The whoosh sound is typical of the rapid spread and evolution of an oxygen-enriched fire." Id. at 3; see Exhibit 54 at 79 (nurse heard "swoosh" sound, like a "charcoal grill" lighting). DeRichemond explained how oxygen flowed from the face mask along a channel in the towels and drape toward the surgical site. Id. at 3. He concluded: "This fire was caused by sparks or heat from electrosurgical cutting and coagulation in an oxygen-enriched atmosphere at the surgical site."[3] Id. at 4. At the close of his report, DeRichemond noted: "To minimize the likelihood of such a fire, ECRI has long recommended many precautionary measures." Id.

III. Simple Precautions Can Prevent Surgical Fires

Long before 2002, multiple authorities recommended safety precautions that would have prevented Mrs. Faulkner's fire. The guiding principles are elementary:

1) The surgeon must not use an ESU in an oxygen-enriched environment.

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[2] In depositions and documents, the electrosurgical unit (ESU) is also described as a "bovie," "electrocautery," or "cautery." In this memorandum, we use the terms interchangeably.

[3] Plaintiffs' engineering expert Dr. Bruce Barkalow, reached the same conclusion. Affidavit of Bruce Barkalow at ¶¶ 10-11.

2) In head and neck surgery, with the oxygen source close to the surgical site, the anesthesia provider must turn off the oxygen before the surgeon turns on the ignition.

3) Communication between the anesthesia provider and the surgeon is essential.

Exhibit G to Affidavit of Grena Porto (collecting authorities); Porto Aff. ¶ 12; Barkalow Aff. ¶13. DeRichemond testified that "by the time of Mrs. Faulkner's fire, ECRI had been putting out that message for 23 years." Exhibit 26 at 175-76.

In June 2002, other health care providers in North Carolina complied with these basic guidelines to prevent surgical fires. A hospital policy at Durham Regional Hospital required anesthetists to discontinue supplemental oxygen at least one minute before the electrocautery was used. Exhibit 28. At North Carolina Baptist Hospitals in Winston-Salem, the hospital policy required discontinuation of oxygen "3-5 minutes prior to the initiation of electrocautery use about the head and neck." Exhibit 29. At UNC Hospitals in Chapel Hill, surgeons insisted that oxygen be stopped for at least a minute before turning on the cautery. Exhibit 30 at 129-32.

IV. Kevin Henson and FRMC Were Negligent

A. Kevin Henson

Kevin Henson, the anesthetist employed by FRMC, administered supplemental oxygen to Mrs. Faulkner in an open system while Dr. Yerby was using the ESU only inches away. Henson left a redundant plastic mask on top of the nasal cannula. Exhibit 31 at 210 ("There was no purpose in leaving it on . . ."). The mask created a dangerous pool of

concentrated oxygen, which was then vented toward the surgical site with each patient breath. Exhibit 27 at 3; Exhibit B to Barkalow Aff. Henson never communicated with Dr. Yerby about his use of oxygen. Exhibit 31 at 73; Exhibit 32 at 49. Dr. Yerby first knew that oxygen was being used when he saw fire coming out of the oxygen tube. Exhibit 32 at 87.

Five anesthesia experts testified that Henson violated the standard of care: Edward Sanders, M.D.; David Lees, M.D.; Pamela Blackwell, CRNA; Jack Norris, CRNA; Robert Dickinson, CRNA.

The Doctors Company, HMA's liability insurer, recently published a "risk management bulletin" titled "Playing With Fire." Exhibit 33. The bulletin emphasizes the need to turn off nasal oxygen when a cautery is being used near the face, and the importance of communication between the anesthesia provider and the surgeon about the use of oxygen. Id. at 3. The bulletin concludes: "Fires are preventable in most cases. Cases involving OR fires can be virtually indefensible." Id.

B. FRMC

When Mrs. Faulkner was burned, FRMC had a policy titled "Guidelines for the Prevention of Fire Hazards in an Oxygen Enriched Environment." Exhibit 15. Despite the title, the policy contains not one word about fire prevention: the policy addresses only what should be done after a fire occurs. According to plaintiffs' patient safety expert Grena Porto, former president of the American Society of Healthcare Risk Management and current member of JCAHO's Sentinel Event Advisory Group, FRMC's fire policy is "grossly deficient." Porto Aff. ¶ 20. The FRMC policy stands in contrast to policies at other

North Carolina hospitals, which contain clear guidelines for preventing surgical fires. See Barkalow Aff. ¶ 15; Exhibit 28; Exhibit 29.

V. HMA Operates "Louisburg H.M.A., Inc." as a Mere Instrumentality

Plaintiffs alleged in their complaint that defendant Health Management Associates, Inc. (HMA) controls and operates defendant Louisburg, H.M.A., Inc. (Louisburg HMA), its wholly owned subsidiary, as a mere instrumentality. Complaint, ¶ 4; Second Amended Complaint, ¶ 4. HMA denied the allegation, and contends that Louisburg HMA operates as an autonomous corporate entity. The evidence strongly supports plaintiffs' position.

1. HMA and Louisburg HMA have identical officers. In 2002, the principal officers of HMA were Joseph Vumbacco (President and CEO), Robert Farnham (Senior Vice President and CFO), and Timothy Parry (Senior Vice President). Exhibit 34. In the 2002 Business Corporation Annual Report submitted to the North Carolina Secretary of State, Louisburg HMA identified its "principal officers" as Joseph Vumbacco (President and CEO), Robert Farnham (Senior Vice President and CFO), and Timothy Parry (Senior Vice President). Exhibit 35. The address of each Louisburg HMA officer was listed as 5811 Pelican Bay Boulevard, Suite 500, Naples, Florida – HMA's corporate headquarters. Id.; Exhibit 34.

2. Under the by-laws of Louisburg HMA, Vumbacco, Farnham and Parry had total control of the corporation. The by-laws provide: "The business and affairs of this corporation shall be managed by its Board of Directors, three in number." Exhibit 36 at 10 (Article III, Section 1). Under the by-laws, "The President [i.e., Vumbacco] shall be the principal executive officer of the corporation and, subject to the control of the Board of

Directors, shall in general supervise and control all of the business and affairs of the corporation." Id. at 16 (Article IV, Section 5) (emphasis added).

3. Louisburg HMA failed to observe even the most minimal corporate formalities. In their initial discovery requests, served on April 25, 2003 on Vice President and General Counsel Timothy Parry, plaintiffs asked defendant Louisburg HMA to produce "Minutes of all Board meeting of Louisburg HMA from January 1, 2001 to present." Exhibit 37 (R/P 33). As documented in plaintiffs' multiple discovery motions, defendants first refused to produce any responsive documents. Exhibit 38. Then, under court compulsion after lengthy delays, defendants produced only minutes of FRMC's local "Governing Board." Exhibit 39. In his deposition on June 9, 2004, Parry confirmed that the FRMC "Governing Board" was not an independent entity, and possessed only the authority delegated to it by the Board of Directors of Louisburg HMA – i.e., Vumbacco, Farnham and Parry. Exhibit 40 at 83. After Parry described the "perfunctory" annual Board "meeting" of Louisburg HMA and all other hospital subsidiaries at HMA headquarters in Naples, id. at 85-87, plaintiffs' counsel again requested copies of the minutes of those meetings, first at the deposition, id. at 87, and then by letter. Exhibit 41. Finally, on June 29, 2004 – fourteen months after plaintiffs' discovery request, eight months after Judge Titus' order compelling production, and two months after Judge Manning's order imposing sanctions for discovery abuses – HMA produced minutes of the Louisburg HMA board meetings. Exhibit 42; Exhibit 43. A review of the minutes, charitably described by HMA's local counsel as "pro forma," Exhibit 42, makes it apparent why HMA tried so hard to keep them hidden. The minutes and Parry's testimony demonstrate that Louisburg HMA, like the

other local HMA subsidiaries, is a sham corporation, completely dominated and controlled by the sole shareholder, HMA. Exhibit 44 at 3-23.

4. HMA exercises its operational control by installing HMA employees as Chief Executive Officer, Chief Financial Officer and Chief Nursing Officer at each HMA hospital. Exhibit 45 (Bates No. 000084). Tom Dunning, CEO of FRMC, reports to his employer HMA through HMA's Regional Vice President, Page Vaughan. Exhibit 21 at 4, 17, 25.

5. At the same time that it was denying its domination of FRMC in this litigation, HMA took the opposite tack in representations to the public, investors and federal regulators. In its website, HMA proclaimed that "Franklin Regional Medical Center is owned and <u>operated</u> by Health Management Associates, Inc. (HMA) of Naples, Florida." Exhibit 46 (emphasis added). In its 10-K filing with the SEC in 2002, HMA declared that, as of September 30, 2002, Health Management Associates, Inc. "<u>operated</u> 41 general acute care hospitals. . . ." Exhibit 45 (Bates No. 000084).

VI. <u>HMA Fiddles While Patients Burn</u>

In 1999, and 2000, two patients were burned in surgical fires in HMA hospitals in South Carolina and Georgia. Page Vaughan was the CEO of each hospital when the fire occurred. Exhibit 47 at 73, 90-91. Bruce Barkalow, CCE, plaintiffs' expert in medical technology safety, reviewed the depositions of Vaughan (Exhibit 47 and 48), other HMA and FRMC employees, and documents regarding the South Carolina and Georgia fires. Barkalow Affidavit, ¶ 9. Based on his review of those materials and his training and

experience, Barkalow summarized the facts about the fires that preceded Mrs. Faulkner's, and described HMA's responsibility:

> 10. On September 23, 1999, a patient was burned in a surgical fire at Carolina Pines Regional Medical Center (Carolina Pines RMC), an HMA-owned and operated hospital in Hartsville, South Carolina. The patient was undergoing the surgical removal of a lesion on her cheek, an outpatient procedure performed under conscious sedation. At the time of the fire, the patient was receiving supplemental oxygen via nasal cannula. The surgeon was using an ESU. A flash fire occurred, burning the patient's face. The fire was preventable, and would not have occurred if recognized safety standards had been followed.
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> 11. At the time of the surgical fire at Carolina Pines RMC, the administrator of Carolina Pines RMC was Page Vaughan, an HMA employee. Carolina Pines RMC and HMA failed to conduct an adequate investigation of the fire at Carolina Pines RMC, and failed to perform a proper root cause analysis.
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> 12. After the fire at Carolina Pines RMC, HMA failed to inform HMA employees, agents and medical staff members about the risk and prevention of surgical fires, and failed to promulgate policies and procedures to reduce the risk of surgical fires at Carolina Pines RMC and other HMA hospitals, including FRMC. HMA's acts and omissions in the aftermath of the Carolina Pines fire virtually guaranteed that another similar fire would subsequently occur at an HMA hospital.
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> 13. On June 19, 2000, a patient was burned in a surgical fire at East Georgia RMC, an HMA-owned and operated hospital in Statesboro, Georgia. The patient was undergoing the removal of cancerous lesions on his nose, an outpatient procedure performed under conscious sedation. At the time of the fire, the patient was receiving supplemental oxygen via nasal cannula. The surgeon was using an ESU. A flash fire occurred, burning the patient's face. The fire was preventable, and would not have occurred if recognized safety standards had been followed.
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> 14. At the time of the surgical fire at East Georgia RMC, the administrator of East Georgia RMC was Page Vaughan, the former administrator of Carolina Pines RMC. Vaughan, East Georgia RMC and HMA failed to conduct an adequate investigation of the fire at East Georgia RMC. HMA asserts that a root cause analysis of the Georgia fire was performed, but claims that "these

materials were not retained."[4] The destruction of all copies of a root cause analysis after a surgical fire indicates a disregard of the importance of identifying and correcting conditions that threaten patient safety.

15. After the fire at East Georgia RMC, HMA failed to inform HMA employees, agents and medical staff members about the risk and prevention of surgical fires, and failed to promulgate policies and procedures to reduce the risk of surgical fires at East Georgia RMC and other HMA hospitals, including FRMC. HMA's acts and omissions in the aftermath of the East Georgia fire virtually guaranteed that another similar fire would subsequently occur at an HMA hospital.

16. After the fire at East Georgia RMC, HMA promoted Page Vaughan to the position of Regional Vice President, responsible for HMA hospitals in North Carolina, South Carolina and Georgia, and assigned Vaughan the role of conducting annual quality assurance meetings for HMA officers and managers throughout the HMA system. Vaughan held the position of Regional Vice President of HMA on June 25, 2002, when the fire at FRMC occurred. Despite Vaughan's knowledge of the surgical fires at Carolina Pines RMC and East Georgia RMC, and despite his role in HMA's quality assurance program, Vaughan failed to take any steps to reduce the risk of surgical fires at HMA hospitals, including FRMC, before June 25, 2002.

17. Scott McIntyre was employed by HMA as Chief Operating Officer of FRMC when the surgical fire occurred at FRMC on June 25, 2002.[5] McIntyre was employed by HMA as assistant administrator of East Georgia RMC when the surgical fire occurred at East Georgia RMC on June 19, 2000. Despite McIntyre's knowledge of the surgical fire at East Georgia RMC, McIntyre failed to take any steps to reduce the risk of surgical fires at FRMC before June 25, 2002.

18. HMA failed to provide adequate training to its employees and medical staff members in the anticipation and prevention of surgical fires, and failed to promulgate policies and procedures to reduce the risk of surgical fires at HMA hospitals, including FRMC, before June 25, 2002.

19. HMA's acts and omissions after the South Carolina and Georgia fires demonstrate a disregard for the safety of patients and employees in HMA hospitals.

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[4] Exhibit 49 at ¶ 9 (Affidavit of Beth Wells).

[5] See Exhibit 50 (Deposition of Scott McIntyre).

See Exhibit 51 at 276, 281-83 (Barkalow II) (June 11, 2004).

VII. After Mrs. Faulkner Is Burned, HMA Fails to Take Action to Protect Other Patients

After Mrs. Faulkner was burned, HMA replicated its response to the South Carolina and Georgia fires. Again, it conducted an inadequate root cause analysis. Porto Aff. ¶ 18. Again, it failed to implement effective risk reduction strategies. Id. Again it refused to examine and change policies and practices that posed grave risks for patients and staff. Id. at ¶ 22.

HMA's liability insurer retained ECRI to investigate the cause of the fire. ECRI conducted a thorough investigation and issued a detailed report, clearly identifying the cause of the fire. The report states that the investigation was undertaken "in partial fulfillment of FRMC's quality assurance program." Exhibit 27 at 1. But HMA squandered that opportunity for quality improvement by burying the ECRI report. HMA refused to share the report not only with the Faulkners, but also with the employees and medical staff at FRMC. As a result, there has been no effective education about fire prevention, and no change in practice to protect other patients.

- Cynthia Pulley, FRMC's Director of Risk Management and Quality, never received a copy of the ECRI report. Id. at 57-58. Pulley testified that no changes were made in the hospital's policies and procedures as a result of Mrs. Faulkner's fire. Exhibit 51 at 71.

- Sandy Sphar, employed by HMA as FRMC's Chief Nursing Officer, never saw a copy of the ECRI report. Exhibit 52 at 25. Sphar said that no changes in policies were made as a result of the fire because "the policies we had in place were appropriate for what we were doing." Id. at 26. When asked what caused the fire, Sphar responded: "I don't know that." Id. at 26-27. Sphar was unable to explain how she could effectively discharge her responsibility to reduce the

risk of harm to patients without receiving information about the cause of the fire. Id. at 36-41.

- Tom Dunning, the hospital CEO, has never seen the ECRI report. Exhibit 21 at 13, 61. Dunning testified that FRMC took no remedial action as a result of the fire. Id. at 62-63.

- After the Faulkner fire, Kevin Henson, the nurse anesthetist employed by FRMC, sought to educate himself about fire prevention. Exhibit 31 at 216. He asked Pulley, FRMC's risk manager, what ECRI had concluded about the cause of the fire. Id. According to Henson, Pulley "said that information was not available to me." Id. As a result, Henson maintains the illusion that the fire was an unpreventable "freak event," and has made no changes in his practice. Id. at 218.

- HMA did not provide a copy of the ECRI report to Dr. Yerby, the surgeon who performed Mrs. Faulkner's operation. Exhibit 32 at 119-20. Dr. Yerby has not spoken with anyone since June 25, 2002 about the cause of the fire. Id. at 122. He has not reviewed medical literature to learn about the causes of surgical fires and how to prevent them. Id. at 122-23. When asked whether he had taken any steps to prevent another fire from occurring, Dr. Yerby answered: "I do not know what caused the fire, and I have not taken any steps to do things differently than I have been doing for 27 years." Id. at 122.

- Dr. Steven Schwam, director of the anesthesia department and chief of the medical staff at FRMC, was present in the operating room when the fire occurred. Exhibit 53 at 37-38, 125-33. Dr. Schwam was not provided the results of the ECRI investigation. Id. at 187. Contrary to the opinion of every expert witness, Dr. Schwam believes that the use of supplemental oxygen did not contribute to the fire in any way. Id. at 151. Dr. Schwam has not changed his practices since the fire. Id. at 197-98. In Dr. Schwam's opinion, Mrs. Faulkner's fire was an "unforeseeable and unpreventable occurrence," for which no one is responsible. Id. at 204-05.

Grena Porto, a national authority on patient safety, reviewed the depositions of Pulley, Sphar, Dunning, Henson, Yerby and Schwam. Porto concluded: "By failing to share the ECRI report with those who had the greatest need for the information, HMA again demonstrated a wanton and reckless disregard for the safety of patients." Porto Aff. ¶ 19.

Bruce Barkalow, plaintiffs' expert in medical technology safety, summarized HMA's response to the fire that burned Mrs. Faulkner:

> 20. HMA's conduct after Mrs. Faulkner was burned further confirms its disregard for patient safety. Immediately after the fire on June 25, 2002, HMA destroyed all partially burned items – key evidence in any fire investigation. HMA hired ECRI to investigate the cause of the fire, but then refused to share the results of the investigation with FRMC employees and medical staff members, depriving them of knowledge that could be used to prevent similar fires in the future. As of December 1, 2004, FRMC had not amended, supplemented or replaced its deficient fire "prevention" policy. After the FRMC fire, just as it had done after the Carolina Pines RMC and East Georgia RMC fires, HMA failed to inform HMA employees and medical staff members at HMA hospitals about the risk and prevention of surgical fires, and failed to promulgate policies and procedures to reduce the risk of surgical fires at FRMC and other HMA hospitals. <u>HMA's acts and omissions in the aftermath of the FRMC fire virtually guarantee that another similar fire will subsequently occur at an HMA hospital.</u>

Barkalow Aff. ¶ 20 (emphasis added). <u>See</u> Porto Aff at ¶ 18 – 22.

<u>ARGUMENT</u>

<u>PLAINTIFFS' EVIDENCE IS SUFFICIENT TO SUPPORT A CLAIM FOR PUNITIVE DAMAGES AGAINST HMA.</u>

The purpose of punitive damages is "to punish a defendant for egregiously wrongful acts and to deter the defendant and others from committing similar wrongful acts." N.C.G.S. § 1D-1. Punitive damages may be awarded if the defendant is liable for compensatory damages and a statutory aggravating factor "was present and was related to the injury for which compensatory damages was sought." § 1D-15(a)(3). One of the aggravating factors is "willful or wanton conduct." The punitive damages statute defines "willful or wanton conduct" as "the conscious and intentional disregard of and indifference to the rights and safety of others, which the defendant knows or should know is reasonably

likely to result in injury, damage, or other harm." § 1D-5(7). In the case of a corporation, punitive damages may be awarded if "the officers, directors or managers of the corporation participated in or condoned the conduct. . . ." § 1D-15(c).

Plaintiff's evidence against HMA meets the statutory test.

I. HMA Engaged in Willful and Wanton Conduct

A. HMA's Response to the South Carolina and Georgia Fires

Through affidavits, depositions, exhibits and discovery responses, plaintiffs' evidence is sufficient to show that HMA's response to the two prior fires constitutes "willful or wanton conduct."

1. Grena Porto affidavit

Grena Porto, plaintiffs' expert in patient safety, risk management and quality improvement, analyzed in detail HMA's response to the South Carolina and Georgia fires. Porto Aff. at ¶¶ 9-17. Porto concluded:

> By failing to take any effective remedial measures after the 1999 and 2000 fires in the hospitals in South Carolina and Georgia, HMA acted with conscious and intentional disregard of and indifference to the safety of patients in HMA hospitals. As a result, Joan Faulkner was severely burned and disfigured in a surgical fire that was completely preventable.

Id. at ¶ 17. Porto's affidavit is sufficient in itself to defeat HMA's motion for partial summary judgment.

2. Bruce Barkalow affidavit

Bruce Barkalow's affidavit, quoted at pp. 15-16 above, is also sufficient to defeat HMA's motion.

3. Depositions, exhibits and discovery responses

Plaintiffs' expert affidavits are based on facts contained in the depositions, exhibits, and discovery responses referenced in the affidavits. Those materials, with or without the expert affidavits, are sufficient to establish that HMA's conduct in response to the South Carolina and Georgia fires was willful and wanton, within the meaning of the statute.

B. HMA's Response to the Fire at FRMC

HMA's conduct after the Faulkner fire epitomizes the "conscious and intentional disregard of and indifference to the rights and safety of others."

After Mrs. Faulkner was burned, FRMC, HMA's alter ego,[6] immediately destroyed the evidence. When Dr. Faulkner persisted in asking for a copy of the investigative report, HMA fired him without cause. HMA deliberately chose not to share the ECRI report with the FRMC employees and medical staff members who most needed to see it, leaving them ignorant about the cause of the fire and fostering the continuation of dangerous practices. Despite obvious deficiencies, FRMC retained a fire "prevention" policy that says not one word about preventing fires. HMA withheld information about the Faulkner fire and the earlier fires from its hospitals, depriving them of the chance to learn how they could avoid a similar calamity.

[6] See Glenn v. Wagner, 313 N.C. 450, 329 S.E.2d 326 (1985) (defining standard for piercing the corporate veil).

II. HMA Is Responsible for the Acts of its Officers and Managers

HMA's corporate officers and managers participated in and condoned the willful and wanton conduct, triggering corporate liability for punitive damages under § 1D-15(c).

Page Vaughan, the Typhoid Mary of OR fires, served HMA as CEO of the hospital in South Carolina, CEO of the hospital in Georgia, and then Regional Vice President for the Carolinas Region, with company-wide responsibility for HMA's "annual quality meeting." Exhibit 47 at 118-19. Although Vaughan had direct personal knowledge of two terrifying fires, he did nothing to prevent their recurrence at his hospitals, or in other HMA hospitals.

After the fire at FRMC, willful and wanton conduct occurred at the manager's level in Louisburg, when Dunning, Sphar and Pulley did not act to prevent another fire. HMA officers in Florida engaged in willful and wanton conduct when Barber fired Dr. Faulkner, HMA buried the ECRI report, and senior HMA officials took no action to protect patients after a third devastating fire.

CERTIFICATE OF SERVICE

I hereby certify that the foregoing Plaintiffs' Memorandum in Opposition to HMA's Motion for Partial Summary Judgment on Punitive Damages was served by hand delivery to:

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William P. Daniell
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This the 15th day of August, 2005.

Burton Craige

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