UNITED STATES DISTRICT COURT
FOR THE NORTHERN DISTRICT OF TEXAS

ROBERT "LEE" LEROY PASSMORE, III, ET AL.	§	
	§	
	§	CIVIL ACTION NO.
V.	§	3:13-CV-05016-K P
	§	
BAYLOR HEALTH CARE SYSTEM, ET AL.	§	

PLAINTIFFS' BRIEF IN SUPPORT OF THEIR RESPONSE TO DEFENDANTS BAYLOR'S MOTION FOR PARTIAL SUMMARY JUDGMENT

TO THE HONORABLE COURT:

COME NOW Plaintiffs who file this Brief in support of their Response to the Baylor Defendants' Motion for Partial Summary Judgment.

Respectfully submitted,

THE GIRARDS LAW FIRM

By: /s/ James E. Girards

James E. Girards
State Bar No. 07980500
10000 North Central, Suite 400
Dallas, Texas 75231
Telephone 214.346.9529
Facsimile 214.346.9532
jim@girardslaw.com

ATTORNEYS FOR PLAINTIFFS

CERTIFICATE OF SERVICE

I hereby certify that a true and correct copy of the foregoing has been served upon all counsel of record via the Court's CM/ECF system on or before January 10, 2018.

/s/ James E. Girards

James E. Girards

TABLE OF CONTENTS

Statutes

Other Authorities

Rules

Regulations

I.

SUMMARY OF BAYLOR MOTION

Defendants Baylor claim that Plaintiffs cannot prove their case because Defendants are immune from liability; in the alternative they say Plaintiffs cannot prove their case because they cannot prove malice [i.e., "intent to harm the patient"]; in the alternative they say Plaintiffs cannot prove gross negligence against Defendants Baylor; and further in the alternative they say that if Plaintiffs can prove gross negligence at all Plaintiffs cannot prove gross negligence of any "vice-principal" of Defendants Baylor.[1]

II.

SUMMARY OF RESPONSE

The motion for partial summary judgment should be denied because Plaintiffs present more than a scintilla of proof of the challenged elements of their claims, which is sufficient to defeat Defendants' motion.

III.

EVIDENCE IN SUPPORT OF THIS RESPONSE

The accompanying Appendix and the separately filed audio recording provide the evidence referenced below. These materials include:

1. Passmore Operative Reports for December 30, 2011 and January 6, 2012
2. Christopher Duntsch CV
3. Declaration Kevin Moore
4. Declaration Martin Lazar, MD

[1] Doc. 73, pages 6-8

5. Baylor Regional Medical Center at Plano v. Minimally Invasive Spine Institute, Cause No. 366-04799-2012, filed in the 366th Judicial District Court of Collin County, Texas, Plaintiff's Original Petition and attachments
6. Deposition Kevin Wisler
7. Baylor Regional Medical Center at Plano Bylaws
8. Duntsch Neurosurgery Residency Certificate
9. Fred Boop MD Questionnaire
10. Robert Henderson MD Sworn Statement
11. Robert Henderson MD Audio Recording of his phone call with Fred Boop, MD [FILED SEPARATELY AS INSTRUCTED BY US DISTRICT CLERK]
12. Transcript of Robert Henderson MD Audio Recording of his phone call with Fred Boop, MD
13. Email from Duntsch to Jerri Garison, September 19, 2011
14. Deposition Megan Kane
15. Deposition Barbara Ellison
16. Defendant Morgan Sworn Statement of August 12, 2013
17. Hoyle Affidavit
18. State of Texas v. Duntsch, Cause No. F15-00411-L, 10 R.R. 15-20, 23-242 (Hoyle, MD transcript)
19. State of Texas v. Duntsch, Cause No. F15-00411-L, 8 R.R. 45 (Henderson, MD testimony)
20. State of Texas v. Duntsch, Cause No. F15-00411-L, 17 R.R. 134-142 (Moffitt, RN testimony)
21. State of Texas v. Duntsch, Cause No. F15-00411-L, 17 R.R. 81 (Ramnath, MD transcript)
22. Declaration of Keegan Begley
23. State of Texas v. Duntsch, Cause No. F15-00411-L, 20 R.R. 109 (Jury Verdict)
24. Duntsch email of December 9, 2011 to Defendant Morgan
25. State of Texas v. Duntsch, Cause No. F15-00411-L, 16 R.R. 41 (Closing Arguments)
26. State of Texas v. Duntsch, Cause No. F15-00411-L, 9 R.R. 33-41 (Mignucci, MD testimony)
27. Duntsch emails with Jerri Garison

28. Email of November 22, 2011 from Duntsch to Jerri Garison
29. State of Texas v. Duntsch, Cause No. F15-00411-L, 11 R.R. 95 (Sample, MD testimony)
30. Sproles Recommendation letter
31. Recommendation letter of December 20, 2012
32. Affidavit Victoria Franklin authenticating item nos. 1, 2, 8, 18-21, 23-26, and 29-31, and 33.
33. National Practitioner Data Bank Report

IV.

BACKGROUND FACTS

The following facts are offered to provide background for the discussion below in order to provide context, and such is without reasonable dispute:

34. The surgeon in question is Christopher Duntsch [Apx. 4-10];
35. Duntsch graduated from surgical training in June 2010 [Apx. 11-26];
36. During training, from 2007 through 2010, Duntsch had only been involved in 76-neurosurgeries when normally a neurosurgeon trainee would be performing 76 neurosurgeries each month of his training. For his fellowship alone, Duntsch should have had 450-500 surgeries with many of those as lead surgeon [Apx. 66];
37. Providing a surgical experience case-list from the neurosurgery training program to the hospital by the physician-candidate who is right out of fellowship training is universal practice [Apx. 66]. Thus, it can be concluded that Baylor knew this case list information at the time it allowed Duntsch to come on staff [Apx. 66; Apx. 27-35];
38. Duntsch was recruited to practice at Baylor by Baylor. Baylor used a mechanism in the law allowing Baylor to claim it is an "underserved community" to use Minimally Invasive Spine Institute ["MISI"] as a conduit for the money Baylor would pay to Duntsch in what amounts to a joint venture arrangement. [Apx. 107-214]. Duntsch would ostensibly work "for" MISI. [Id.].
39. Once Baylor Plano allowed Duntsch on staff, Baylor had one of its employees, a marketing specialist, actively market patients on Duntsch's behalf. [Apx. 226-252]. Baylor Plano was also in the process of making Duntsch a Medical Director of Minimally Invasive Spine Surgery in pursuit of

what was referred to as a "partnership" between Duntsch and Baylor. [Id. at pp. 237-238];

40. Duntsch requested privileges to perform neurosurgery; to wit, surgery on structures adjacent to the spinal cord and nerve roots. Obviously, incompetent surgeons can damage these structures and paralyze or kill patients. Neurosurgery by its nature is so dangerous it has been referred to in the neurosurgical community as akin to "tap dancing on a razor blade." [Apx. 698];

41. Baylor Bylaws required it to specifically ask the director of the residency or fellowship training program to "confirm the absence of any history of alcohol, substance abuse or health conditions in" Duntsch. [Apx. 416];

42. The neurosurgery training Program Director for Duntsch was Fred Boop, MD [Apx. 448-449];

43. Defendants Baylor chose not to specifically ask program director Fred Boop, MD to "confirm the absence of any history of alcohol, substance abuse or health conditions" in Duntsch. In fact, Boop was not asked a question about alcohol or substance abuse at all. [Apx. 449];

44. Boop knew that Duntsch had been put in a drug treatment program in his neurosurgery training and was willing to talk about it when specifically asked. [Apx. 466, 498];

45. From the time Duntsch graduated from surgical training until the time he performed his first operation at Baylor Plano, he had been out of the operating room for approximately a year and a half [*Compare*, Apx. 11, 508]. This was obviously known to Baylor. A neurosurgeon cannot maintain competence with that size of a gap in surgical experience [Apx. 65, 672];

46. Defendants Baylor chose not to require a proctor/observer for Duntsch to evaluate his competence at any time;

47. Duntsch was an abuser of cocaine, prescription narcotics and alcohol [Apx. 515-573, 778]. He reportedly liked to use cocaine during surgeries because he claimed it helped his "neurotransmitters" [Id.];

48. Duntsch was incompetent as a surgeon, for example:

    a. In one surgery that took place prior to Passmore's first surgery, Duntsch was so incompetent his surgical assistant and a medical device representative had to place Duntsch's hands and show him how to install instrumentation into a patient's spine [Apx. 883];

    b. Those who observed Duntsch perform surgery described him as dangerous, unskilled, performing at the level of a 1st Year Surgical resident. One surgeon was convinced Duntsch was an imposter posing as a surgeon [Apx. 988-989, 1009-1018, 1154-1160];

c. Weeks before the Passmore surgeries, Duntsch put screws into the spinal canal of a patient named Ami Gillentine [Apx. 1164];

d. During Passmore's first surgery, Duntsch misplaced hardware such that it is pressing on Passmore's spinal cord nerve roots. During that surgery, an assistant surgeon got into a physical altercation with Duntsch to stop Duntsch from continuing to operate because the assistant surgeon said he was "dangerous" and was going to damage Passmore's spinal cord. The assistant surgeon told the operating room personnel that he would never operate with Duntsch again and to take his name off the surgical schedule when Duntsch was scheduled to operate. [Apx. 988-989, 1166];

e. After the Passmore surgery, Duntsch was so incompetent that he was sentenced to life in prison for the harm he did to one of the many patients he injured or killed. [Apx. 1170];

49. Prior to Duntsch's surgeries on Leroy Passmore, Duntsch confessed to Defendant Morgan to being a "stone-cold killer"; a "cold blooded killer" and compared himself to the antichrist. [Apx. 1174-1175];

50. Duntsch has admitted, through his legal counsel, to being untrained, unskilled, and practicing at the level of a 1st Year Surgical resident. [Apx. 1217];

51. Duntsch operated on Leroy Passmore on December 30, 2011 and again on January 6, 2012. [Apx. 3-10];

52. Passmore is now permanently disabled due to hardware Duntsch placed, which intruded into the spinal canal and damaged the nerve roots. [Apx. 1286].

V.

SUMMARY JUDGMENT STANDARD

A motion for summary judgment cannot be granted if the non-movant produces evidence showing a genuine issue of material fact as to the elements addressed by the motion. See Fed.R.Civ.P. 56(c).The motion must be denied if such evidence amounts to more than a scintilla. Little v. Liquid Air Corp., 37 F.3d 1069, 1075 (5th Cir. 1994). All evidence must be accepted as true and interpreted in the light most favorable to the non-movant; here, the Plaintiffs. *See,* Matsushita Elec. Indus. Co. v. Zenith Radio Corp., 475 U.S. 574, 587 (1986).

VI.

BAYLOR ACTS THROUGH ITS BOARD OF TRUSTEES

According to the Joint Commission on Accreditation of Health Care Organizations, "credentialing" is the process of obtaining, verifying, and assessing the qualifications of a practitioner to provide care or services in or for a health care organization. Credentials are documented evidence of licensure, education, training, experience, or other qualifications. Examples of credentials are certificates, letters, badges, or other official identification that confirms somebody's position or status. [Apx. 26-27]. "Privileging" is the process whereby the specific scope and content of the patient care services (that is clinical privileges) are authorized for a health care practitioner by a health care organization, based on an evaluation of the individual's credentials and performance. [Id.]. Both concepts are implicated in this case. [Id.]. As explained below, Baylor was grossly negligent as to each function. [Id.].

Baylor's motion leaves out some very important pertinent information about how Baylor operates that impacts the Court's ruling on the issues raised. For this reason, provided here is pertinent background on how Baylor operates, as well as the role of the Board of Trustees in the issues presented by the instant motion.

Baylor, like all Texas hospitals, is operated by a governing body, its Board of Trustees. [*See,* 25 Tex.Admin. Code § 133.41(f)(1); Apx. 410]. The Board of Trustees runs the hospital and has ultimate responsibility, authority and accountability for everything the hospital does, including patient care. [*See,* id.; Hospital Governance Academy Trustee Guidebook, Inspiring Excellence in Health Care Governance: The Governing Board & the CEO, p. 6-7 (8th ed. 2013)].

The Board of Trustees is responsible for creating and enforcing the hospital's bylaws. [The Governing Board & the CEO, at p. 11]. It is responsible for appointment/credentialing of the medical staff; it is responsible for patient care through delegation of medical acts to those

medical staff members. [Id. at pages 11-12 ("The board ultimately is responsible for the quality of health care provided."); Jennings, H, et al, The Ethics of Hospital Trustees, at pp. 44, 46 & 54 (2004)(the Board of Trustees has the "ultimate responsibility" for both patient care and competence of the medical staff)]. The President/CEO, administration and committees act as "technical advisors" to the Board of Trustees in its performance of these functions but ultimate responsibility/liability for those functions remains with the Board of Trustees. [The Governing Board & the CEO, at p. 9].

Specifically with respect to the credentialing of physicians, the Board of Trustees is required to review the credentialing recommendations of the Credentialing and Medical Executive Committees as well as the actual credentialing documents those committees have gathered assuring that all required documentation has been both provided and verified. [See, Hospital Governance Academy Trustee Guidebook, Inspiring Excellence in Health Care Governance: Quality and Patient Care, p. 23 (8th ed. 2013)]. Each member of the Board of Trustees is required to review all such documentation, reports and ask pertinent questions. [Id.]. Failing to do such is considered "governance malpractice." [Id. at p.28]. The appointment/credentialing of the medical staff is one of the most important quality responsibilities of the Board of Trustees; it never "rubber stamps" committee recommendations but instead the Board of Trustees ensures that it receives all pertinent practitioner information, assures it has been validated, and evaluates it. [Id. at page 39]. The Board of Trustees does not "just passively receive information," but makes reasonable inquiry into such matters. [Id. at p. 41]. Failing to do so can expose members of the Board to criminal liability under federal law. [Id.].

The Board of Trustees designates a President/CEO to actually run the day-to-day operations of the hospital on its behalf. [Baylor Regional Medical Center at Plano Medical Staff Bylaws, pages 1 & 2; 25 Tex.Admin. Code § 133.41(f)(5); The Governing Board & the CEO, at p. 7]. The President/CEO, in turn, delegates to her designees [i.e., hospital administration and various committees] the authority to run various aspects of the hospital on her behalf, but she remains responsible and accountable to the Board of Trustees for her designees' actions. [*See*, id.] Since the President and each administrative official, as well as the hospital committees, are designees of the Board of Trustees performing non-delegable duties that belong to the Board of Trustees, the knowledge held, and the actions taken, by the President/CEO, the hospital administration officials, and the hospital committees are legally the actions of the Board of Trustees and the hospital entity itself; i.e, each of these persons/committees is a "vice-principal" whose actions are the very actions of the entity itself when each is acting in the administration or committee role. For this reason, the actions or knowledge of any of these personnel when acting within their administrative or committee roles will be referred to collectively as "Baylor" in this document. Such acts/omissions were all within the scope of their authority delegated to them by the Board of Trustees. As such, they also are sufficient to form the basis for exemplary damages against the hospital.

It should be pointed out that Defendants Baylor have side-stepped this important legal responsibility issue by saying, without further explanation, that the credentialing committee makes the decisions about credentialing and not hospital administration. [Doc. 73, p. 10, n. 3]. But, this is not actually true. The hospital bylaws place that responsibility squarely on the Board of Trustees. [Apx. 412]. The Credentialing Committee's role is merely to make a recommendation on the physician-candidate to the Medical Executive Committee, which in turn

makes its own recommendation to the Board of Trustees on that physician-candidate. [Id.]. The Board of Trustees then reviews all pertinent documentation, assuring it is complete, accurate, and verified, and then makes its own decision about whether to admit the physician-candidate. [Apx. 412-413; Quality and Patient Care, p. 23 (8th ed. 2013)]. But again, the Board of Trustees is prohibited from simply rubber-stamping those recommendations and must perform a detailed review of all required information and assuring all required documentation is provided and verified. [Quality and Patient Care, p. 23].

Consistent with this duty, Baylor's Bylaws state that its Board of Trustees shall determine which practitioners are eligible for appointment to the medical staff. [Apx. 410, 412-413]. And, the Baylor Board of Trustees makes the ultimate decision on those medical staff appointments. [Id.]. Again, this duty is not delegable. [See 25 Tex.Admin. Code § 133.41(f)(4)(E)&(H)].

Texas case law reflects the foregoing as well: a hospital is charged with the legal duty of thoroughly and carefully investigating each physician who applies for privileges. [Romero v. Kph Consol., Inc., 166 S.W.3d 212, 216 (Tex. 2005)]. Thus, Baylor's Board of Trustees and its designees were charged with this legal duty with respect to Duntsch. [*See*, id.; Apx. 412, 417].

A physician engaged in drug abuse presents an extreme risk to patients. [Romero v. Kph Consol., Inc., 166 S.W.3d 212, 221 (Tex. 2005)]. Baylor was charged with this knowledge, as well. [*See*, id.; see also, e.g., Berge, et al, Chemical Dependency and the Physician, Mayo Clin. Proc. July 2009;84(7):625-631; Gold, et al, Physicians Impaired by Substance Abuse Disorders, J. Global Drug Policy and Practice, vol. 2, issue 2 (2008)(available at http://globaldrugpolicy.org/Issues/Vol%202%20Issue%202/Physicians%20Impaired%20by%20Substance%20Abuse%20Disorders.pdf *accessed* January 2, 2018); Cottler, et al., Lifetime Psychiatric and Substance Use Disorders Among Impaired Physicians in a Physicians Health

Program: Comparison to a General Treatment Population, J Addict Med. 2013 ; 7(2): 108–112; Oreskovich, Prevalence of Alcohol Use Disorders Among American Surgeons, Arch Surg. 2012;147(2):168-174].

Drug- and alcohol-impaired physicians are a growing threat to patients in the US. [Romero v. Kph Consol., Inc., 166 S.w.3d 212, 232 (Tex. 2005)(concurring opinion by Justices O'Neill and Medina)]. Similarly, Baylor was charged with this knowledge, as well. [*See,* id.].

A hospital cannot simply rely upon what a surgeon says about himself in making credentialing/privileging decision. [Apx. 715].

In addition to the foregoing, Baylor specifically assumed duties pertinent to this case. Section 1.7 of Baylor's Bylaws states as follows [emphasis added]:

> 1.7-1 Review and Verification of Information.
>
> [Baylor] shall assess whether the Practitioner meets all the qualifications for Medical Staff membership by verifying, to the best of its ability, the accuracy and veracity of the information submitted by the Practitioner, as follows:
>
> > (d) Health status. Confirm absence of any history of alcohol, substance abuse or health conditions that may adversely affect the Practitioner's ability to perform the privileges requested from the director of the residency or fellowship program….

Thus, Baylor's Board of Trustees [and the Board's designees] had an affirmative duty to confirm the absence of a history of drug or substance abuse of this surgeon with the director of the residency or fellowship program, in this case Fred Boop, MD. More on this below.

VII.

CREDENTIALING, DUNTSCH AND BAYLOR'S KNOWLEDGE

Baylor appears to say that the credentialing cause of action in Texas is constitutional but that Plaintiffs are required to present evidence from the Credentials Committee in order to prove it. And, that since Plaintiffs can never get the Credentials Committee's information they can

never meet their burden of proof. But, both cannot be true. If the cause of action exists but can never be proven due to discovery privilege preventing disclosure of what the Credentials Committee actually knew the statute is without question unconstitutional. Thus, if the cause of action exists and is constitutional then Plaintiffs must be able to prove their case without having any Credentialing Committee records; that is to say, with the legally permissible discovery they are allowed to have. This is confirmed by the Romero case. [Id. at p. 224 (Even though Plaintiffs could not access peer review information, "[h]ad the [Plaintiffs] offered evidence that [hospital] should not have allowed [surgeon] to operate on [Plaintiff Romero] there would be some evidence of malice" and the summary judgment motion would have been defeated)]. Thus, Plaintiffs here are allowed to prove what the committee knew without proof of its "actual" knowledge and without its internal documentation. That is to say, if the cause of action is constitutional, Plaintiffs must be allowed to prove their case by showing Baylor's constructive knowledge or what it must have known, rather than by proof of what it actually knew.

Baylor also seems to be saying that Plaintiffs must prove Baylor knew Duntsch was a drug abuser prior to allowing him on staff or at some point prior to Passmore's surgeries. [Doc. 73, at p. 18 & 23]. Not true. Instead, Plaintiffs must simply prove that Baylor knew information that this surgeon should not be performing surgery unsupervised and that allowing him to do so under the circumstances here amounts to recklessness or gross negligence; given the constitutional issues raised in Docs. 71 and 71-1. [*See*, Romero, at p. 224]. Evidence from any source and of any nature that the hospital should not have allowed a surgeon to operate is some evidence of malice. [Romero, at p. 224-225]. Given the gross ineptitude Duntsch revealed when he actually was observed in the operating room weeks after the Passmore surgeries, it is fair to conclude that had Duntsch been supervised when he was first credentialed at Baylor he would

not have been able to perform surgeries later, to include Passmore. The evidence produced with this response shows Baylor knew that it should not have allowed Duntsch to perform surgery unproctored/unsupervised under circumstances that meet the definitions of gross negligence and recklessness, at the very minimum.

In addition to item nos. 1-9, 11 & 12 listed above, Baylor knew with certainty the information listed below, prior to Passmore's first surgery on Lee Passmore. This knowledge should have resulted in Baylor preventing Duntsch from performing surgeries unsupervised:

1. 10-12% of physicians suffer from substance abuse. [Chemical Dependency and the Physician, p. 625]. With certainty, Baylor knew this;
2. Performing surgery in close approximation to the spinal cord and its nerve roots is an extremely high risk activity. [*See, e.g.*, Treatment Algorithms and Protocol Practice in High-Risk Spine Surgery, Neurosurg. Clin. N Am. 24 (2013) 219-230]. This, too, would have been actually known by Baylor;
3. Substance abuse in a neurosurgeon is extremely dangerous to patients. [*See*, Romero, at p.221]. Obviously, this would also have been actually known by Baylor;
4. Baylor requires that it affirmatively *confirm the absence of any* substance abuse history with the training program director. Obviously, Baylor knows the failure to do so allows a druggie physician to be admitted to the medical staff undetected, exposing patients to an extreme risk of harm. [*Cf.*, Romero, at p.221].

    a. Baylor found this issue important enough to make this a written requirement. This is evidence that Baylor *objectively* knew of the extreme degree of risk in failure to affirmatively confirm this information considering the probability and magnitude of the potential harm to others; and that Baylor had actual, *subjective* awareness of such risks. In other words, this is evidence Baylor was consciously indifferent to the safety of its patients when it failed to confirm the absence of a substance abuse

history in this neurosurgeon and is evidence of gross negligence/reckless disregard;

b. The Baylor Board of Trustees, Credentialing Committee and Medical Executive Committee all possessed questionnaires that had been sent to Fred Boop, MD and others regarding Duntsch's request for hospital privileges. Baylor chose not to include even one question on those questionnaires about substance abuse history, much less asked the recipient to affirmatively "confirm absence of any" substance abuse history as required by Baylor bylaws. [Questionnaires]. Given Baylor's own written, assumed duty to affirmatively confirm the absence of any substance abuse history, failing to do so must be considered intentional. Given Baylor's knowledge of the extreme risks posed to patients by the 10-12% of substance abusing physicians, making a decision to not specifically confirm the absence of any substance abuse history with Duntsch's training program director rises to the level of gross negligence and reckless disregard for the rights of others;

c. Had Baylor contacted Duntsch's training program director Fred Boop, MD and asked him specifically to confirm the absence of substance abuse history in Duntsch (or included that question on its questionnaires) Baylor would have learned what Boop knew, which is reflected in a phone call Boop had with surgeon Robert Henderson, MD; to wit, that Duntsch had been the subject of a report of cocaine use, dodged a drug screen, and was placed in an impaired physicians program while in training. Boop was obviously willing to disclose the information, if asked. But, Baylor made a decision not to ask. The reason Henderson called Boop in the first place is because Henderson was convinced Duntsch was not a surgeon at all but was an imposter. This was due to the extreme incompetence Duntsch displayed in surgery. [Apx. 1033];

5. A surgeon coming out of a training program submits a case list to the hospital showing his surgical experience. This is universal. Thus, we know for a fact Baylor knew Duntsch's surgical case information. [Apx. 28, 65].

a. Duntsch's case list showed he had only 76 total cases in his training – none of which were as lead surgeon. [Apx. 28, 65]. Normally, a case list for such a surgeon would include somewhere around 500 cases for the last six-months of training, alone. Thus, Baylor knew that Duntsch was grossly unqualified to perform neurosurgery independently at the time it allowed him to do so simply by the surgical case list that Baylor possessed. [Apx. 28, 64-65];

6. Duntsch had not performed surgery for a year and a half between graduating from his training program and his first surgery at Baylor. Duntsch graduated from training in June

2010 and performed his first surgery at Baylor Plano in approximately November 2011 [Apx. 11, 508];

a. A neurosurgeon cannot maintain technical competence when he has performed no surgeries in 17-months. [Apx. 65]. Thus, Baylor knew for a fact that Duntsch must be considered unqualified to perform neurosurgery independently until proven otherwise. [Apx. 28-34, 65-66];

7. Because of items 5 and 6 above, Baylor knew with certainty that Duntsch must be considered dangerous to patients if he were allowed to operate unsupervised until that were proven otherwise by direct observation/proctoring by another neurosurgeon. Observation by another neurosurgeon would not only have been the minimum prudent step required and would have revealed gross incompetence in Duntsch, similar to that described by nurses and surgeons when they observed Duntsch operate later in the timeline. Yet, Baylor decided consciously to disregard the risks it actually knew Duntsch may pose to patients by virtue of paragraphs 5 and 6 above, and allowed Duntsch to perform neurosurgery without having another neurosurgeon proctor him or even observe him one time;
8. MISI unexpectedly fired Duntsch weeks after the joint venture arrangement described above was finalized. This was known to Baylor. Baylor's failure to find out why must be considered intentional. This red flag was ignored in actual conscious disregard for the safety of patients that may have been implicated by the bases for the termination of the agreement by MISI. Rather than investigate the circumstances of this unusual event, Baylor moved forward with plans for a Medical Directorship and "partnership" with Duntsch. [Apx. 1309-1311];
9. Throughout the pertinent time period, Duntsch kept in almost constant contact with Baylor Plano President, Jerri Garison, during which Duntsch complained about the year

and a half he was out of the operating room referenced above, his split with MISI, as well as the catastrophic financial situation he found himself in by the beginning of December 2011, weeks before the Passmore surgeries. [Apx. 1306-1309]. Garison did not so much as query Duntsch's surgical assistant Defendant Kimberly Morgan about whether Morgan noticed anything unusual or reportable about Duntsch. In fact, in early December 2011 Morgan had received emails from Duntsch that reflected a thought process that can only be described as psychotic, which she might have shared if such a query had been made. [Apx. 1172, *et seq*.].

VIII.

DISCUSSION

Baylor's actual knowledge of Duntsch's frank surgical inexperience, its decision not to "affirmatively confirm the absence of" any substance abuse history in Duntsch, given the context, and its allowing Duntsch to perform surgery unsupervised amounts to gross negligence and reckless disregard for the rights of others. [Apx. 33-34]. Baylor's actual knowledge of the facts described above, even without knowledge that Duntsch was a cocaine user, required Baylor to either refuse to credential Duntsch at all or to require him to be proctored/observed for a minimum number of neurosurgeries. [Id.]. Failure to do so amounts to gross negligence and conscious disregard for the rights of others given that the information Baylor actually possessed required it to presume Duntsch was dangerous to his patients until proven otherwise. [Apx. 30, 65-66]. This is also supported by the fact that Duntsch had such a high number of catastrophic injuries in such a short period of time following Baylor's decision. [Apx. 711]. Passmore was injured, and other patients killed, due to a "complete breakdown" of Baylor's credentialing, privileging, and verification system. [Apx. 719].

Had close monitoring, observation or proctoring occurred with Duntsch, it would have been seen that he was grossly incompetent prior to Passmore's first surgery and he would not have been granted continued privileges. This is a certainty because both surgeons and nurses who watched Duntsch in surgery later in the timeline describe him as grossly incompetent to the degree that one surgeon actually believed Duntsch was an imposter posing as a neurosurgeon. [Apx. 1033]. This would have prevented harm to Leroy Passmore.

Because the gross negligence was committed by the Board of Trustees it was committed by the hospital entity itself. Therefore, the motion for partial summary judgment must be denied.

In Baylor's motion, it relies upon Kinnard v. United Reg. Health Care Sys., 194 S.W.3d 54, (Tex.App.—Fort Worth 2006, no pet.) and Yates-Williams v. El Nihum, No. H-09-2554, 2011WL 1157378 (S.D. Tex Mar. 24, 2011) (unpublished) for the proposition that evidence of inadequate investigation or failure to comply with hospital or industry standards does not rise to the level of malice. But, the definition of malice in those cases is only "intent to injury the patient," and not gross negligence as is incorrectly stated on p. 19 of Doc. 73. Properly stated, those cases stand for the proposition that evidence of inadequate investigation or failure to comply with hospital or industry standards does not rise to the level of intent to harm Leroy Passmore. This begs the question of whether it amounts to recklessness or gross negligence, and whether recklessness or gross negligence is sufficient for recovery given the constitutional challenge Plaintiffs offer. Plaintiffs say the "intent to harm the patient" standard as the sole standard for recovery is constitutionally impermissible. The evidence specified above is certainly evidence of gross negligence, which Plaintiffs say is a constitutionally permissible standard. [Agbor, at p. 506].

Similarly, Defendants Baylor obfuscate by pointing the finger at other physicians or actors and what those physicians should have done. [Doc. 73, at pp. 20-23]. But, Plaintiffs' recovery here does not depend on what actors other than Baylor did or failed to do.

With respect to the issue of "intent to harm the patient," the Tex.Civ.Prac. & Rem.Code § 41.007(7) is silent on to what extent objective versus subjective intent comes into play. Objective intent is that intent which can be determined through the outward manifestations of behavior. [*See, e.g.*, United States v. Vascular Solutions, Inc., 181 F.Supp.3d 342, 344 (W.D. Tex., 2016)]. Subjective intent is determined by internal deliberation or communication. [Id.]. The concept of objective intent is used in contract interpretation and in criminal law. To the extent Plaintiffs are required to prove intent to harm the patient in order to recover in a malicious credentialing claim, Plaintiffs say that they have proven Baylor's objective intent to harm this patient with the evidence brought before the Court in this response. Certainly, Baylor intended for Duntsch to cut open patients and damage both healthy and diseased tissue at its facility; i.e., the very definition of patient harm. And, when Baylor gives a man who it knows is frankly inexperienced in neurosurgery, who has not been vetted for any substance abuse history, and who has not performed surgery in a year and a half permission to cut people open and drill and cut on structures adjacent to the spinal cord while that man is unproctored and unsupervised surely that rises to the level of at least an objective intent to harm the patient.

XI.

RATIFICATION

After Baylor knew the full extent of the carnage created by Duntsch, Baylor ratified its credentialing and privileging decisions and, indeed, the very acts of Christopher Duntsch. This was done in at least two affirmative actions.

By Spring 2012, Baylor had reports of Duntsch doing 8-balls of cocaine with a patient in the hours before Duntsch turned that patient into a quadriplegic in an OR at Baylor Plano. It had determined that Duntsch killed a patient (Kellie Martin). It had determined that Duntsch had dodged a drug screen by providing tap water instead of urine. And, Baylor had determined Duntsch was a danger to his patients and told him so. [Apx. 1319, *et seq.*].

After it knew all of that, it did the following:

1) Baylor Plano administrator Patricia Sproles wrote a letter clearing Duntsch of wrongdoing and handed that to him so he could use it to get privileges at another hospital. [Apx. 1382];
2) Baylor Health Care System Vice President Dana Choate wrote a letter of recommendation for Duntsch directly to another hospital in which he stated that Duntsch had voluntarily resigned rather than been terminated, which included this language--

> "Based on our knowledge, this practitioner is compliant with the "Six (6) areas of General Competencies" (Patient Care, Medical/Clinical Knowledge, Practice-based Learning & Improvement, Interpersonal & Communication Skills, Professionalism, and System Based Practice) as required by The Joint Commission. There is no indication of disciplinary action of restriction/denial of privileges on file." [Apx. 1380].

Baylor also made a decision not to report Duntsch to the National Practitioner Data Base. [Apx. 1350, 1384].

At the time of these actions, Baylor had actual knowledge of its prior bad acts in credentialing and privileging Duntsch that are detailed in this response, as well as knowledge of Duntsch's bad acts. By taking these actions, Baylor affirmatively put its stamp of approval on all of those acts and ratified same. [*See* THI of Tex. at Lubbock I, L.L.C. v. Perea, 329 S.W.3d 548, 590 (Tex.App.—Amarillo 2010, pet. denied) (Campbell, J., concurring and dissenting) (citing

Shamrock Communs., Inc. v. Wilie, No. 03-99-00852-CV, 2000 WL 1825501 at *5 (Tex. App.—Austin 2000, pet. denied.) (not designated for publication), *citing* Prunty v. Arkansas Freightways, Inc., 16 F.3d 649, 653 (5th Cir. 1994)]. Thus, these actions are the actions of both Baylor Plano and Baylor Health Care System, jointly and severally.

X.

PRAYER

FOR THESE REASONS, Plaintiffs pray that Defendants' Motion for Partial Summary Judgment be in all things denied.

Respectfully Submitted,

THE GIRARDS LAW FIRM

/s/ James E. Girards
James E. Girards
State Bar No. 07980500
10,000 N. Central Expressway, Suite 400
Dallas, Texas 75231
214/346-9529 telephone
214/346-9532 facsimile
jim@girardslaw.com

ATTORNEY FOR PLAINTIFFS

CERTIFICATE OF SERVICE

A true and complete copy of the foregoing document was served upon all counsel of record on January 10, 2018 via the Court's ECF system.

/s/ James E. Girards
James E. Girards