IN THE

# Supreme Court of Virginia

RECORD NO. 121797

BRADLEY J. CASHION, M.D.,

*Appellant,*

v.

ROBERT S. SMITH, M.D., *et al.*,

*Appellees.*

## BRIEF OF APPELLEE CARILION MEDICAL CENTER

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## TABLE OF CONTENTS

TABLE OF AUTHORITIES ..... iii

STATEMENT OF THE CASE ..... 1

ASSIGNMENT OF CROSS-ERROR ..... 4

STATEMENT OF FACTS ..... 4

STANDARD OF REVIEW ..... 13

ARGUMENTS AND AUTHORITIES ..... 14

I. Any Objections Regarding the Non-Euthanasia Statements Have Been Waived, and if Not, The Trial Court Did Not Err In Granting A Demurrer Determining that The Non-Euthanasia Statements Were Opinion and Not Actionable As Defamation ..... 14

A. Dr. Cashion Waived His Argument as to the Non-Euthanasia Opinion Statements ..... 14

B. The Non-Euthanasia Statements Are Opinion Because They Are Viewpoint Specific, Subjective Reviews ..... 16

II. The Circuit Court Did Not Err In Ruling that a Qualified Privilege Attached to the Alleged Euthanasia Statements Made Near the Operating Room and in the Wake of the Surgery ..... 21

A. The Privilege Attached As A Matter of Law to Conversations in the Wake of the Surgery ..... 21

B. The Circuit Court Did Not Err In Finding Dr. Smith's Criticisms of Dr. Cashion to Be In Good Faith and in Confirming the Absence of Malice ..... 24

1. Dr. Smith's Concern was Reasonable ..... 24

2. Dr. Cashion Did Not Create A Genuine Issue of Material Fact As To Whether The Privilege Was Overcome ..... 28

ON CROSS-ERROR ..... 32

III. The Trial Court Erred in Ruling That Statements Allegedly Containing the Word Euthanasia Were Not Rhetorical Hyperbole. (Relating to Assignment of Cross-Error I.) ..... 32

CONCLUSION ..... 37

CERTIFICATE OF SERVICE ..... 39

## TABLE OF AUTHORITIES

**Page(s)**

**Cases**

*Anderson v. Van Landingham*,
236 Va. 85 (1988) ..... 15, 16

*Aroonsakul v. Shannon*,
664 N.E.2d 1094 (Ill. App. 2nd Dist.), *appeal denied*, 671 N.E.2d 726 (Ill. 1996) ..... 19

*Arthur v. Offit*,
2010 WL 883745 (E.D. Va. Mar. 10, 2010) ..... 17

*Blue Ridge Bank v. Veribanc, Inc.*,
866 F.2d 681 (4th Cir.1989) ..... 17

*CACI Premier Technology, Inc. v. Rhodes*,
536 F.3d 280 (4th Cir. 2008) ..... 34

*Chaves v. Johnson*,
230 Va. 112 (1985) ..... 18, 31

*Colantonio v. Mercy Medical Center*,
901 N.Y.S.2d 370 ..... 20

*Coleman v. Comm.*,
27 Va. App. 768 (1998) ..... 15, 16

*Crawford v. United Steel Workers, AFL-CIO*,
230 Va. 217 (1985), *cert. denied*, 475 U.S. 1095 (1986) ..... 36

*D'Souza-Klamath v. Cloud County Health Center, Inc.*,
2009 WL 902377 (D. Kan. 2009), *aff'd.*, 363 Fed.Appx. 658 (10th Cir. 2010) ..... 23

*State ex rel. Diehl v. Kintz*,
162 S.W.3d 152 (Mo. App. E.D. 2005) ..... 37

*Dudas v. Glenwood Golf Club, Inc.*,
261 Va. 133 (2001) ..... 14

*Fuste v. Riverside Healthcare Ass'n, Inc.*,
265 Va. 127 (2003) ..... *passim*

*Gazette v. Harris,*
229 Va. 1, *cert. denied*, 472 U.S. 1032 (1985) ..... 28, 30, 31

*Great Coastal Exp., Inc. v. Ellington,*
230 Va. 142 (1985) ..... *passim*

*Greenbelt Co-op. Publ'g Assoc., Inc. v. Bressler*,
398 U.S. 6 (1970) ..... 36

*Horsley v. Rivera*,
292 F.3d 695 (11th Cir. 2002) ..... 34

*Hyland v. Raytheon*,
277 Va. 40 (2009) ..... *passim*

*Jackson v. Hartig*,
274 Va. 219 (2007) ..... 13, 14, 28, 32

*Larimore v. Blaylock,*
259 Va. 568 (2000) ..... 28

*Lewis-Gale Medical Center, LLC v. Alldredge*,
282 Va. 141 (2011) ..... 33

*Lizotte v. Welker*,
709 A.2d 50 (Conn. Sup. Ct. 1996), aff'd. 709 A.2d 1 (Conn. 1998) ..... 37

*Magre v. Charles*,
729 So.2d 440 (Fla. 5th DCA, 1999) ..... 24

*National Rifle Ass'n v. Dayton Newspapers, Inc.*,
555 F.Supp. 1299 (D.C. Ohio 1983) ..... 35

*Nigro v. Virginia Commonwealth University*,
No. 10-2425, 2012 WL 2354635 (4th Cir. Jun. 21, 2012)
(unpublished) ..... 20

*Polish Am. Immigration Relief Comm., Inc. v. Relax*,
596 N.Y.S.2d 756 (1993) ..... 37

*Preston v. Land*,
220 Va. 118 (1979) ..... 29

*Qureshi v. St. Barnabas Hosp. Center*,
430 F. Supp. 2d 279 (S.D.N.Y. 2006) ..... 23

*Raytheon Technical Servs. Co. v. Hyland*,
273 Va. 292 (2007) ..... 18, 19, 20

*Schnare v. Ziessow*,
104 Fed.Appx. 847 (4th Cir. 2004) ..... 32, 33

*Southeastern Tidewater Opportunity Project, Inc. v. Bade*,
246 Va. 273 (1993) ..... 29

*Tharpe v. Saunders*,
285 Va. 476 (2013) ..... 31

*Tronfeld v. Nationwide Mut. Ins. Co.*,
272 Va. 709 (2006) ..... 13, 17, 26

*Union of Needletrades v. Jones*,
268 Va. 512 (2004) ..... 26, 28, 30, 31

*Yeagle v. Collegiate Times*,
255 Va. 295 (1998) ..... *passim*

*Yuzefovsky v. St. John's Wood Apartments*,
261 Va. 97 (2001) ..... 14

*Zoumadakis v. Uintah Basin Medical Center, Inc.*,
2009 WL 1423559 (Utah App. 2009) ..... 23

**Statutes**

Virginia Code § 8.01-384 ..... 15

**Rules**

Rule 3:20 of the Rules of the Supreme Court of Virginia ..... 14

## STATEMENT OF THE CASE

The Circuit Court correctly held that criticisms of an anesthesiologist allegedly uttered by the Vice Chair of Surgery after a difficult attempt to save a critically injured trauma patient were opinion or were protected by a qualified privilege with no showing of "common law" malice. Health care providers must be permitted to have full and frank exchanges with each other regarding patient care, and statements among physicians uttered in the heat of the moment, after an emotionally draining attempt to save another's life, should not give rise to costly and disruptive civil suits.

### Dr. Cashion Claims He Was Defamed When Dr. Smith Criticized His Care of A "Critically Injured" Patient.

Dr. Bradley J. Cashion ("Dr. Cashion"), an anesthesiologist for Anesthesiology Consultants of Virginia Inc. ("ACV"), claims that he was defamed by Dr. Robert S. Smith ("Dr. Smith"), then the Vice Chair of Surgery at Carilion Medical Center ("Carilion"), a health care provider in Virginia. (JA 2, ¶¶ 6-8.) ACV had an exclusive contract with Carilion to provide anesthesiology services in the Roanoke area. (JA 131, RRA # 44.)

Drs. Smith and Cashion worked together on the same surgery "team" (JA 5, ¶ 24) in Roanoke, Virginia on November 19, 2009. The doctors treated a "critically injured" pedestrian who was struck by a tractor-trailer on

an interstate near Wytheville, Virginia. (JA 3, ¶ 12.) Carilion is joined in this matter solely under *respondeat superior.* (JA 12, ¶ 63.)

Dr. Cashion alleges that Dr. Smith made a series of defamatory statements in the operating room, or nearby, and in communications with other hospital administrators regarding the patient's care. (JA 6-8, ¶¶ 31, 33, 35-40.) The alleged defamatory language included: "This was a very poor effort"; "You didn't really try"; "[Dr. Cashion] refused to administer Factor VIIa through the IV line" and several statements that included the word euthanasia, or a derivative. (JA 6-7, ¶¶ 29, 31, 33, 36.) The Amended Complaint further alleged that Dr. Smith later asserted: "We [the trauma surgeons] were playing full court press and you were playing four corners." (JA 8, ¶ 40.)

<u>The Circuit Court Finds Most of the Alleged Statements Are Opinion.</u>

Dr. Smith and Carilion demurred to the Amended Complaint on the grounds that the alleged statements were either opinion or rhetorical hyperbole and not actionable, and that they were protected by qualified privilege. (JA 17-27.) The Circuit Court held that all of the statements, except those allegedly including the term euthanasia, "indicate Dr. Smith's medical critiques of Dr. Cashion and are opinions which do not state actual

facts." (JA 66.)[1] The Circuit Court also ruled, however, that Dr. Cashion could pursue the "euthanasia" claim. (JA 66.) Dr. Cashion prepared the Order (JA 67) which dismissed all claims except for the euthanasia claim, and signed the Order, stating: "We Ask For This." (JA 61.)

> Based Upon Dr. Cashion's Responses to Requests for Admission, The Circuit Court Finds That A Qualified Privilege Attached and There Was No Evidence of "Common Law" Malice to Overcome the Privilege as to the Euthanasia Claim.

Carilion and Dr. Smith subsequently moved for summary judgment on the grounds that the undisputed facts—taken from the Amended Complaint and Dr. Cashion's Responses to Carilion's First Request for Admissions—showed that the remaining statements concerning "euthanasia" were rhetorical hyperbole, or in the alternative were protected by a qualified privilege with no disputed evidence of "common law" malice to overcome the qualified privilege. Dr. Cashion opposed the motion by introducing excerpts of Dr. Smith's deposition. (JA 163-73, Exh. B to Dr. Cashion's Brief.) Because the excerpts were incomplete, defendants were permitted to supply the pages accurately completing his response. (JA 205-06.)

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[1] Dr. Cashion has only challenged the Circuit Court's Dec. 8, 2010 ruling as to the statements listed in his Assignment of Error I, included at page 6, *infra*, and leaves undisturbed the court's ruling that various other statements included in the Amended Complaint were protected opinions.

The Circuit Court ruled that the alleged euthanasia statements were not rhetorical hyperbole (JA 242), but found that a qualified privilege attached to the communications, stating: "[T]here was a duty that both surgeon and anesthesiologist owed to the patient on the operating table. The duty existed during the operation and certainly continues while questions as to the cause of the patient's death are still relevant." (JA 243.) The Circuit Court also found "as a matter of law, . . . there existed no malice relative to the euthanasia comment sufficient to negate the qualified privilege." (*Id.*) This appeal followed, with Dr. Cashion challenging the dismissal of his case and Carilion and Dr. Smith assigning cross-error to the Circuit Court's ruling on rhetorical hyperbole.

## Assignment of Cross-Error

The Circuit Court Erred in Denying Carilion's Motion for Summary Judgment on the Ground that Dr. Smith's Statements Allegedly Containing the Word "Euthanasia" Were Not Rhetorical Hyperbole as a Matter of Law. This is Particularly True Where the Context of the Statements and the Allegations of the Amended Complaint Made Clear that the Patient Died of his Severe Injuries and Where the Hyperbolic Statements Were Made in the Wake of a Stressful and Unsuccessful Surgery. (Preserved at JA 83, 96, 107-11, 240.)

## Statement of Facts

On the evening of November 19, 2009, a pedestrian was "critically injured" near Wytheville, Virginia when he was struck by a tractor-trailer

which was traveling at a "high" rate of speed on the interstate. (JA 3, ¶ 12.) Wytheville is approximately seventy five miles from Carilion's Roanoke Memorial Hospital, and it ultimately took over three hours for the patient to arrive at the hospital following the accident. (JA 3, ¶ 13.) The patient was delivered to the operating room (JA 3, ¶ 13) where Dr. Smith found two liters of blood in the victim's abdomen. (JA 5, ¶ 23, 135.)

The patient had significant liver damage (JA 135), and the team performed several procedures including a laparotomy (JA 137, 135), but the patient remained "profoundly hypotensive" (very low blood pressure) due to hemorrhage (JA 137), and steps were taken to prepare the patient for an Interventional Radiology team, which would perform angiography in an attempt to staunch the internal bleeding. (JA 5, ¶ 24, 135.) Unfortunately, the patient expired before the Interventional Radiology team could begin its efforts. (JA 5, ¶ 25.)

During treatment, Dr. Cashion questioned Dr. Smith's orders and advocated conserving resources rather than administering pharmological agents to the patient. (JA 121, 137-38.) Dr. Cashion also once declared the patient to have pulseless electrical activity when the patient, in fact, still had a pulse. (*Id.*) Dr. Cashion, on several occasions, questioned whether certain drugs and blood products relied upon by Dr. Smith should be

administered to such a gravely injured patient when the resources might better be conserved for future patients. (JA 135, 137-38.)

Dr. Cashion claims that Dr. Smith made defamatory statements in the operating room after Dr. Cashion resisted Dr. Smith's efforts and decisions. (JA 6, ¶ 29.) Dr. Smith is then alleged to have made additional remarks in the hallway outside the operating room. (*Id.*, ¶ 31.) The remarks still at issue are: (1) "He could have made it with better resuscitation"; (2) "This was a very poor effort"; (3) "You didn't really try"; (4) "You gave up on him"; and (5) "You determined from the beginning that he wasn't going to make it and purposely didn't resuscitate him". (*Id.*, ¶ 29.)

Just outside the operating room, Dr. Cashion alleges that Dr. Smith said, "[y]ou just euthanized my patient," (*id.* at ¶ 31) and then made several statements using the word euthanasia in some form. (JA 6-7, ¶ 33.)[2] Only health care providers who had been providing care to the patient, or

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[2] It is never stated in the Amended Complaint whether the patient was still alive at the time of this exchange. (JA 137, 168, 206.) Both letters written by the doctors and admitted in discovery indicate the patient was still alive when the exchange occurred. (JA 135-38.) Notably, Dr. Smith denied making the specific statement "you just euthanized my patient" (JA 168), but the evidence must be viewed in best light to the plaintiff. Dr. Smith recounted that he told Dr. Cashion his conduct (*i.e.* seeking to preserve resources, declaring the patient dead when he had a pulse, *etc.*) "bordered on passive euthanasia." (JA 171-72.)

another anesthesiologist, are alleged to have overheard these statements. (JA 6, ¶ 30.)[3]

Dr. Smith Had Serious Concerns About Dr. Cashion's Treatment of the Patient.

The same night that the patient died, Dr. Smith sent an e-mail to the Chairman of Surgery and the Senior Vice President of Carilion (*Id.* at ¶ 34) describing what Dr. Smith believed was unacceptable behavior by Dr. Cashion. Dr. Smith raised the following major concerns:

> —He [Dr. Cashion] loudly announced to the OR staff, on several occasions during the procedure and resuscitation, that care of this patient was futile
>
> —At one point, he wanted to declare the patient dead based on a radial arterial line reading while both EKG activity and a palpable carotid pulse was present
>
> —He refused to administer Factor VIIa through the IV line; the Surgery resident, Dr. Kelly Hyde had to perform this activity
>
> —He did not give all available blood products to the patient, stating that he wanted to "preserve resources" for other patients

[3] In fact, when the two doctors had the exchange in the hallway, Dr. Cashion called Dr. Crawford, the anesthesiologist, over to join the discussion. (JA 138.) Dr. Cashion, that same day, sent an e-mail to Dr. Crawford outlining these same events. (JA 137-38.)

(JA 120, 135).[4]

Dr. Cashion also wrote an e-mail that same night to Dr. Crawford, the head of anesthesiology, acknowledging the events that gave rise to Dr. Smith's concerns. (JA 137-38.) In this document written within hours after the patient's death, Dr. Cashion wrote that he did not recall what specific words—"euthanize" or "euthanasia"—were used by Dr. Smith. (JA 138.) He further stated that whatever was said in the hallway *was not said in "earshot" of other health care providers.* (*Id.*)

Although Dr. Cashion's e-mail portrays a somewhat different scene than Dr. Smith's, Dr. Cashion's account nevertheless confirms all of Dr. Smith's primary issues of concern regarding the patient care provided by Dr. Cashion. For instance, in the first bullet issue of concern, Dr. Smith stated that he was upset because Dr. Cashion opined during resuscitation that the care of the patient was "futile." (JA 135.) Dr. Cashion confirmed in his e-mail that during treatment he questioned Dr. Smith because of the "patient's seemingly poor prognosis" and because the patient's "demise seemed imminent." (JA 137.)

The second bullet point in Dr. Smith's e-mail states, in pertinent part, that Dr. Cashion "wanted to declare the patient dead based on a radial

[4] Dr. Smith raised additional concerns that can be found at JA 135.

arterial line reading while both EKG activity and a palpable carotid pulse was present." (JA 135.) Dr. Cashion, again, agreed: "I did make an assessment of PEA (based on a-line, capnography, and pulse oximetry) *and quickly reversed this assessment* based on the removal of the patient's c-collar *and palpitation of the thready but present carotid pulse.*" (JA 138, emphasis added.)

In the third bullet, Dr. Smith complained that Dr. Cashion did not administer Factor VIIa to the patient and the drug eventually had to be administered by a surgical resident. (JA 135.) Dr. Cashion wrote that he, at the very least, "inquired" of Dr. Smith as to whether to give a drug Dr. Smith specifically had ordered because "[t]he patient's condition had only worsened and his demise seemed imminent. I again quietly and politely inquired if he was sure he wanted the medication given . . . ." (JA 137.) Dr. Cashion also admitted that someone else administered the drug. (JA 122.)

Finally, in the fourth bullet point, Dr. Smith wrote that Dr. Cashion "did not give all available blood products to the patient, stating that he wanted to 'preserve resources' for other patients." (JA 135.) Dr. Cashion, again, concurred in that he:

> stated "I'm not going to argue and I'll give them if you want me to," *but* [I] *proceeded to ask him if he was sure he wanted to transfuse the platelets in light of their shortage and the patient's seemingly poor prognosis.*

(JA 137, brackets and emphasis supplied.)

The Patient Was Not Expected to Survive His Injuries.

Though Dr. Smith undertook extensive measures to try to save the patient, Dr. Cashion's Amended Complaint contains two pages of allegations regarding the various problems with hospital facilities and personnel that made efforts to save the patient essentially futile. (JA 3-5, ¶¶ 13-26.)[5] The Amended Complaint alleges unnecessary delay (both in the transport of the patient to the hospital and thereafter), and mismanagement in the emergency room, including the lack of necessary supplies (*id.*) and inadequate supplies and personnel in the operating room.[6] (JA 4-5, ¶¶ 20-26.) The patient ultimately died in the operating room because of his "severe injuries." (JA 5, ¶ 25.) This outcome was, by the Amended Complaint's own account, not unexpected.

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[5] Again, the patient was a pedestrian struck by a tractor-trailer traveling at a high rate of speed on an interstate. (JA 3, ¶ 12.)

[6] Carilion denies that improper care was rendered, or that there were shortages, but facts alleged are viewed in best light to Dr. Cashion, the plaintiff below.

There Was No "Bad Blood" Between Dr. Cashion and Dr. Smith Prior to the Alleged Incident.

The Amended Complaint does not identify any "bad blood" between Dr. Cashion and Dr. Smith prior to the incident in question. (JA 1-14.) Similarly, during discovery, Dr. Cashion did not produce any evidence that Dr. Smith had pre-existing animus toward Dr. Cashion. Dr. Cashion did not believe that Dr. Smith, on a personal or professional level, "disliked" Dr. Cashion, had "any disagreement or conflict" with Dr. Cashion," "hated" Dr. Cashion, had "personal spite" toward Dr. Cashion, "desired to injure" Dr. Cashion, or "wanted revenge" against Dr. Cashion. (JA 127-29, RRA ## 31-36.)

The thrust of Dr. Cashion's "malice" claim as pled and argued was that Carilion had a policy of marginalizing non-Carilion employees to prevent referrals outside of the Carilion system. (JA 8-9, ¶ 42-43; JA 12, ¶ 61; JA 288.) Dr. Cashion later acknowledged, however, that ***his employer*** – ACV – actually had an exclusive contract for all of Carilion's anesthesiology work (*i.e.*, there was no "marginalizing" as it related to Dr. Cashion). (JA 131, RRA # 44.) Thus, the record reveals *no* evidence of malice or of pre-existing discord. Rather, the pleadings and record highlight that the alleged defamatory statements arose solely because Dr.

Smith believed that Dr. Cashion's performance on this single occasion was problematic.

Context

All medical staff in and around the operating room were aware that the patient who had been transported from Wytheville was gravely wounded when struck by the high-speed eighteen-wheeler on the interstate. Three and a half hours later when, according to the Amended Complaint, the patient arrived in Carilion's operating room (JA 3, ¶ 13), his prognosis was not good, his injuries were "severe" (JA 5, ¶ 25) and the patient had a "significant amount of blood in [his] abdomen." (*Id.*, ¶ 23, brackets supplied; *see also* JA 135.) After analyzing the injury, the best the team could hope for was to provide care preparing the patient for the Interventional Radiology team. (JA 135, 5.)

Again, according to the Amended Complaint, only health care providers who had been in the operating room were alleged to have heard the "non-euthanasia" comments. (JA 6, ¶ 30.) In the hallway, Dr. Cashion alleges Nurse Zwart and Dr. Crawford, the Chief of Anesthesiology, heard the "euthanasia" comment. (JA 6, ¶ 32.) However, in his e-mail to Dr. Crawford, written the night of the incident, he acknowledged that the

comment was not within "earshot" of others. (JA 138.) This was consistent with Dr. Smith's account. (JA 168.)[7]

## STANDARD OF REVIEW

A demurrer admits properly pleaded material facts, but not legal conclusions. *Tronfeld v. Nationwide Mut. Ins. Co.,* 272 Va. 709, 713 (2006). The determination of whether an alleged defamatory statement is an opinion is a question for the court to decide as a matter of law. *Hyland v. Raytheon*, 277 Va. 40, 47 (2009).

Whether a statement is protected by a qualified privilege is also a question of law for the Court's determination. *Great Coastal Exp., Inc. v. Ellington*, 230 Va. 142, 153 (1985). Whether a qualified privilege has been defeated is a question of fact unless, like here, there are undisputed facts which show the absence of malice. *Jackson v. Hartig*, 274 Va. 219, 222 (2007).

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[7] Appellant argues both that Dr. Smith denied making the euthanasia comment and that he also admitted it was "false." (JA 331-32.) Appellant tried to rely on Dr. Smith's deposition for this purpose, (JA 163-73), but cut off his answer. (JA 205-06.) The deposition indicates that Dr. Smith did not make the euthanasia comment attributed to him, and that his comment that Dr. Cashion's actions and inactions (*i.e.* failure to give blood products, declaring the patient dead when he had a pulse, *etc.*) "bordered on passive euthanasia" were to jolt Dr. Cashion into performing more zealously. (JA 168.) He certainly, however, never admitted believing his words were made in anything but good faith. (JA 168, 205-06.)

To overcome a privilege, the burden is on the *plaintiff* by clear and convincing evidence to show "common law" malice. *Jackson*, 274 Va. at 228-29. Moreover, courts scrutinize defamation claims prior to submitting them to juries to protect free expression. *See Hyland*, 277 Va. at 47; Va. Constit., art. I, § 12.

Finally, Rule 3:20 of the Rules of the Supreme Court of Virginia mandates summary judgment if it appears from the pleadings and admissions "that the moving party is entitled to judgment" and no material facts are genuinely in dispute. In determining whether there is any genuine dispute of material fact, a trial court should consider the facts in light of the controlling legal standard. *See Jackson*, 274 Va. at 228-229. The court is not required to accept inferences that are "forced, strained, or contrary to reason." *Dudas v. Glenwood Golf Club, Inc.*, 261 Va. 133, 136 (2001). Nor is it required to accept the "correctness of the pleader's conclusions of law." *Yuzefovsky v. St. John's Wood Apartments*, 261 Va. 97, 102 (2001).

## ARGUMENTS AND AUTHORITIES

### I. Any Objections Regarding the Non-Euthanasia Statements Have Been Waived, and if Not, The Trial Court Did Not Err In Granting A Demurrer Determining that The Non-Euthanasia Statements Were Opinion and Not Actionable As Defamation.

#### A. Dr. Cashion Waived His Argument as to the Non-Euthanasia Opinion Statements.

Dr. Cashion *sought* the Order that permitted him to pursue claims on the "euthanasia" statements while granting the demurrers which dismissed the remaining statements as opinion. His counsel signed the Order: "We ask for this," without objection. (JA 61.) This is a clear abandonment of his claim as to the opinion issue. *See Anderson v. Van Landingham*, 236 Va. 85, 87-88 (1988); *Coleman v. Comm.*, 27 Va. App. 768, 774 (1998) ("We ask for this" requests that the Court take specific action.) *In fact, Carilion and Dr. Smith objected to the Order, while Dr. Cashion specifically requested its entry. (JA 62.)*

This ruling followed a hard-fought demurrer hearing where Dr. Cashion suggested that an apology as to the "euthanasia" claim *alone* would resolve the case, (JA 9, ¶ 44), and Carilion argued the "euthanasia" claim was the only one to which Dr. Cashion alleged injury (JA 277), such that the others were not actionable. The "euthanasia" claim was the focal point of the proceeding and, following the ruling, Dr. Cashion was content to proceed on that claim alone (as evidenced by the Order he tendered) and to jettison the others.

Even Virginia Code § 8.01-384 provides that: "No party shall be deemed to have agreed to, or acquiesced in, any written order of a trial court so as to forfeit his right to contest such order on appeal *except by*

*express written agreement in his endorsement of the order.*" (emphasis added.) What else can: "We ask for this" mean, but that the party expressly accepts all aspects of the Order? This Order, prepared by Dr. Cashion (JA 67), permitted Dr. Cashion to proceed on his "euthanasia" claim, but clearly rejected all other claims based on the "non-euthanasia" statements:

> Upon consideration of the Defendants' Pleas in bar and Demurrers the following is ADJUDGED, ORDERED and DECREED, to-wit:
>
> 1. The "euthanasia" statements made by Dr. Smith, as referenced in paragraphs 31 and 33 of the Amended Complaint, are actionable as defamation per se and the Pleas in Bar and Demurrers are OVERRULED;
>
> 2. The remaining statements alleged in the Amended Complaint are opinion and are not actionable independently.

(JA 60.) By affirmatively seeking this outcome, Dr. Cashion abandoned the other claims. *Anderson,* 236 Va. at 87-88; *Coleman,* 27 Va. App. at 774. Accordingly, these non-euthanasia statements are not properly preserved for appeal.

### B. The Non-Euthanasia Statements Are Opinion Because <u>They Are Viewpoint Specific, Subjective Reviews.</u>

Courts are to scrutinize claims of defamation prior to submitting them to a jury in order to protect opinion, *Hyland*, 277 Va. at 47, because "the

defense of baseless defamation claims imposes an additional cost, in the form of potentially deterred speech." *Arthur v. Offit*, 2010 WL 883745, at *3 (E.D. Va. Mar. 10, 2010).[8] Relevant to the court's determination are the "speaker's choice of words; the context of the challenged statement within the writing or speech as a whole; and the broader social context into which the statement fits." *Blue Ridge Bank v. Veribanc, Inc.*, 866 F.2d 681, 685 (4th Cir.1989); *see also Fuste v. Riverside Healthcare Ass'n, Inc.*, 265 Va. 127, 133 (2003); *Hyland*, 277 Va. at 47.

The Circuit Court correctly ruled the non-euthanasia statements were opinion. The heat-of-the-moment statements were Dr. Smith's belief regarding Dr. Cashion's efforts toward the patient: (1) "He [referring to the patient] could have made it with better resuscitation"; (2) "This was a very poor effort"; (3) "You didn't really try"; (4) "You gave up on him"; and (5) "You determined from the beginning that he wasn't going to make it and purposefully didn't resuscitate him." (JA 6, ¶ 29.)

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[8] Dr. Cashion argues that because his allegations in the Amended Complaint included "factual statements" the Circuit Court was not at liberty at the demurrer stage to conclude that the statements were opinion. This is incorrect. "[B]efore submitting a defamation claim to a jury, a trial judge *must* determine as a matter of law whether the allegedly defamatory statements . . . are merely statements of opinion." *Hyland*, 277 Va. at 47 (emphasis added). It is well established that at demurrer a court is not required to accept the legal conclusions of the complaint. *Tronfeld,* 272 Va. at 713.

Each subjective appraisal of Dr. Smith's efforts is an expression of opinion and thus "constitutionally protected and [...] not actionable as defamation." *Hyland*, 277 Va. at 47 (citations omitted). "[S]peech which does not contain a provably false factual connotation, or statements which cannot reasonably be interpreted as stating actual facts about a person cannot form the basis of a common law defamation action." *Yeagle v. Collegiate Times*, 255 Va. 295 (1998). "When a statement is relative in nature and depends *largely* on a speaker's viewpoint, that statement is an expression of opinion." *Hyland*, 277 Va. at 47 (emphasis added); *see Chaves v. Johnson*, 230 Va. 112, 118-19 (1985) (claims that professional was "inexperienced" or his fees were "excessive" were opinion).

Additionally, a statement that includes some terms or words susceptible to empirical evaluation may still be a constitutionally protected opinion that should not be submitted to a jury. *Raytheon Technical Servs. Co. v. Hyland*, 273 Va. 292, 305-06 (2007). For example, in *Raytheon*, this Court found the following statement to be constitutionally protected opinion:

> [s]he has received specific feedback from her customers, the Beacon group study, her employees, and her leader on her need to listen and learn from others, yet she has appeared to be unwilling to accept and work with this feedback

273 Va. at 305. Though the question of whether the subject had received

specific feedback was provable, it was clear that the negative comment – an unwillingness to accept feedback – was opinion. *Id.* at 305-06.

The challenged statements here are classic opinion because they are "relative in nature and depend[] largely" on Dr. Smith's "viewpoint." *Id.* For example, Dr. Smith believed that better resuscitation could have saved the patient (statement 1), or that Dr. Cashion's efforts were poor (statement 2), but someone else is free to opine otherwise. Likewise, the word "could" in the resuscitation statement (statement 1), as opposed to "would," is a clear indication that there is no fact which can be absolutely proved or disproved, and thus, the statement is opinion. The same is true on the question of whether the lack of success in resuscitating the patient was purposeful (statement 5), whether Dr. Cashion really tried and whether he gave up on the patient (statements 3 and 4.) Simply stated, a difference in medical beliefs is not enough to state a cause of action—it is protected opinion. *See, e.g., Aroonsakul v. Shannon*, 664 N.E.2d 1094, 1100 (Ill. App. 2nd Dist.), *appeal denied*, 671 N.E.2d 726 (Ill. 1996) ("[i]n the field of medicine, doctors may arrive at conflicting conclusions regarding proper treatment") (citations omitted).[9]

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[9] To that end, in applying Virginia law, the United States Court of Appeals for the Fourth Circuit recently found a variety of opinions rendered *cont'd to next page....*

In the challenged statements, Dr. Smith's alleged use of the words "better" or "poor" (statements 1 and 2) reveal subjective appraisal from the standpoint of Dr. Smith. Similarly, effort— whether one is really trying, or has given up (statements 3 and 4) — is a purely subjective opinion where there is no factual specificity as to whether one gave the maximum effort. *Raytheon*, 273 Va. at 305 ("negative conduct, and whether and how often it occurred—[*i.e.*, frequently]— is a matter of the speaker's perspective and, as such, constitutes opinion, not fact"); *Fuste*, 265 Va. at 133 (holding that statements that physicians were "unprofessional" or "uncooperative" are opinion as a matter of law).[10]

A court is to look at the entirety of the alleged statements in determining whether they are opinion. *Hyland*, 277 Va. at 47. All of the challenged statements here were made to other health care personnel,

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on a medical resident's performance to be protected, including statements that "there has been no evidence of improvement or intention to improve in weak areas"; and that plaintiff "has not shown any improvement at the Front Royal Family Practice Clinic, since receiving the letter of non-renewal of contract." *Nigro v. Virginia Commonwealth University*, No. 10-2425, 2012 WL 2354635, at *7 (4th Cir. Jun. 21, 2012) (unpublished).

[10] *See also Colantonio v. Mercy Medical Center*, 901 N.Y.S.2d 370, 373-74, N.Y. A.D. 2 Dept. (2010) (statements that a physician "has poor judgment," was "imminent danger to patients," "created havoc in the ICU," "is belligerent and very unreasonable," and "inappropriate" are opinions).

most of whom were in the operating room with Doctors Cashion and Smith. (JA 6, 8, ¶¶ 29-30, 40-41.) These individuals were aware that the patient's chances of survival were very poor, at best. In fact, Dr. Cashion's pleading confirms this. (JA 3-5, ¶¶ 13-21, 25.)

Thus, at bottom, Dr. Smith is alleged to have made statements that showed he thought Dr. Cashion did a half-hearted job in treating the patient. In his words, "We [the trauma surgeons] were playing full court press and you [Cashion] were playing four corners." (JA 8, ¶ 40.) This is a view on which individuals can differ – and clearly Doctors Smith and Cashion do differ – but it is a permissible opinion entitled to constitutional protection. The Circuit Court correctly rejected Dr. Cashion's defamation claims based on the "non-euthanasia" statements.

## II. The Circuit Court Did Not Err In Ruling that a Qualified Privilege Attached to the Alleged Euthanasia Statements Made Near the Operating Room and in the Wake of the Surgery.

### A. The Privilege Attached As A Matter of Law to Conversations in the Wake of the Surgery.

The Circuit Court ruled that "there was a duty that both surgeon and anesthesiologist owed to the patient on the operating table. The duty existed during the operation and certainly continues while questions as to the cause of the patient's death are still relevant." (JA 243.) "It seems clear," the court continued, "that when a patient dies on the operating table,

there will occur numerous privileged conversations regarding the cause of death among the doctors and/or nurses . . . as well as among the hospital administration." (*Id.*) The Circuit Court did not err in determining that communications about the patient's care, made in the wake of the surgery, were privileged.

Virginia recognizes "qualified privilege" as a common law defense to a claim of defamation. *Great Coastal Exp.*, 230 Va. at 153. This privilege exists where there is a "communication, made in good faith, on a subject matter in which the person communicating has an interest, or owes a duty, legal, moral, or social . . . to a person having a corresponding interest or duty." *Id.* (citation omitted). Whether such a privilege exists is a question of law for the court. 230 Va. at 153.

As the Circuit Court correctly decided, medical providers must be able to share full and frank expression on matters of patient care. The time for such exchange extends beyond when care is rendered and exists so long as the care is at issue. Indeed, Dr. Cashion admitted that "generally, a physician should engage in lawful communication with other physicians and nurses concerning the care or treatment of a patient when the physician and other health care providers are caring for the same patient in the same room." (JA 125, RRA # 26.)

Numerous other jurisdictions recognize, as common sense dictates, that a qualified privilege exists where the allegedly defamatory statements revolve around discussions and statements between medical professionals regarding competency and/or the care provided. For example, in *D'Souza-Klamath v. Cloud County Health Center, Inc.*, 2009 WL 902377, at 14 (D. Kan. 2009), *aff'd.*, 363 Fed.Appx. 658 (10th Cir. 2010), the Court noted that "if a qualified privilege 'should ever operate, indeed if there is one instance where society should encourage uninhibited communication, it is in the review of the competency of medical professionals.'" Similarly, in *Qureshi v. St. Barnabas Hosp. Center*, 430 F. Supp. 2d 279, 290-91 (S.D.N.Y. 2006) the court held that a qualified privilege applied to comments made by a supervising physician to various professional boards and hospitals indicating that a resident who left the residency program had deficiencies. The holding was under New York law which, like Virginia law, states that a qualified privilege "is afforded statements made in good faith regarding a matter in which the speaker has an interest or duty that is shared with the listener." *Id.*[11]

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[11] *See, e.g., Zoumadakis v. Uintah Basin Medical Center, Inc.*, 2009 WL 1423559, at *1 (Utah App. 2009) (qualified privilege applies to statements regarding doctor's "prescribed patient treatment" because the parties "share a legitimate common interest in providing quality health *cont'd to next page....*

Here, the Circuit Court correctly ruled that shared critiques – even vehement ones – are subject to a qualified privilege. Thus, all the elements are present for a qualified privilege to exist under Virginia law – *e.g.*, a "communication, made in good faith, on a subject matter in which the person communicating has an interest, or owes a duty, legal, moral, or social . . . to a person having a corresponding interest or duty." *Great Coastal Exp.*, 230 Va. at 153.

B. The Circuit Court Did Not Err In Finding Dr. Smith's Criticisms of Dr. Cashion to Be In Good Faith and in Confirming the Absence of Malice.

1. Dr. Smith's Concern was Reasonable

Whether a privilege exists is a question of law properly decided by the Court. *Fuste*, 265 Va. at 135. The Circuit Court did not err in determining that the privilege applied because Dr. Smith had a good faith basis for being concerned about Dr. Cashion's performance. Among other things, Dr. Cashion *acknowledged* questioning Dr. Smith's orders,

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care"); *Magre v. Charles*, 729 So.2d 440, 442-43 (Fla. 5th DCA, 1999) (patient care discussions privileged under Florida law where "[a] communication made in good faith on any subject matter by one having an interest therein, or in reference to which he has a duty, is privileged if made to a person having a corresponding interest or duty, even though it contains matter which would otherwise be actionable, and though the duty is not a legal one but only a moral or social obligation.")

advocating to conserve resources at the expense of the patient's care, (JA 121, 137), and declaring the patient dead when the patient still had a pulse (JA 121, 138) – all confirming the "good faith" nature of Dr. Smith's concerns, particularly when considered as a whole.

Dr. Cashion also argues in his brief that because he pleaded that Dr. Smith did not "believe" that Dr. Cashion literally committed active euthanasia, the Circuit Court should not have determined that Dr. Cashion's statements were made in good faith and subject to a qualified privilege. As an initial matter, the cases upon which Dr. Cashion relies for this proposition are readily distinguishable. In both cases he relies upon, by Dr. Cashion, there was *abundant* evidence *outside* of the remarks themselves indicating ill-will on the part of the defendant. *Great Coastal Exp.*, 230 Va. at 145 (employer believed that employee involved in union activity); *Smalls*, 241 Va. at 56 (defendant made numerous complaints against police and evidence suggested she had a "vendetta").[12] This Court

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[12] The jury instructions relied upon to overcome the privilege in *Great Coastal Exp.* required a lack of honest belief in a statement's truth *and* a lack of good faith, highlighting that one does not equal the other. 230 Va. at 153. More to the point, the instruction in *Great Coastal Exp.* expressly included elements of *New York Times* malice – a theory disavowed by Dr. Cashion here. (JA 334.) The jury instruction in *Smalls* simply tracked the instruction from *Great Coastal Exp.* (including *New York Times* malice concepts) in a case involving clear evidence of a "vendetta" by the speaker. *cont'd to next page....*

has clarified that a privilege may be overcome by *malice*, and that malice need be shown by evidence ***independent*** of the statements themselves. *See Union of Needletrades v. Jones,* 268 Va. 512, 519-20 (2004); *Fuste,* 265 Va. at 134-35 (2003).

Further, Dr. Cashion's pleading is conclusory at best as to "good faith," consisting of legal assertions rather than specific facts (JA 12, ¶ 61) that are not controlling. *Tronfeld,* 272 Va. at 713. The only specific allegation is that Dr. Smith wrote – long after the event – that he did not believe Dr. Cashion intended to commit active euthanasia. (JA 11, ¶ 55.) This is not dispositive (nor does the letter referenced appear in the record).[13]

In discovery, Dr. Smith certainly did *not* retract his view that Dr. Cashion's lack of zeal was a genuine cause of concern and that more

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By contrast, *New York Times* malice was renounced by Dr. Cashion in this case (JA 334), and there is no evidence of a vendetta or ill-will between the doctors. (JA 127-29, RRA 31-36.)

[13] Dr. Smith denies making any statement involving active euthanasia. On summary judgment, Dr. Cashion introduced a snippet of Dr. Smith's deposition by which he sought to parse Smith's comments on the topic. (JA 163-73.) Because this statement was cut off in mid-comment, the Court, without objection, permitted counsel to provide the remainder of the statement to show the full context of the comment. (JA 205-06.)

strenuous efforts might have been beneficial to the patient. To the contrary, Dr. Smith explained that advocating "preserving resources" for future patients and pronouncing a lack of PEA activity while the patient is still alive does concern those attempting feverishly to save a gravely injured patient. (JA 168, 205-06.)

Despite Dr. Cashion's efforts to manufacture factual disputes, the record consistently showed that Dr. Smith had a good faith and legitimate basis for expressing concerns regarding Dr. Cashion's failure to provide zealous treatment. Indeed, Dr. Cashion's own letter recounting the incident confirmed that Dr. Cashion:

- Declared the patient dead while he still maintained a pulse (JA 138),
- Questioned Dr. Smith's decisions to administer drugs to the patient because the patient's "demise seemed imminent" (JA 137), and
- Resisted providing certain blood products to the patient because he wanted to preserve resources, given "the patient's seemingly poor prognosis." (JA 137.)

These issues triggered legitimate, good faith concerns, resulting in privileged communication.

2. Dr. Cashion Did Not Create A Genuine Issue of Material Fact As To Whether The Privilege Was Overcome.

Once a statement is deemed qualifiedly privileged, the speaker/writer is shielded "from liability unless a showing of malice is made by clear and convincing evidence." *Larimore v. Blaylock,* 259 Va. 568, 576, (2000); *see, Jackson,* 274 Va. at 230. Malice sufficient to overcome a qualified privilege is "behavior actuated by motives of personal spite, or ill-will, *independent of the occasion on which the communication was made.*" *See, e.g., Union of Needletrades,* 268 Va. at 519-20 (emphasis added); *Fuste*, 265 Va. at 134-35.

This type of malice, also called "common law" malice, is more stringent than what is, under defamation law, sometimes referred to as "*New York Times*" malice where the plaintiff need only show "that the statement was made with knowledge that it was false or with a reckless disregard for the truth, even if the defendant bore no ill-will toward the plaintiff." *Union of Needletrades,* 268 Va. at 520, fn. 4, (citations omitted); *Gazette v. Harris,* 229 Va. 1, 18, *cert. denied*, 472 U.S. 1032 (1985) ("Unlike some jurisdictions, Virginia does not permit a qualified privilege to be defeated upon a showing of mere negligence. We require proof of common-law malice, that is, behavior actuated by motives of personal

spite, or ill-will, independent of the occasion on which the communication was made."); *Preston v. Land,* 220 Va. 118, 120 (1979).[14]

The inquiry of whether there is malice to defeat a qualified privilege focuses on the circumstances existing *at the time* the alleged defamatory words were spoken. *Southeastern Tidewater Opportunity Project, Inc. v. Bade,* 246 Va. 273, 276 (1993) (in order to avoid the privilege it is necessary for the plaintiff to show that, existing at the time the words were spoken, the communication was actuated by some sinister or corrupt motive such as hatred, revenge, personal spite, ill-will, or desire to injure the plaintiff.)

Dr. Cashion cannot show the existence of common law malice in this case. That is because Dr. Cashion has admitted that prior to Dr. Smith's utterance of the word(s) "euthanasia" or any of its forms on the night of November 19, 2009, Dr. Cashion had no reason to believe that Dr. Smith, professionally or personally, "disliked" Dr. Cashion; had "any disagreement or conflict" with Dr. Cashion"; "hated" Dr. Cashion; (c) had "personal spite" toward Dr. Cashion; "desired to injure" Dr. Cashion; or (e) "wanted revenge" against Dr. Cashion." (JA 127-29, RRA ## 31-36.) Based on

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[14] Dr. Cashion could not and did *not* pursue *New York Times* malice below. In the Circuit Court, his counsel bluntly confirmed, "We are not arguing *New York Times* malice." (JA 334.)

these admissions, Dr. Cashion cannot show that at the time the alleged defamatory statements were made, Dr. Smith's behavior was actuated by motives of personal spite, or ill-will, *independent of the occasion on which the communication was made.*" *See, Union of Needletrades,* 268 Va. at 519-20 (emphasis added); *Fuste,* 265 Va. at 135; *Harris*, 229 Va. at 18.

Dr. Cashion's suggestion that a lack of belief as to the accuracy of a defamatory statement overcomes the qualified privilege should be rejected. First, Dr. Cashion disavowed *New York Times* malice below (JA 334) and he lacks case support for the proposition that a lack of literal belief in a statement alone creates a jury question as to common law malice which is the proper standard for a qualified privilege analysis.[15] Moreover, unlike the cases relied on by Dr. Cashion, here, he acknowledged that there was no pre-existing malice or animosity between Doctors Cashion and Smith. (JA 127-29, RRA ## 31-36.)[16]

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[15] Again the cases heavily relied upon by Dr. Cashion turned on whether there was *malice* to overcome the privilege, and in each case there was evidence outside of the remarks themselves indicating malice on the part of the defendant. *Great Coastal Exp.*, 230 Va. at 145 (employer believed that employee involved in union activity); *Smalls*, 241 Va. at 56 (defendant's numerous complaints against police, evidence suggested she had a "vendetta").

[16] Below, Dr. Cashion suggested malice existed because Carilion allegedly had a policy of marginalizing non-Carilion providers in an effort to *cont'd to next page....*

Dr. Cashion further attempts to find malice in the alleged statements themselves, by arguing that the use of the word "euthanasia" or the like *must* be evidence of malice. (Opening Br. 25.) No case is cited by Dr. Cashion for this proposition, which is directly contrary to this Court's requirement that such a showing must arise "independent of the occasion on which the communication was made." *Union of Needletrades,* 268 Va. at 519-20, *Fuste,* 265 Va. at 135, *Harris,* 229 Va. at 18.[17] Here, Dr. Smith's statements do not reflect malice – they exhibit genuine passion for a patient's care – passion and care Dr. Smith believed Dr. Cashion failed to demonstrate in this single instance. Stated simply, Dr. Smith's showing at summary judgment was "insufficient as a matter of law" (particularly under

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prevent procedures from being referred out to non-Carilion doctors (JA 8-9, ¶¶ 42-43, JA 12, ¶ 61, JA 288), but this is illogical as Dr. Cashion ultimately acknowledged that *his employer* was the *exclusive provider* of anesthesiology to Carilion. (JA 131, RRA # 44.) ACV did not risk losing any work from Carilion as ACV got all of Carilion's anesthesiology work by contract – thus, there could not have been any "marginalization." (*Id.*) Moreover, since Dr. Cashion's theory of liability against Carilion is exclusively based on *respondeat superior*, it is Dr. Smith's alleged malice that is relevant.

[17] In several cases a speaker has had an economic or competitive basis for slurring a competing business or professional. *See Chaves,* 230 Va. at 121-22; *Tharpe v. Saunders*, 285 Va. 476 (2013); *Fuste,* 265 Va. at 131. Here, however, Dr. Smith's concerns are clearly limited to medical concerns and safety issues. There is no economic conflict, no pre-existing personal conflict, the predominating focus is on the level of medical care.

a clear and convincing standard) to establish "common law" malice to overcome a qualified privilege. *Jackson*, 274 Va. at 230.

ON CROSS-ERROR

III. The Trial Court Erred in Ruling That Statements Allegedly Containing the Word Euthanasia Were Not Rhetorical Hyperbole. (Relating to Assignment of Cross-Error I.)

A reasonable health care provider standing by or near the operating room on November 19, 2009 could not have believed that Dr. Smith was literally accusing Dr. Cashion of committing euthanasia in the middle of a hectic surgery. The alleged statements are exaggerated outbursts – not literal and not actionable.

Under Virginia law, statements that are "rhetorical hyperbole" are not actionable even if they are false. *Yeagle*, 255 Va. at 295-96. Rhetorical hyperbole occurs where "no *reasonable* inference [can] be drawn that the individual identified in the statements, as a matter of fact, engaged in the conduct described." *Id.* (emphasis added.) In other words, rhetorical hyperbole "might appear to make an assertion, but a reasonable reader or listener would not construe that assertion seriously." *Schnare v. Ziessow*, 104 Fed.Appx. 847, 851 (4th Cir. 2004). This is true even if the language used is "insulting, offensive, or otherwise inappropriate." *Yeagle*, 255 Va. at 296.

Whether a statement is rhetorical hyperbole is a question of law for the court. *Id.* at 296. In making this determination, a court should "look to the circumstances in which the statement is made." *Schnare*, 104 Fed.Appx. at 851. For instance, in *Lewis-Gale Medical Center, LLC v. Alldredge*, 282 Va. 141, 152 (2011), where an emergency room physician brought an action against a medical center, a hospital official's statement that the plaintiff was an "organizational terrorist" did not rise to the level of defamation given the *context* in which it was made:

> We also reject [plaintiff's] allegations that [the C.O.O.'s] statements such as her use of the term "organizational terrorist" to describe [plaintiff] were independently tortious and therefore rose to improper methods. *These statements were certainly unwise, unprofessional hyperbole,* and may even indicate a personal animus toward [plaintiff]. *In the context of [the C.O.O.'s] discussions with [the staffing company]*, however, the statements did not rise to the level of fraud, misrepresentation, deceit, or *defamation* that could constitute improper methods of interference with the contract between [plaintiff] and [the staffing company].

282 Va. at 152 (brackets and emphasis added).

In short, where rhetorical hyperbole is concerned: context is everything. Here, the context of the alleged defamatory statements—"you euthanized my patient" or any form of the word euthanasia—is not actionable because it is hyperbole. The statements were made *only* in

front of health care personnel in a medical setting after a gravely injured patient received treatment on an operating table. The statements were made in circumstances where (as Dr. Cashion specifically alleged) it was apparent that the patient had little chance of surviving in the first place. The statement was made following desperate surgery that occurred in a room full of health care providers. No reasonable health care provider could believe that Dr. Cashion "put the patient down like an animal" (Opening Br. at 15, 25) in the OR as he suggests.

If the statement had been made at a cocktail party filled with laymen, the circumstances might be different. Here, "no reasonable inference [can] be drawn that the individual identified in the statements, as a matter of fact, engaged in the conduct described"—*e.g.*, that Dr. Cashion had, in fact, intentionally murdered the already critically injured patient. *Yeagle*, 255 Va. at 295-96.

Not surprisingly, the Fourth Circuit has held that statements regarding "killing" are hyperbole where, as here, no listener could believe the comment to be true. *CACI Premier Technology, Inc. v. Rhodes*, 536 F.3d 280, 301-02 (4th Cir. 2008) (calling a defense contractor a "hired killer" was hyperbole). Other courts have reached the same conclusion. *Horsley v. Rivera*, 292 F.3d 695, 701-02 (11th Cir. 2002) (statement made on a talk

show that the plaintiff was an "accomplice to homicide" was rhetorical hyperbole); *National Rifle Ass'n v. Dayton Newspapers, Inc.*, 555 F.Supp. 1299, 1309-10 (D.C. Ohio 1983) (statement that the NRA "happily encourages . . . murders and robberies" not actionable).

Appellant's Brief tries to dismiss *Yeagle* as a case involving "silly"/impossible accusations. (Opening Br. 27, 28.) In fact, the accusation that a college administrator was "Director of Butt-Licking" left the administrator vulnerable to ridicule (aside from referencing her participation in a "criminal act.") Here, like the plaintiff in *Yeagle*, Dr. Cashion asserts that he is accused of a criminal act (Opening Br. 13, 18) – but no reasonable listener could believe the statement was literal and, like *Yeagle*, there is no evidence that criminal charges arose from the hyperbolic statement. Common sense did dictate in *Yeagle* that there was no administrative position at the college involving "sucking up" – but the accusation still cast a cloud over the administrator's performance and yet was not actionable because it was hyperbole.

Dr. Cashion similarly suggests that he is accused of putting the patient down "like an animal" (Opening Br. 15, 25), but again, as in *Yeagle,* no one could literally believe, in context, that a murder occurred in the middle of a crowded and frenetic operating room. Nor could anyone

believe that a patient who had been hit by a high-speed tractor trailer (JA 3, ¶ 12) and arrived, three and a half hours later, in critical condition (JA 3, ¶¶ 12-13), had died as the result of criminal activity by an attending physician in the busy operating room.

Dr. Cashion suggests, nonetheless, that an anesthesiologist "can" commit euthanasia and therefore the "euthanasia" statement rings true. Again, context is everything. The patient did not expire in an isolated ICU room under Dr. Cashion's watch – or in an "assisted suicide" setting. He died amidst the desperate efforts of a surgical team in a crowded room. In this setting no other health care provider would believe that Dr. Cashion "put the patient down like an animal." Indeed, the United States Supreme Court has found comments to be rhetorical hyperbole, even where, as here, it is logically possible for the alleged statement to be true. This is particularly true during heated discussions. *See, e.g., Greenbelt Co-op. Publ'g Assoc., Inc. v. Bressler*, 398 U.S. 6, 13-14 (1970) (characterizing a real estate developer's negotiation position as "blackmail" is rhetorical hyperbole when made during heated debate). *Crawford v. United Steel Workers, AFL-CIO*, 230 Va. 217, 234, (1985), *cert. denied*, 475 U.S. 1095

(1986) (the words "cock------" and "mother------" are rhetorical hyperbole in the context used).[18]

Dr. Cashion's claim of defamation as to the euthanasia comment should be rejected because it is rhetorical hyperbole. Stated simply, no reasonable listener/health care provider in the hallway outside the operating room could believe under the particular circumstances that Dr. Cashion actually murdered the patient in question. *Yeagle*, 255 Va. at 296-96.

## CONCLUSION

The Circuit Court correctly ruled that the "non-euthanasia" statements were protected opinions expressed between health care professionals in the wake of a difficult surgery. That ruling should be affirmed and Dr. Cashion has affirmatively waived his challenge to these statements. The Circuit Court also correctly applied the qualified privilege as to the euthanasia statements in order to permit medical professionals the frank,

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[18] *See also, Lizotte v. Welker*, 709 A.2d 50, 59 (Conn. Sup. Ct. 1996), aff'd. 709 A.2d 1 (Conn. 1998) (stating real estate developer made "corrupt deals," and took "payoffs" was rhetorical hyperbole); *Polish Am. Immigration Relief Comm., Inc. v. Relax*, 596 N.Y.S.2d 756, 758-59 (1993) (statement calling a relief organization "thieves" is hyperbole under the specific circumstances at issue). *State ex rel. Diehl v. Kintz*, 162 S.W.3d 152 (Mo. App. E.D. 2005) (calling waste management company a "trash terrorist" is rhetorical hyperbole under particular situation).

open exchange required to permit them to police their own and maintain standards in the interest of patient safety. Dr. Cashion failed to provide evidence of "common law" malice to overcome the privilege, and the rule espoused by Appellant – that virtually any critical comment among medical co-workers presents a jury question as to good faith or malice – would have a grave chilling effect on both free speech and the ability of physicians to address legitimate concerns about suspect medical care. The decision below should be upheld as to the privilege, and this Court should reverse the Circuit Court's ruling as to rhetorical hyperbole.

Respectfully submitted,

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## CERTIFICATE OF SERVICE

The undersigned certifies that fifteen copies of the foregoing Brief of Appellee, and an electronic copy on CD, were hand filed with the Clerk's Office of the Supreme Court of Virginia this 2nd day of May, 2013. This same day, three copies of the foregoing Brief of Appellee, and an electronic copy on CD, have been sent to opposing counsel by first class mail at the below referenced address:

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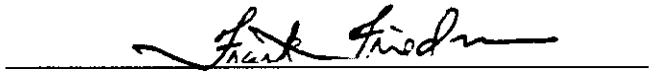
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