

THE STATE OF SOUTH CAROLINA

In The Court of Appeals

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SC Court of Appeals

APPEAL FROM HORRY COUNTY

Benjamin H. Culbertson, Circuit Court Judge

Appellate Case No. 2021-000838

Case No. 2018-CP-26-5438

Tara Gurry,

Appellant,

v.

Myrtle Beach Dermatology, LLC,

Respondents.

Shannon Hussey, Richard Hussey M.D.

RECORD ON APPEAL

Tara Gurry

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INDEX

	<u>Page</u>
Transcript of Deposition of Schield M. Wikas, D.O., dated June 21,2021.....	1
Pre-Trial Hearing Court Transcript, dated June 28, 2021.....	197
Notice of Motion in Limine to Challenge, Limit, and/or Exclude Dr. Schield Wikas's Testimony with Exhibits A-B, filed June 28, 2021.....	258
Order Motion in Limine to Exclude Dr. Wikas's Testimony, filed July 1, 2021....	315
Order Granting Defendants' Motion for Summary Judgment, filed July 1 2021....	336
Form 4 Order , filed June 28, 2021.....	340
Summons and Complaint, filed September 27, 2018	343
Summons and Complaint Answer, filed October 25, 2018.....	352
Amended Summons and Complaint, filed February 17,2020.....	360
Answer to Amended Complaint, filed February 25, 2020.....	367
Dismissal Second Cause of Action in Amended Complaint, filed April 13, 2021.....	377
Certificate of Counsel	378

1
2
3
4
5
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IN THE COURT OF COMMON PLEAS
STATE OF SOUTH CAROLINA
COUNTY OF HORRY

TARA GURRY,)
)
Plaintiff(s),)
)
vs.)
) Case No.
) 2018-CP-26-05438
MYRTLE BEACH)
DERMATOLOGY, LLC,)
SHANNON HUSSEY AND)
RICHARD HUSSEY, M.D.,)
)
Defendant(s).)

- - - - -
DEPOSITION OF SCHIELD MARTIN WIKAS, D.O.
Friday, June 28, 2019
- - - - -

Deposition of SCHIELD MARTIN WIKAS, D.O., called
by the Defendant for examination under the
South Carolina Rules of Civil Procedure, taken
before me, the undersigned, Lisa A. Stropko,
Notary Public in and for the State of Ohio, at
Sheraton Cleveland Airport Hotel, 5300
Riverside Drive, Aires Board Conference Room,
Cleveland, Ohio 44135 commencing 10:15 a.m.,
the day and date above set forth.

- - - - -

1 APPEARANCES:

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1 SCHIELD M. WIKAS, D.O.
2 of lawful age, called by the Defendant for
3 examination under the South Carolina Rules of
4 Civil Procedure, after having been first duly
5 sworn, as hereinafter certified, was examined
6 and testified as follows:

7 EXAMINATION

8 BY MS. SCALISE:

9 Q I'm Marian Scalise. I represent the
10 defendants in the case that you have been
11 named as an expert witness for the
12 plaintiff in.

13 And sitting here with us today is the
14 plaintiff, who is acting as her own
15 attorney.

16 Have you been retained by her to be
17 an expert witness in this case?

18 A Yes.

19 Q When were you first contacted about being
20 an expert in this case?

21 A I don't know. I don't remember.

22 Q Did you bring any of the letters, emails,
23 any of the correspondence?

24 A I think Ms. Gurry was supposed to provide
25 you with any emails or anything.

1 MS. GURRY: And I did
2 provide you with that information.

3 MS. SCALISE: I don't have
4 emails.

5 Q So what I need you to do is I need you to
6 provide that to the court reporter.

7 After the deposition, I need you to send
8 those directly to her, and we will mark
9 that as Exhibit 2.

10 I will now mark your notebook binder
11 as Exhibit 1.

12 - - - - -

13 (Defendant's Exhibit 1
14 marked for identification.)

15 - - - - -

16 MS. SCALISE: On the
17 record, I've marked as Defendant's Exhibit 1
18 the notebook that he's brought. And I would
19 ask that it be copied in color. And I know
20 that he's got some pages, or at least colored
21 pages, in between different things.

22 It doesn't matter how that is
23 separated, but somehow if that is separated to
24 show where the breaks in the document are, but
25 I do want it in color.

1 And then we are going to mark
2 as Exhibit 2 any emails and correspondence
3 that he has had with Ms. Gurry, and he will
4 send those directly to the court reporter and
5 later have those printed, and that can be
6 marked as Defendant's Exhibit 2.

7 - - - - -

8 (Defendant's Exhibit 2
9 marked for identification.)

10 - - - - -

11 MS. SCALISE: In South
12 Carolina with his original deposition, it has
13 to be the original exhibits. I'm willing, if
14 you are okay with that, if you can make a
15 color copy of that and that can be marked or
16 put in with the original transcript.

17 Are you okay with that? And
18 then he can keep his originals. So you can,
19 then, mail back his original.

20 MS. GURRY: Okay.

21 Q Doctor, for the record, state your full
22 name.

23 A Schild Martin Wikas.

24 Q And Dr. Wikas, what's your date of birth?

25 A June 3rd, 1946.

1 Q So how old does that make you?

2 A 73.

3 Q And I asked you to bring a curriculum
4 vitae. I think I saw that in the back of
5 Exhibit 1.

6 A Correct. It's there. Did you not
7 receive it?

8 Q I did receive it. I wanted to make sure
9 that this was accurate.

10 A That's the updated one.

11 Q And the reason I'm asking for things is I
12 have noticed in some of the documents
13 that you were sent, they've been altered
14 by Ms. Gurry. They are not complete or
15 not accurate. And so that's why I wanted
16 to get a complete copy of what you have
17 been sent, which is why I wanted Exhibit
18 1, and that's why I had questions about
19 that.

20 So with regards to your CV, does this
21 accurately and fully reflect all of your
22 education, experience and training?

23 A Yes.

24 Q And is there anything -- I notice that in
25 your curriculum vitae, you have a number

1 of publications. Do any of those deal
2 with the issues involving this case?

3 A No.

4 Q Are you going to be relying on any
5 medical literature in support of your
6 opinions in this case?

7 A No.

8 Q Tell me a little bit about your practice.

9 A It's a general medical/surgical
10 dermatology practice. We treat rashes,
11 evaluation of moles, skin cancer
12 diagnosis and treatment of skin cancer.
13 Very little cosmetic dermatology is
14 involved in the practice.

15 We treat people of all ages from,
16 literally, birth to old age. And we,
17 literally, see all sorts of rashes,
18 medical conditions, autoimmune
19 conditions. Almost, literally, anything
20 imaginable in the field of dermatology.

21 Q All right. And just for purposes of the
22 record, what is dermatology?

23 A It's the study of the skin, mucous
24 membranes, hair and nails.

25 Q All right. And in your practice, are

1 there other dermatologists other than
2 you?

3 A I have a partner. We have three
4 locations. And we are never in the same
5 location at one time. Also, I'm program
6 director of the dermatology residency
7 that's been ACGME certified. And
8 presently we have, as of this date, four
9 residents.

10 Q And what's the name of your partner?

11 A Monte, M-O-N-T-E, Fox, F-O-X.

12 Q And what's the name of your practice?

13 A Tri-county Dermatology.

14 Q How long has Monte Fox been your partner?

15 A I can't give you an accurate number of
16 years. It's been at least probably 20
17 years I would expect.

18 Q Where are the three locations for your
19 office?

20 A Do you want cities or addresses?

21 Q Cities will be fine.

22 A Cuyahoga Falls, Ohio; North Canton, Ohio;
23 Kent, Ohio.

24 Q All right. And the residency program
25 that you referenced, where is that

1 located?

2 A Within my practice. It's sponsored by
3 Kansas City University of Medicine and
4 Biosciences. The initials are KCUMB.

5 Q And KCUMB, is that an accredited medical
6 school?

7 A Yes.

8 Q Is it a Doctor of Osteopath Medical
9 School, or an M.D. Medical School?

10 A It's an Osteopathic Medical School.

11 Q Where is that located?

12 A Kansas City, Missouri.

13 Q And is that actually where you obtained
14 your doctor of Osteopath degree?

15 A Correct.

16 Q I noted that you were board certified by
17 the American Osteopathic Board of
18 Dermatology, correct?

19 A Correct.

20 Q And does that mean that you were not
21 eligible to be board certified by the
22 American Academy of Dermatology?

23 A I was board eligible by the American
24 Board of Dermatology because I went to an
25 allopathic residency.

1 Q Okay. And by the "allopathic residency,"
2 explain for me what that means.

3 A M.D. residency. Cleveland Clinic.

4 Q So if you were board eligible, why did
5 you not take that board?

6 A If I was board certified by an
7 institution, it would give me all the
8 privileges to do anything that any other
9 board certification would give me. So I
10 just couldn't see taking two tests when
11 one was sufficient.

12 Q And the board test you took with the
13 American Osteopathic Board of
14 Dermatology, when did you take that?

15 A '84.

16 Q Have you been recertified since that
17 time?

18 A You don't need to.

19 Q Have you voluntarily chosen to retake the
20 boards?

21 A No.

22 Q And so by saying you don't need to be, is
23 that because you're grandfathered in?

24 A Correct.

25 Q What was the cut-off date as to when the

1 grandfathering clause no longer applied?

2 A I don't know.

3 Q How long have you been doing the
4 residency program with KCUMB?

5 A Well, the residency has had many
6 evolutions. I can't give you the exact
7 dates of when things changed. I started
8 off with a dermatology residency in 1990
9 with Cuyahoga Falls General Hospital, and
10 then the hospital decided that they
11 wanted to close the residency. So that
12 was actually twice they decided to do
13 that because they asked me to come back
14 and start it up again, so I did.

15 And then after they decided to close
16 it a second time, I was under sponsorship
17 by Lake Erie College of Osteopathic
18 Medicine. I'm not sure how many years
19 that occurred, that lasted.

20 And then there was unification with
21 the ACGME D.O. programs unified with the
22 ACGM, which is the M.D. certified
23 institution.

24 So Lake Erie did not want to act as a
25 sponsoring agent with ACGME, and then I

1 got sponsorship by the Kansas City
2 School. So it all began in 1990.

3 Q So from 1990 until May of 2019, how many
4 years were you involved with the
5 residency training program?

6 A All those years.

7 Q But I thought you said at some point some
8 of the programs closed and then they
9 later restarted?

10 A Well, there may have been a two-year
11 period hiatus. I don't think it was
12 anything more than two years, but then it
13 was pretty much continued through that
14 period of time.

15 Q And at any point in time, what were the
16 total number of residents that you would
17 have been working with?

18 A I could have been working with anywhere
19 from -- it depended on the time. There
20 were a lot of different factors. It
21 could be anywhere from two to six at a
22 time.

23 Q And how does that work? You mentioned
24 that this residency program is actually
25 in your office. So how does that work?

1 A The office is the central location where
2 the administration occurs. So, actually,
3 I've got an unusual residency.

4 I have a coordinator, who is in my
5 office, who is my office manager. I,
6 also, have at this time right now,
7 because there is going to be other
8 iterations of it occurring, the assistant
9 program director as of this date is in
10 New Jersey.

11 So we, also, have an ACGME-approved
12 curriculum, which means that residents
13 will spend some time with me, and other
14 times they will go on rotations with a
15 pediatric dermatologist, a dermatological
16 surgeon. They always spend time weekly
17 with a dermatopathologist in another
18 location, not my own. And if they go on
19 elective, then it will be whoever they
20 are elective with.

21 Q And you talk about the ACGME curriculum.
22 Is that standardized throughout the
23 United States, or is it a curriculum
24 specific to your location?

25 A This is a curriculum standardized

1 throughout the United States. It's the
2 same curriculum at Cleveland Clinic,
3 Harvard, Yale, Johns Hopkins. This goes
4 throughout the United States.

5 Q Do you have copies of that curriculum?

6 A No. But if you want it, I could get it.

7 Q All right. With regard to the
8 curriculum, does it say or specify what
9 you are to teach on different topics?

10 A It has the material that the residents
11 are supposed to be exposed to.

12 Q And so would that include, for example,
13 with melanoma, how to diagnose and treat
14 melanoma?

15 A I shouldn't have said that. Excuse me.
16 I shouldn't have interrupted you. I
17 apologize. It will not say that. It
18 will just say that these are things they
19 are going to be exposed to.

20 Q Of the ones, is more kind of bullet
21 points, as compared to actual, I don't
22 want to see lectures, but actual
23 materials as to things that they are
24 supposed to learn in a residency program?

25 A It will be things that they are to be

1 exposed to.

2 Q But as far as the specifics within that
3 exposure, is that left to the teachers,
4 so to speak, or is that part of the
5 curriculum?

6 A They are going to be exposed to these
7 subjects, and the details will be
8 discussed during the rotations, and they
9 are also going to see it during grand
10 rounds. They are going to see it in
11 their reading of the dermatologic
12 textbooks. They are going to see it
13 dermatopathology. They are going to see
14 it in dermatologic surgery and in my
15 practice because we see melanomas like
16 weekly nowadays it seems like. So there
17 is going to be overlapping layers of
18 exposure.

19 Q And with regard to melanoma, is part of
20 your practice, as far as to biopsy
21 suspicious-looking moles or areas, to see
22 whether it is melanoma?

23 A Weekly.

24 Q And then is it also part of your practice
25 to actually excise those melanomas?

1 A Only those I feel comfortable excising.

2 Q What would be a parameter as to what you
3 would feel comfortable excising?

4 A The parameters would consistent of
5 location, thickness, histologic
6 characteristics, medical status of the
7 individual, among other things.

8 Q I know that you have reviewed some of the
9 records with regards to Ms. Gurry. With
10 regards to her type of melanoma that she
11 had on her leg, would that be something
12 that you would have excised, or would you
13 refer that to somebody else?

14 A I would refer it.

15 Q And why was it that you would refer it?

16 A Because of the thickness.

17 Q We will get into some of that later, but
18 what type of provider would you refer
19 with someone like Ms. Gurry?

20 A Generally, a plastic surgeon.

21 Q Why a plastic surgeon?

22 A Because they can do an adequate incision,
23 and, if necessary, do a central lymph
24 node evaluation. And I would also refer
25 her to an oncologist.

1 Q What is a central lymph node evaluation?

2 A When you have a melanoma, it depends on
3 the location, but when they do the
4 excision, at the same time they inject
5 some sort of tracer, whether it's dye or
6 a radioactive substance. The substance
7 will travel by the lymphatics to the
8 nearest set of draining lymph nodes.

9 And the first lymph node goes into
10 what is called the sentinel lymph node.
11 This one is usually sampled, sent for
12 histologic evaluation at the time of the
13 procedure. And it is, also, sent for
14 regular sections at a later date in
15 addition in the determination if should
16 more lymph nodes be removed. It, also,
17 determines the potential for metastatic
18 spread.

19 Q Is it true that melanoma can travel
20 through the lymphatic system and not be
21 picked up right away on a PET Scan?

22 A It's possible.

23 Q What I'm wondering is if a patient opts
24 not to have a sentinel lymph node
25 evaluation, can the patient still have

1 metastasis at that point?

2 A It's possible.

3 Q Okay. And how is it possible? What do
4 you mean by that?

5 A You can't always predict where they are
6 going to spread, how they are going to
7 spread. You can only deal with the
8 statistics.

9 Q If a lymph node is later found to have
10 cancer in it, then does that mean there
11 has been metastasis?

12 A That's the definition.

13 Q And then to determine what stage of
14 cancer a patient has, how is that
15 determined?

16 A That's determined by the histologic
17 classification of the original lesion and
18 locations where the melanoma has spread
19 to.

20 Q And for various stages of metastatic
21 melanoma, are there different life
22 expectancies associated with that?

23 A There are statistics that verify that.

24 Q Is that something that you're trained and
25 educated in?

1 A We are. But it's something that's influx
2 all the time because the organizations
3 change their classification not
4 infrequently.

5 Q What organization are you referring to?

6 A I don't know the specific name. These
7 are national organizations that do that.

8 Q And so the national organizations, they
9 are the ones who would say for a stage
10 one metastatic melanoma, there is a life
11 expectancy of X percentage, correct?

12 A Correct.

13 Q And you said that over the years those
14 percentages have changed, is that what
15 you were saying?

16 A No. Statistics are changed or modified
17 with other variables.

18 Q If a sentinel lymph node section is
19 performed and there is cancer found in a
20 sentinel lymph node, what would be the
21 treatment for the patient at that point?

22 A That would be up to the medical
23 oncologist.

24 Q And by that meaning whether the patient
25 needs chemotherapy, radiation, et cetera?

1 A Correct.

2 Q And is that outside your area of
3 expertise with regard to that?

4 A It's not what I do.

5 Q Okay. So would you be commenting at all
6 at trial as to that particular aspect of
7 it, if a patient has metastasis what care
8 and treatment is then required?

9 A That's in the field of a medical
10 oncologist.

11 Q So again, you would not be offering any
12 opinions about that, is that fair?

13 A Correct.

14 Q As part of the ACGME curriculum talking
15 about melanoma, and you talked about
16 which types of patients you would then
17 refer elsewhere, is that part of what you
18 are teaching the residents of knowing
19 when they basically should try to remove
20 the melanoma versus when they should
21 refer it?

22 A Correct.

23 Q Do you all talk about at all if they are
24 going to remove the melanoma, what kind
25 of margins they need to obtain?

1 A Those are fairly standard.

2 Q So what is the standard margin for
3 melanoma?

4 A It depends on the thickness. It depends
5 on the size.

6 Q So for someone like Ms. Gurry, what would
7 the standard margin that should be
8 obtained for her melanoma?

9 A Probably one centimeter.

10 Q That's on either side of the melanoma?

11 A Correct.

12 Q How about depth?

13 A You go at least into the reticular
14 dermis.

15 Q And the reticular dermis, does that
16 include part of the fat?

17 A You go to the fat.

18 Q Is it your testimony that for someone
19 like Ms. Gurry with her melanoma that was
20 removed, that the excision of that
21 melanoma you would go to the fat but not
22 into the fat?

23 A Correct.

24 Q Are you a member of the American Academy
25 of Dermatology?

1 A Yes.

2 Q Are you familiar with their guidelines
3 with regard to melanoma?

4 A I don't have them in front of me.

5 Q If, in fact, their consensus guidelines
6 say that the consensus opinion of the WG
7 is that invasive CM, which is cutaneous
8 melanoma, should generally be excised to
9 the depth of, but not including, the
10 underlying muscular fascia, do you agree
11 with that?

12 A Yes.

13 Q So, in fact, the --

14 MS. GURRY: Excuse me. I
15 don't have that. You haven't shown that to
16 me.

17 MS. SCALISE: I'm asking
18 him questions about it.

19 MS. GURRY: Okay.

20 Q So with regard to the American Academy of
21 Dermatology, you would agree that their
22 representation is to actually go down to
23 the fascia which is above the muscle?

24 A I would agree with that.

25 Q So that would include removing that fat

1 layer, correct?

2 A That would.

3 Q As part of your education and experience
4 and training, do you know how the type of
5 excision surgery that Ms. Gurry had, how
6 that was accomplished?

7 A I saw the operative report of the
8 surgeon.

9 Q Okay. What is your understanding -- let
10 me go back then.

11 Is that something that you
12 specifically have been trained and
13 educated in on how to do that, or is that
14 further training that someone else would
15 need?

16 A No. I've been trained to do that.

17 Q Okay. And so explain to us in layman's
18 terms, then, how that surgery is
19 accomplished.

20 A With hers?

21 Q Yes, sir.

22 A I could go over that with you.

23 Q Yeah. That would be great. Thank you.

24 Actually, I think I've got one I can
25 mark as an exhibit.

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- - - - -
(Defendant's Exhibit 3
marked for identification.)
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Q Exhibit 3 is Dr. Masessa's operative
note, which is Bates stamped at the
bottom Masessa 5 through 9. You what
know, it's missing page 6.

MS. SCALISE: Now, Tara,
you can't talk to him during the deposition.
When a deposition starts, you are not
permitted to talk to him about anything that's
going on. You have the right to ask him
questions after I get through, but you can't
talk to him. I have page 6, but if you can
find it, that might be easier.

A Shall I go over it?

Q Yes, sir.

A So the area was prepped with an
antiseptic solution and draped in the
usual fashion. So an antibacterial
solution was applied and it was draped.
A round excision was performed on the
right anterior distal thigh with a 15
blade. It was excised to the layer of

1 the adipose tissue. Complex repair was
2 performed because the damaged skin
3 surrounding the defect made closure
4 difficult because extensive undermining
5 was required because inelasticity of skin
6 made closure difficult because Burow's
7 triangles were required, and because
8 there is insufficient tissue mobility to
9 close the wound with local tissue.

10 Extensive wide undermining was performed.

11 Hemostasis was achieved with
12 electrocautery. The dermal sutures were
13 0-0 PDS. Epidermal closure was achieved
14 with 1-0 Nylon and 2-0 Nylon. Simple
15 interrupted and horizontal mattress. The
16 final wound lines was 16 centimeters.

17 Bacitracin and dry sterile dressing was
18 applied. Suture removal was in 14 days.

19 Q Okay. So tell us in layman's terms what
20 occurred in that surgery?

21 A The area was cleansed with an
22 antibacterial cleanser, and it was draped
23 so as to keep the surrounding area
24 sterile. A round excision was performed,
25 which I thought was kind of unusual, to

1 the thigh with a number 15 blade. That's
2 just a relatively small blade.

3 Q Okay. But as far as "round," meaning
4 like a circular excision?

5 A That's what it says, "round." Usually
6 you do these with an elliptical excision.
7 So that would be the reason you would
8 need the Burow's triangle because round
9 excisions don't come together nicely.

10 Q Okay.

11 A Complex repair was performed. The reason
12 for a complex repair was because this is
13 fairly common procedure because you need
14 to minimize tension. And usually with
15 tension, it's the lower part of the
16 dermis and the upper subcutaneous fat but
17 not into the fat. So that increased
18 mobility with that the sides came
19 together easier.

20 Q Before we go on, I'm going to mark as
21 Defendant's Exhibit 4 something I just
22 got off the Internet.

23 - - - - -

24 (Defendant's Exhibit 4
25 marked for identification.)

1 - - - - -

2 Q What I wonder is where it has got this
3 "abnormal area," at least drawn on this
4 particular slide, which is Defendant's 4,
5 if that truly was the melanoma, can you
6 describe or draw on there how this
7 excision took place?

8 A This is the lower part of the dermis, the
9 areas that have protrusion. And then
10 this is the subcutaneous fat. And then
11 you basically put a blunt surgical
12 instrument between the reticular dermis
13 and the fat to loosen up the tissue.

14 Q Okay. Before you go further, would this
15 help to kind of explain what you are
16 referring to or not?

17 A Yeah. Basically, you go into the lower
18 part of the dermis --

19 Q Hold on a second. Let me mark that as
20 Exhibit 5. And what I would like is if
21 you can draw on either Exhibit 4 or
22 Exhibit 5 what you are referencing as far
23 as how the excision is going.

24 - - - - -

25 (Defendant's Exhibit 5

1 marked for identification.)

2 - - - - -

3 A You go into the lower part of the dermis.

4 And this is what he said here.

5 "Extensive wide undermining was
6 performed. The lesion was excised to the
7 layer of the adipose tissue." He didn't
8 say he went into it, which I thought was
9 interesting.

10 Q But as you have just explained with the
11 American Academy of Dermatology, they
12 talk about needing to go down to the
13 fascia, which is right above the muscle,
14 correct?

15 A Correct. But he didn't mention that.

16 Q And again, without us taking
17 Dr. Masessa's deposition, would you agree
18 we really don't know how far down he
19 went, correct?

20 A Just give me one moment. I think it was
21 that transcript by Jenowitz.

22 Q And let me ask you about that. Are you
23 aware that that was Ms. Gurry basically
24 having a pocket recorder and tape-
25 recording the physician assistant in a

1 conversation with him?

2 A I know it was recorded. That's all I
3 know.

4 Q And in that, did you see where the
5 physician assistant had only been with
6 Dr. Masessa, in essence, the past six
7 months?

8 A Yes.

9 Q So you would agree the physician
10 assistant was not present for the surgery
11 back in January of 2016, correct?

12 A Correct.

13 Q And physician assistants, they typically
14 are not the ones who would operate and
15 perform this type of surgery, correct?

16 A Correct.

17 Q And did you see, also, in that
18 transcription, that the physician
19 assistant asked Ms. Gurry about having
20 Dr. Masessa come in to explain what had
21 occurred, and she said, "No, he didn't
22 come in"?

23 A Correct.

24 Q So do you agree that while you have a
25 transcript that Ms. Gurry has typed of

1 her recording of this physician
2 assistant, we don't know sitting here
3 today what Dr. Masessa would say as to
4 how deep he excised that melanoma,
5 correct?

6 A But the clinical notes say that he went
7 down to the fat.

8 Q But as far as whether he went into the
9 fat or if it truly was just right above
10 the fat, you can't say, correct?

11 A I can only say what he said.

12 Q Okay. And with someone like Ms. Gurry
13 with a BMI of 17 or 18, you would agree
14 she doesn't have a lot of fat, does she?

15 A Correct.

16 Q So even if there was some fat there, it
17 wouldn't be the amount that we are
18 looking at in Defendant's Exhibits 4 or
19 5, correct?

20 A Right. We can't say that. You just
21 can't say that.

22 Q You can't say what?

23 A You are assuming something.

24 Q What am I assuming?

25 A You are assuming she doesn't have any

1 fat. My experience in doing surgeries is
2 that you have a lot of people that are
3 really, really thin, and you go and do
4 procedures and there is fat there.

5 Q Okay. And to her credit, looking at her,
6 she doesn't look like she has a lot of
7 fat, that you think that she does have
8 potentially some fat on her legs?

9 A I think if we made a cut down to her
10 muscle, I think you would see about that
11 much fat.

12 Q You were just demonstrating. How much is
13 that?

14 A I can tell you that there would be fat
15 there. In my experience, I've always
16 found fatty tissue in that area.

17 Q All right. But if, in fact, Dr. Masessa
18 did not go into that fat, and preferably
19 down to the muscle layer, then you would
20 agree that would be contrary to what the
21 American Academy of Dermatology
22 recommends?

23 A The American Academy of Dermatology's
24 statements are guidelines. They are not
25 absolute statements, mandating this has

1 to be done every time. It's based on the
2 education and experience of the operator.

3 Q Going back to my original question in
4 looking at Exhibit 4 and Exhibit 5, when
5 Dr. Masessa says that he excised the
6 melanoma, would you agree that he would
7 have, I guess basically taken a chunk, so
8 to speak, in layman's terms, a chunk out
9 of her thigh?

10 A Correct.

11 Q And was it your understanding that then
12 after he took that, quote, "chunk out,"
13 that then he tried to reapproximate the
14 sides, meaning sew the two sides
15 together, correct?

16 A He did reapproximate the sides.

17 Q And those sides would include both the
18 dermis level, as well as the epidermis
19 level, correct?

20 A Correct.

21 Q And by sewing those two together, you
22 would agree that if, for some reason,
23 those sutures popped open, you now would
24 have a deficit since Dr. Masessa would
25 have removed this melanoma, correct?

1 A If the sutures would have come apart,
2 then you would have had a dehiscence.

3 Q And can there be a dehiscence underneath
4 the surface level of the skin?

5 A A dehiscence by definition means that the
6 top layer of the skin opens up.

7 Q What is it called where the underneath
8 layer, such as the epidermis or dermis
9 layers, when those open up?

10 A I guess you could call it a subcutaneous
11 opening.

12 Q If there is a subcutaneous opening, will
13 that, then, cause a depression of the
14 skin?

15 A Yes. If that occurred.

16 Q Let me go back to some of your kind of
17 background questions about you.

18 Do you hold hospital privileges
19 anywhere?

20 A Yes.

21 Q Where are they?

22 A Akron General Medical Center.

23 Q What location is that?

24 A Akron, Ohio.

25 Q I don't know my geography, so where are

1 we located now, Cleveland?

2 A Cleveland.

3 Q How far is Cleveland from Akron?

4 A 31 miles approximately. From the eastern
5 suburbs of Cleveland. It depends where
6 you are coming from. It could be 45
7 miles, depending on where you are going.
8 But it's about 31 miles, 24 miles to
9 Cuyahoga Falls.

10 Q Do you perform any surgeries in Akron
11 General Medical Center?

12 A No.

13 Q For the procedures that you do as a
14 dermatologist, are all of those in-office
15 procedures?

16 A Yes.

17 Q Are they at any surgery centers at which
18 you have privileges?

19 A Not anymore.

20 Q What would be the last time you held
21 privileges at a surgery center?

22 A It would be through a hospital, and not
23 directly through a surgery center, as
24 such, and that would have been about 25
25 years ago.

1 Q Your hospital privileges at Akron General
2 Medical Center, are they courtesy
3 privileges?

4 A Right now. In all likelihood, they are
5 consulting privileges. They may be
6 courtesy by now. We have had changes.
7 The whole dermatology community in Akron
8 has changed the way they want to deal
9 with hospital issues.

10 Q Okay. What happened?

11 A It means that the dermatology community
12 has decided they will not do on-call
13 consultations. In the past, we had a
14 rotating where we did -- we were
15 responsible for doing consultations at
16 multiple hospitals and throughout Akron,
17 and that changed over time.

18 Q So by consulting privileges, what does
19 that mean? What are you allowed to do?

20 A You are requested to come in and see a
21 patient to make a diagnosis, to possibly
22 do a biopsy, to prescribe therapy.

23 Q What would be the last time that you have
24 had to go to Akron General Medical Center
25 to do any of these things?

1 A About two years ago.

2 Q Why haven't you done anything in the last
3 two years?

4 A Because we don't do consults anymore.

5 Q So is it fair to say you have not had to
6 care for or treat a patient at Akron
7 General Medical Center in at least the
8 last two years?

9 A I can't tell you that. It may have been
10 three. I'm not sure.

11 Q Prior to that, how frequently were you
12 seeing patients in Akron General Medical
13 Center?

14 A We had monthly calls. And I normally
15 would have call about two to four months
16 a year.

17 Q Meaning you would go to the hospital once
18 every two to four months?

19 A No.

20 Q What does that mean?

21 A We would be responsible for taking calls
22 seven days a week for that month. 30
23 days.

24 Q Out of that 30 days, how frequently would
25 a dermatologist be needing to see a

1 patient?

2 A It could be anywhere from zero weekly to
3 six times a week.

4 Q It just all varied?

5 A It varied.

6 Q And then once you saw that patient in the
7 hospital, did you continue to see them
8 for the rest of their hospitalization?

9 A We were called to evaluate the patient,
10 make a diagnosis, provide therapy. And
11 then usually hospital stays were very
12 short, and the patient was given the
13 opportunity to see us as an outpatient.

14 Q And what states have you held medical
15 licenses in?

16 A I have one in Ohio, one in Arizona, and
17 an inactive one in Pennsylvania.

18 Q All right. Why did your license in
19 Pennsylvania become inactive?

20 A I had an opportunity to provide medical
21 care in Pennsylvania, but it really never
22 worked out, and it just wouldn't have
23 worked at all. And so we just -- the
24 Pennsylvania Medical Board, rather than
25 totally getting rid of the license, they

1 just made it inactive.

2 Q What year was that that it became
3 inactive?

4 A Probably -- I can't tell you the exact
5 year. I can only extrapolate. Maybe
6 about 30 years ago. I don't remember.

7 Q Why do you hold a license in Arizona?

8 A Because I do consulting. And the
9 organization I work for, I do prior
10 authorizations in the state of Arizona
11 for surgical procedures. And also,
12 similar kinds of activities, such as
13 evaluating appeals.

14 And apparently, it was mandated that
15 for me to do that in the state of
16 Arizona, I had to have an Arizona
17 license.

18 Q What's the name of the company for whom
19 you do the consulting?

20 A I work for so many different companies.
21 Do you mind if I look in my phone?

22 Q That's fine.

23 A I can't remember because there is so many
24 companies I work for.

25 Q That's one thing I would like to know is

1 all the different companies you work for.

2 As you are going through your phone and

3 see stuff, just shout them out.

4 A National Medical Reviews. Network

5 Medical Reviews. Dane Street. D-A-N-E.

6 A company by the name of MSL Group, LLC.

7 Oh, Avande. A-V-A-N-D-E. That's the one

8 that demands that I have the license in

9 Arizona.

10 Q Any other organizations or groups that

11 you do work for?

12 A No. I can't think of any others. There

13 may be others. I really can't keep

14 track. Some of them just call me maybe

15 once a year, if that much.

16 Q With Avande, how frequently are you doing

17 their work?

18 A Five times a week.

19 Q How does that work to do the work in Ohio

20 versus folks in Arizona?

21 A They send me a file, and I review the

22 file, determine if the request for

23 medical care or surgical care or request

24 for approval of evaluation is

25 appropriate.

1 Q Are all of the files that you are
2 reviewing, do those have to do with
3 dermatologic issues or are there other
4 issues?

5 A That's my area of expertise only.

6 Q So yes, it would be just dermatologic?

7 A Correct.

8 Q How much are you paid for that work?

9 A It varies, because I'm paid by my time.

10 Q How much do you charge them?

11 A I don't charge them, as such. I give
12 them the number of minutes I work, and
13 they do their little formulas and then
14 they pay me. Because the time it takes
15 to do an evaluation is anywhere from five
16 to ten minutes, so it's a short period of
17 time.

18 Q So for the approximately five to ten
19 minutes, what kind of number do you get
20 back as far as an amount?

21 A Of money?

22 Q Yes, sir.

23 A It can be \$140 a month to \$350 a month.

24 Q So \$140 to \$350 a month for you are
25 saying "reviews," and I guess you're

1 doing reviews five times a week, and
2 that's the total of what you get?

3 A Those are for prior authorizations.

4 Q About how any hours or minutes a month
5 are you spending on these files?

6 A Maybe 150 hours. Excuse me. That was
7 wrong. 150 minutes to 250 minutes a
8 month.

9 Q So for that time frame, as far as your
10 reimbursement, it is \$140 to \$350?

11 A It could be. I don't know.

12 Q But I think that's what you just
13 testified to earlier.

14 A I can't tell you exactly. I'm not really
15 good from the business point of view.

16 Q But you are estimating for 150 to 250
17 minutes, you are making \$140 to \$350?

18 A That would be -- that's only a
19 guesstimate. I cannot tell you exactly.

20 Q But is it more than that that you are
21 making or less than that that you are
22 making?

23 A Not from that company.

24 Q So that would be approximately the amount
25 you are making with that company?

1 A It varies every month.

2 Q But is that approximately how much you
3 are making?

4 A That's only a guesstimate.

5 Q Okay. The MSSL group that you mentioned,
6 what do you do for them?

7 A MLS?

8 Q MLS. Sorry. Okay.

9 A I evaluate people who would like
10 medications or medical tests approved. I
11 evaluate those.

12 Q Where are these patients, in what state
13 are they in?

14 A All over the country.

15 Q So the MLS group, how do they get in
16 touch with these patients? How are they
17 involved?

18 A They are contacted usually by insurance
19 companies, and they act as the middleman.

20 Q And so what do you review to determine if
21 a patient needs a medication or a medical
22 testing?

23 A I review two things. One is the plan
24 language.

25 Q The insurance plan?

1 A Yes. And then I, also, evaluate the
2 medical records and determine if the
3 request is compatible with the plan
4 language.

5 Q What types of medications are you looking
6 at?

7 A They vary. They can be injectable
8 biologics for psoriasis, psoriatic
9 arthritis, atopic dermatitis.

10 Q So they are dermatologic medications that
11 you are looking at?

12 A That's only my area of expertise.

13 Q I just wanted to make sure.

14 How frequently are you doing these
15 reviews?

16 A Those are very infrequently because they
17 send out emails to multiple reviewers.
18 The first one that gets it gets the
19 review.

20 Q And approximately how much do you make
21 with that group?

22 A It can vary from zero to \$350 a month.

23 Q Again, as far as the time that you would
24 spend that would give you \$350 a month,
25 about how much time are you spending to

1 get that kind of a paycheck?

2 A 15 minutes.

3 Q How did MLS first contact you, or how did
4 they know you were willing to do this?

5 A They emailed me.

6 Q Are you seeking these people out, or did
7 they seek you out?

8 A They sought me out because I would --
9 technically, I advertise.

10 Q Okay. Where all do you advertise?

11 A Various companies have me on their lists,
12 booklets for people who are available for
13 file review.

14 Q Tell me the locations or entities for
15 which you advertise.

16 A The one I primarily use is a company by
17 the name of SEAK, S-E-A-K. That is the
18 primary one that I use now because I
19 dropped all of the others.

20 Q And so with SEAK, are you listed as
21 someone willing to review cases as far as
22 medical/legal cases in addition to these
23 file reviews?

24 A Those are two different booklets.

25 Q That's a good point. So with SEAK, you

1 can advertise as a medical expert for
2 litigation purposes, but then you can
3 also advertise with them as to being
4 someone willing to do case reviews for
5 insurance purposes?

6 A Correct.

7 Q So you advertise in both areas?

8 A Correct.

9 Q And then Dane Street, what is that?

10 A They evaluate files for approving or
11 denying disability requests.

12 Q Okay. Where are these patients coming
13 from?

14 A Various insurance companies.

15 Q And again, these would deal with
16 disability requests related to
17 dermatology issues?

18 A That's all I'm qualified for.

19 Q And how frequently are you working with
20 Dane Street?

21 A Maybe about once every three months.

22 Q How much do you make with that company?

23 A Probably \$100 to \$150 per file review.

24 Q How long do those file reviews take you?

25 A Too long. So I refuse most of the ones

1 that they give me.

2 Q But for you to get the 100 to 150 check,
3 how long are you spending on those?

4 A About two hours.

5 Q And then I think you said National Expert
6 Reviews?

7 A No.

8 Q What did you say?

9 A National Medical Reviews.

10 Q Okay. What do you do for them?

11 A Review group health files.

12 Q And again, all dermatology, correct?

13 A Totally.

14 Q How frequently are you doing case
15 reviews, health file reviews for National
16 Medical Reviews?

17 A Now it's maybe once a month. It used to
18 be more than that. Like I said, they put
19 out an email, and the first one that gets
20 it gets it, and everybody is quicker than
21 me.

22 Q And whenever you are doing your work with
23 National Medical Reviews, how much are
24 you paid?

25 A Usually \$150 per case.

1 Q Is that whether you take 15 minutes or
2 you take five hours, it's still \$150?

3 A Correct.

4 Q And then I thought there was another
5 entity that you have done reviews for.
6 After you said National Medical Reviews,
7 I thought you said something Expert
8 Reviews.

9 A May I look?

10 Q Yes, sir.

11 A I don't have the exact name because I
12 have to look it up on the web. But it's
13 NMR is the name of the company, and that
14 may be Network Medical Reviews.

15 Q Okay. What type of reviews do you do for
16 them?

17 A Primarily file reviews for requests for
18 medications that have been denied by
19 insurance companies. They do want me to
20 do some disability reviews, but I don't
21 like to do them.

22 Q What in the dermatology field or
23 dermatologic field would qualify as
24 disability?

25 A A person could have severe contact

1 dermatitis, they could have severe
2 urticaria, have some burns, have severe
3 atopic dermatitis. There is, also,
4 associated psychological problems with
5 those.

6 Q Going back to Network Medical Reviews,
7 how much do you make with them?

8 A It varies. It's about maybe \$2,500 a
9 month. Maybe more, maybe less.

10 Q And how many hours are you spending to
11 get \$2,500?

12 A It would be approximately two hours a
13 night during the week.

14 Q So 14 hours a week?

15 A It could be more like eight hours a week.
16 And that really varies with the amount.
17 I have had some months when I have gotten
18 a thousand, some months when I have
19 gotten four thousand, so it really varies
20 per month.

21 Q But you are spending about eight hours a
22 week every week?

23 A Yes.

24 Q Have your privileges at any hospital ever
25 been suspended or revoked in any manner?

1 A No.

2 Q And as far as have you ever been
3 suspended, fined, warned, or had any
4 adverse ruling from any professional
5 society?

6 A No.

7 Q With the various medical boards, have you
8 ever had your privileges suspended,
9 revoked, not privileges, but your
10 license? Have you ever had any
11 disciplinary actions with any of those
12 states of Ohio, Arizona or Pennsylvania?

13 A No.

14 Q Have you ever had any complaints filed
15 against you with any of those medical
16 boards?

17 A No.

18 Q Have you ever been a party to a lawsuit?

19 A Yes.

20 Q How many?

21 A If you count the one that I was named but
22 not the primary, it would be -- well, it
23 would be a total of three that I can
24 remember.

25 Q Were you the primary defendant in any of

1 the lawsuits?

2 A In two.

3 Q So a total of five lawsuits?

4 A No. A total of two that I can remember.
5 If there are more, I can't remember them.

6 Q Okay. But you talked about three that
7 you were not the primary?

8 A No. There was one in which I was not the
9 primary.

10 Q I'm sorry. I was confused.

11 So a total of three lawsuits where
12 you have been named, and two where you
13 were the primary dermatologist, and one
14 you were just named in?

15 A That I can remember.

16 Q And were those suits all filed here in
17 Ohio?

18 A Yes.

19 Q And what happened with each of those
20 suits?

21 A In one suit, the woman received an
22 injection by a nursing staff member and
23 she got a sciatica.

24 Q What happened? What was the resolution
25 of that?

1 A It was settled out of court.

2 Q Do you remember how much?

3 A Maybe \$2,000.

4 Q Okay. How about the next case?

5 A That was a laser case in which a woman
6 got scarring on the face from a laser
7 procedure.

8 Q What was the outcome of that case?

9 A It went to trial.

10 Q What happened at trial?

11 A 1.2 million.

12 Q So 1.2 million dollars against you?

13 A Yeah.

14 Q And how about the third case?

15 A That was one in which my partner was the
16 primary person, and a woman got burned
17 from our phototherapy unit.

18 Q What happened with that one?

19 A It was settled out of court.

20 Q How much was that settled for?

21 A I have no idea.

22 Q Have there been any claims made against
23 your insurance policy that did not go to
24 an actual lawsuit?

25 A I don't remember if there are.

1 Nothing -- those are the kinds of things
2 I would remember, but I can't say that I
3 remember anything.

4 Q But there could have been some other
5 settlements, but you just don't recall?

6 A I don't recall any other settlements. We
7 did have a few people over the years who
8 initiated litigation, but then they
9 finally just decided it wasn't worth it.

10 Q Have you ever been a plaintiff in a
11 lawsuit?

12 A No.

13 Q Tell me about your work as an expert
14 witness. How long have you been doing
15 expert witness work?

16 A I can only document it from 2001. I did
17 expert witness before then, and they were
18 primarily criminal cases. I may have
19 done some criminal cases after, but the
20 primary stuff I did was criminal cases
21 before 2001.

22 Q All right. So how many criminal cases
23 were you involved in?

24 A Child abuse cases. One for the
25 plaintiff. One for the defense.

1 Q And then you talked about in 2001 you
2 have been documenting your work. Where
3 do you have that document?

4 A Do you have my list?

5 Q It says "Testimony History," is that your
6 list?

7 A Yeah. In all likelihood, you may be able
8 to find more, but I was a poor
9 record keeper, and so that is the bulk of
10 what I've participated in.

11 Q All right. And it says at the top, "The
12 Following Jury Verdict Reports/Summaries
13 mention the name of the expert as an
14 expert witness involved in the case."

15 So did you, or somebody on your
16 behalf do some type of jury verdict
17 research?

18 A What happened was I was anticipating
19 going to Federal Court. And as a result,
20 I knew I needed to -- there were a number
21 of times in which I was possibly going to
22 Federal Court. But the first time I
23 realized I needed -- you know, to go to
24 Federal Court, you need to have a list of
25 what you participated in in the past.

1 So I had a company do research for
2 me, and that's all they could come up
3 with.

4 Q But you believe that there are other
5 cases for which you have given either
6 deposition or trial testimony that are
7 not on this list?

8 A There may be. In all likelihood, there
9 are a few, but they're early on, around
10 maybe 2001, or around that period of
11 time.

12 Q And, for example, here in 2019, how many
13 cases have you been asked to review
14 cases?

15 A I've got maybe about three, maybe four
16 cases that I have in notebooks. Thank
17 goodness a lot of them have been settled,
18 but I have maybe two or three pending.

19 Q How about for last year, 2018?

20 A Two or three.

21 Q Let me ask you this. How many cases do
22 you believe that you have reviewed over
23 the course of your career?

24 A More than on that list.

25 Q I guess we will mark it as Exhibit 6.

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(Defendant's Exhibit 6
marked for identification.)
- - - - -

Q So you are saying more than what's on
Exhibit 6?

A Yes. I have been very happy that a lot
of them have been settled before going to
deposition.

Q And as far as depositions for trials, you
believe there could be more than what's
represented on Defendant's Exhibit 6?

A I do.

Q And so can you give me an estimate of
about how many depositions that you have
given?

A I think maybe about five or six that are
not listed. I can't remember. But I
have reviewed a much larger number than
are on that list.

Q More than a hundred?

A I cannot tell you.

Q And for your trial testimony, how many
times have you testified in trial?

A It's on that list.

1 Q It's hard to tell on this.

2 A They should say trial versus deposition.

3 Q Do you remember actually testifying in
4 trial?

5 A Oh, yeah.

6 Q So about how many times do you remember
7 having to go to a courtroom and testify?

8 A I couldn't get close to telling you.

9 Q Do you think it's more than 10?

10 A Probably not more than 10, but that's
11 guesstimating. And I would like to be
12 accurate when I'm talking about stuff
13 like that.

14 Q And looking on Defendant's Exhibit 6, I
15 only saw two instances where you --well,
16 actually, it's one case that you reviewed
17 for a defendant or testified for a
18 defendant.

19 Have there been any other times that
20 you have testified for a defendant?

21 A I've reviewed many cases for defendants.
22 And all I can tell you is those are the
23 actual documented testifying cases.

24 Q And as far as your case reviews, what
25 percentage do you believe have been for

1 the patient/plaintiff as compared to a
2 defendant/medical provider?

3 A At least 95 percent for the plaintiff.

4 Q So other than this one case for the
5 defendant that's on Exhibit 6, can you
6 think of any other cases you have
7 testified by deposition or trial for a
8 defendant?

9 A Can you tell me what case you are looking
10 at?

11 Q It says "Defendant Fiesta Hair and
12 Tanning Salons."

13 A Yeah. I also -- may I look at that?

14 Q Sure. So were you actually testifying
15 for the defendant in that case?

16 A If it says so.

17 Q You tell me.

18 A Where are you talking about?

19 Q Right there. On your key, it mentions
20 that D equals defendant.

21 A This last one, the Perrotti case, I
22 testified for the defense in this case.
23 May I make a change?

24 Q Sure.

25 A Because that's spelled wrong. It's

1 Medina. That one I most recently
2 testified in.

3 Q And that was for the defense?

4 A For the defense.

5 Q Okay. And where you have a P at the
6 beginning, it should be a D?

7 A Yeah, it was for the defendant. I'm so
8 sorry. I will have to fix those things
9 and go through them.

10 Q If you'll also look in Exhibit 6, did any
11 of these cases involve an injection? You
12 can look through those and see.

13 A Yes. But these would -- well, like with
14 Herter, that involves injection of Botox.

15 Q Will you put a star by the one you are
16 referencing?

17 A That's all I know.

18 Q And so with regard to the Herter,
19 H-E-R-T-E-R, case, what did that involve?

20 A A woman got Botox, and she had adverse
21 effects of the Botox.

22 Q What kind of adverse effects?

23 A She was injected with Botox, and she
24 started having all sorts of problems,
25 such as weakness, difficulty breathing,

1 arrhythmias, muscle weakness.

2 Q Again, what was your opinion in that
3 case?

4 A My opinion related to the fact that they
5 weren't given informed consent prior to
6 getting the injection of Botox.

7 Q So you contended that the medical
8 provider was required to provide informed
9 consent?

10 A Yes.

11 Q What informed consent did you contend was
12 not given?

13 A About the potential adverse effects. In
14 fact, if you look at the package insert
15 on Botox, there is a component of that
16 that says it's information to patients,
17 and that would opinionize the physician
18 from the litigation.

19 Q With regard to informed consent, what is
20 your understanding as to what is informed
21 consent?

22 A Educating the patient about the procedure
23 that's about to occur and educating the
24 patient about the potential adverse
25 effects of the procedure or medication.

1 Q And by educating about potential adverse
2 effects, do you agree that that would be
3 the most common and most likely adverse
4 effect and not every potential adverse
5 effect there could be?

6 A Usually you would tell somebody are you
7 going to have pain and some of the other
8 common adverse effects.

9 Q So you would agree, then, that there is
10 no requirement to tell a patient about
11 every possible adverse effect that could
12 occur?

13 A Not when the procedure or medication is
14 done properly.

15 Q So yes, that is correct?

16 A Not when the procedure or medication is
17 done properly.

18 Q Then, yes, you do not need to notify a
19 patient of every possible effect?

20 A Not every possible effect, but exactly
21 what's going to happen prior to the
22 procedure.

23 Q And we talked about the advertising that
24 you do. At some point, did you also have
25 your own personal website?

1 A I probably have a website up, but the
2 website only has my CV.

3 Q In that website, doesn't it also
4 advertise your services as an expert?

5 A Correct.

6 Q So you actively use your own personal
7 website to advertise as an expert?

8 A I only have my CV. It says that I do
9 expert witness work.

10 Q And we talked about some of the other
11 companies for who you have done expert
12 witness work, including SEAK. How about
13 ALM Experts?

14 A I haven't done expert witness work for
15 SEAK. I advertise through them.

16 Q Okay. Have you been contacted by any
17 lawyers or plaintiffs because of your
18 advertising with SEAK?

19 A Correct.

20 Q So you have, correct?

21 A Yes.

22 Q How about with ALM Experts?

23 A I used to advertise with them.

24 Q Why do you no longer?

25 A Because I don't think they were very

1 effective.

2 Q Let me go back. With SEAK, how much do
3 you pay to advertise your services as an
4 expert?

5 A I think for maybe a year, it's not any
6 more than \$750 a year.

7 Q And then when, I guess, SEAK lists you as
8 someone willing to review cases, are they
9 involved as far as the contacting or
10 communication between you and the party
11 that's retaining you?

12 A They just provide me information, contact
13 information, and then I get in contact
14 with whoever is interested.

15 Q Is there any kind of fee that SEAK
16 charges as a result of putting you in
17 contact with individuals?

18 A No.

19 Q How about with ALM Experts, did they
20 charge a fee?

21 A No.

22 Q Did you have to pay to advertise?

23 A I did.

24 Q How much did you pay to them?

25 A I can't remember. But I no longer use

1 their services.

2 Q How about another organization called
3 Expert Witness? Did you advertise with
4 them?

5 A I used to.

6 Q Why do you no longer?

7 A They were not effective.

8 Q When you are saying these organizations
9 were not effective, what do you mean by
10 that?

11 A I have had very few contacts that have
12 gotten their information from those other
13 organizations.

14 Q How about Forensic Expert Litigation
15 Support, did you advertise with them?

16 A Maybe.

17 Q But you no longer today do that?

18 A Not to my knowledge.

19 Q How about hg.org?

20 A That was a long time ago. I don't use
21 their service.

22 Q But at one point you did advertise with
23 them?

24 A I did.

25 Q And then how about dermexpertwitness.com?

1 A Maybe.

2 Q Do you pay to advertise with
3 dermexpertwitness.com?

4 A Not now. If I ever did, I don't
5 remember.

6 Q How about other organizations or entities
7 for whom you have advertised your
8 services?

9 A I, frankly, don't recall.

10 Q Do you know how Ms. Gurry got your name
11 as being an expert witness?

12 A I'm not sure.

13 Q Did it come through SEAK?

14 A I don't know.

15 Q In this the case, we have an affidavit.
16 Who prepared this affidavit?

17 A I did.

18 Q And so is all of the wording your own
19 wording?

20 A Yes. I prepared the opinions. You know,
21 I got information, and I had to sometimes
22 get clarification from Ms. Gurry. She
23 did some help with my grammar, which is
24 not that good, and she provided me some
25 information. But the opinions are mine.

1 Q All right. And in looking at the first
2 page of that affidavit, it says,
3 "Documents examined," and it' has got 25
4 kind of bullet points.

5 So is that a complete list of
6 everything that you have reviewed in
7 preparation for your deposition and
8 opinions in this case?

9 A These are all the materials that I
10 reviewed prior to my affidavit being
11 written.

12 Q After your affidavit was written up until
13 today, as you were getting ready to start
14 your deposition, have there been other
15 documents that you have reviewed or been
16 provided?

17 A Not to my knowledge.

18 Q And were you relying on Ms. Gurry to
19 provide you with documents so that you
20 could render opinions in this case?

21 A Yes, she got me the documents.

22 Q Is there anything that you specifically
23 asked her for that she has not provided?

24 A No.

25 Q Have you performed any type of

1 examination or evaluation of Ms. Gurry?

2 A Yes.

3 Q When was that?

4 A Prior to coming here today.

5 Q And what examination did you perform?

6 A I examined both lower extremities.

7 Q Tell me what your findings were.

8 A She had atrophy as a result of the
9 injection on the right thigh.

10 Q Can you quantify or qualify how much
11 atrophy you are seeing as of today, in
12 June of 2019?

13 A Significant loss of subcutaneous tissue.

14 Q Can you estimate a size?

15 A I would to have a a ruler.

16 Q And by subcutaneous tissue, what are you
17 referencing?

18 A Subcutaneous fat.

19 Q Anything else?

20 A Anything in the subcutaneous fat.

21 Q What typically would be in subcutaneous
22 fat?

23 A It could be blood vessels, nerves,
24 lymphatics.

25 Q And do you know that there actually has

1 been a loss of blood vessels, nerves or
2 lymphatics in that subcutaneous tissue?

3 A Apparently, that's what was documented in
4 some of the imaging I was given.

5 Q Well, that's not the question.

6 Show me what you are referencing by
7 imaging. I may be able to help you on
8 that. Are you referencing something like
9 this?

10 A Yeah.

11 Q Okay. I'm going to mark this as Exhibit
12 7 and Exhibit 8.

13 - - - - -

14 (Defendant's Exhibits 7, 8
15 marked for identification.)

16 - - - - -

17 Q With regards to Exhibits 7 or 8, when you
18 said that there was a loss of blood
19 vessels, nerves, lymphatics et cetera,
20 what you relied on for that was Exhibits
21 7 and 8?

22 A Yeah. I've got that. I can only tell
23 you what I grossly see, knowing that I'm
24 not an expert in imaging.

25 Q Well, that was going to be my question.

1 So would you agree that you are not an
2 expert witness with regards to radiology?

3 A Correct.

4 Q And so with any type of imaging studies,
5 you don't have the experience, education
6 or training to say what the imaging
7 reveals, correct?

8 A Correct. All I can grossly see is there
9 is significant thinning in the area.

10 Q Okay. But you don't know what the cause
11 of that is and whether there is any --
12 well, actually, let me ask you this.

13 Have you actually reviewed the actual
14 PET scans, or any of the other images,
15 the MRIs, or anything in their actual
16 native form?

17 Q No. And the wording that is beside the
18 images on Exhibits 7 and 8, do you know
19 where that wording came from?

20 A No.

21 Q In the records that you reviewed, did you
22 see any words from any physicians that
23 would support the wording that is on
24 Exhibit 7 or Exhibit 8?

25 A No.

1 Q So if, in fact, the wording on Exhibit 7
2 and Exhibit 8 is Ms. Gurry's
3 interpretation as a lay person, you would
4 agree, then, that you have no evidence
5 that actually there was blood vessels,
6 nerves, lymphatics, skin, hair follicles,
7 sweat glands, et cetera, that that was
8 destroyed, or impaired, or injured?

9 A All I can say is there is significant
10 atrophy in that area.

11 Q And how do you define atrophy?

12 A Thinning of the skin, a depression, loss
13 of subcutaneous tissue, loss of
14 subcutaneous fat.

15 Q But what percent was comprised in that
16 tissue or fat that's been lost, you don't
17 have any education, experience or
18 training as to say for Ms. Gurry what
19 specifically was lost; is that fair to
20 say?

21 A I can tell you that the fatty tissue is
22 not comparable to the left side, to the
23 left leg in the same area.

24 Q Okay. Would you agree that on the left
25 side of her leg, she has not had a

1 malignant melanoma removed?

2 A Correct.

3 Q Isn't it true to say you cannot compare
4 the left to the right?

5 A Well, of course you can compare the left
6 to the right.

7 Q But can you accurately -- I guess isn't
8 it true, you would be comparing apples to
9 oranges?

10 A Well, you are comparing normal versus
11 abnormal.

12 Q All right. And the right side -- is it
13 your right side?

14 MS. GURRY: Yes.

15 Q The right side was already abnormal to
16 begin with because of having the melanoma
17 removed, correct?

18 A Well, when you look at the photographs
19 prior to the injection, it had
20 significant substance contour. After the
21 injection, there was a loss of substance
22 in contour. There was depression. There
23 was a kind of chicken skin appearance and
24 touch to the skin.

25 Q Is that currently you feel that in

1 looking or in feeling her right leg, it
2 has chicken skin?

3 A It has a lot of stippling.

4 Q And in looking at the photo -- well, are
5 you aware that Ms. Gurry is a
6 photographer?

7 A I am.

8 Q Do you know whether the photos have been
9 doctored?

10 A I don't know.

11 Q If they have been altered in any manner,
12 would that change your opinions?

13 A I have no documentation as to if that
14 occurred or not.

15 Q All right. Is it fair to say, then, that
16 you can only offer opinions based on the
17 information you have been given?

18 A Correct.

19 Q So if there is anything that's incorrect
20 or improper in the information you have
21 been given, then that negates your
22 opinions? Do you agree?

23 A I can only base my opinion on the
24 information I'm given.

25 Q So it's basically junk in, junk out,

1 correct?

2 A I can only base my opinion on the
3 information I'm given.

4 Q So if the information you have been given
5 is incorrect or inaccurate, then you
6 would agree your opinions would be
7 incorrect or inaccurate?

8 A I could only base my opinions on the
9 information given to me.

10 Q So answer my question. If the
11 information you have been given is
12 incorrect or inaccurate, then would you
13 agree that your opinions based on that
14 information would be incorrect and
15 inaccurate?

16 A Correct.

17 Q Before we get too far into your opinions,
18 let me continue kind of going through
19 some of this.

20 What percentage of your income is
21 derived from your expert witness work?

22 A One percent. Certainly, less than five
23 percent.

24 Q And as far as your education, experience
25 and training, it is only in the field of

1 dermatology, correct?

2 A Yes.

3 Q And so at the trial in this case, you
4 will only be offering opinions in the
5 field of dermatology, correct?

6 A Correct.

7 Q Do you agree that you would not be
8 offering opinions in the field of
9 orthopedics?

10 A Correct.

11 Q Is that because you are not educated,
12 trained or experienced in orthopedics?

13 A Correct.

14 Q Would the same be true for rheumatology?
15 Would you be offering any opinions in the
16 field of rheumatology?

17 A I will not be offering opinions in the
18 field of rheumatology.

19 Q And how about endocrinology?

20 A I would not be offering opinion in the
21 field of endocrinology.

22 Q And again, is that also based on the fact
23 you have no education, experience or
24 training in the fields of rheumatology or
25 endocrinology?

1 A These are not my area of expertise.

2 Q So you will not be offering opinions in
3 those areas, correct?

4 A Correct.

5 Q How about as far as internal medicine?
6 Do you have any education and training in
7 internal medicine?

8 A Yes. But only related to dermatology.

9 Q Okay. So for anything outside of
10 dermatology, you would agree, then, that
11 you are not going to be offering any
12 opinions in that regard, correct?

13 A Correct.

14 Q And would the same be true with
15 obstetrics and gynecology? Are you going
16 to be an expert in obstetrics and
17 gynecology?

18 A I will not be expert in obstetrics and
19 gynecology.

20 Q Is that also because you have no
21 education, training and experience in
22 obstetrics and gynecology?

23 A It's not my area of expertise.

24 Q Going back to your affidavit, were you
25 aware that the treating endocrinologist,

1 Dr. LaRoche, had been deposed?

2 A No.

3 Q So I take it you have not reviewed her
4 deposition?

5 A Correct.

6 Q I, also, noted, and this is why I really
7 questioned some of the records that you
8 were sent, because, I believe, you were
9 sent an affidavit of Dr. Kent Carson.

10 A Yes.

11 Q I want to show you, just for purposes of
12 this deposition, what I will mark as an
13 exhibit.

14 - - - - -

15 (Defendant's Exhibit 9
16 marked for identification.)

17 - - - - -

18 Q Exhibit 9 is what, I believe, was sent to
19 you and is included in your packet.
20 Okay?

21 A Okay.

22 - - - - -

23 (Defendant's Exhibit 10
24 marked for identification.)

25 - - - - -

1 Q Exhibit 10 is what was sent to me from
2 Ms. Gurry. Do you see that there is an
3 additional sentence in Exhibit 10 that
4 was deleted from the one that was sent to
5 you?

6 A I see.

7 Q And it says, "I do not intend to testify
8 at a deposition or trial on this case."
9 Do you see that?

10 A Yes.

11 Q So again, would you agree we don't even
12 know, then, whether Dr. Kent Carson
13 actually truly reviewed this case and
14 signed an affidavit?

15 A We see his signature.

16 Q Right. But now that we see that there
17 are alterations made to his affidavit,
18 would you agree that you can't even say
19 that this truly came from Dr. Carson?

20 A I can't make any opinion regarding that,
21 but I can only base it on what I see with
22 his signature.

23 Do you know mind if I look?

24 Q Sure. Is there a reason to the color of
25 the tabs?

1 A It was just what was available.

2 Q I just wondered. So are you looking at
3 Exhibit 10?

4 A Yes. Okay. I see now.

5 Q Okay. So you would agree that the
6 Exhibit 10 that was sent to me is not the
7 same as to what was sent to you, correct?

8 A Correct.

9 Q Do you know Dr. Kent Carson?

10 A No.

11 Q Have you talked to Dr Kent Carson?

12 A No.

13 Q Another thing I noted was I believe you
14 were sent what I'm going to mark as
15 Exhibit 11.

16 - - - - -

17 (Defendant's Exhibit 11
18 marked for identification.)

19 - - - - -

20 Q I believe Ms. Gurry prepared this, is
21 that correct? Did she prepare that or
22 did you prepare that?

23 A She prepared it.

24 Q And she says on here that her source was
25 a website drugs.com. Are you familiar

1 with that website?

2 A Not really.

3 Q Okay. Do you know whether that's a
4 reliable website to look up what side
5 effects are from a medication?

6 A It's not what I use.

7 Q What would you use?

8 A I have a lot of different websites I use.

9 Q What websites? If you are looking at
10 side effects of a medication, what do you
11 look at?

12 A Epocrates. Lexicomp. The Clinics in
13 Dermatology. Give me a moment. PubMed
14 ClinicalKey. Goodman & Gilman
15 Pharmacology. I think those are the
16 major ones.

17 Q All right. So if you were looking up
18 what potential side effects from
19 medication, would those be some of the
20 places you would look?

21 A The primary ones would be Epocrates or
22 Lexicomp.

23 Q Do you know off the top of your head what
24 are the side effects for an intralesional
25 steroid such as Kenalog?

1 A Pain, atrophy, discoloration. Those are
2 the major ones that I see.

3 Q As far as what is common versus uncommon
4 with Kenalog is pain common or uncommon?

5 A Not uncommon.

6 Q How about atrophy?

7 A Well, that's the primary reason you use
8 injectable Kenalog is to thin or decrease
9 scarring.

10 Q Okay. So is atrophy, then, a common
11 cause or side effect of a Kenalog
12 injection?

13 A Your purpose is to thin the skin. If you
14 do too much Kenalog, you will get
15 atrophy.

16 Q How about discoloration? Is that a
17 common side effect or is it uncommon?

18 A It's infrequent.

19 Q Going back to my question with Exhibit
20 11, it appears that Ms. Gurry has done
21 and put in red is what she contends are
22 side effects from a Kenalog injection
23 that she had. Do you see that where she
24 put those in red?

25 A Yes.

1 Q Okay. One thing I want to show you,
2 though, in Exhibit 12 is what I printed
3 off yesterday from Kenalog side effects,
4 the same exact website. Just take a look
5 at that.

6 - - - - -

7 (Defendant's Exhibit 12
8 marked for identification.)

9 - - - - -

10 Q Would you agree with that, first of all,
11 Exhibit 11 and Exhibit 12 are different?

12 A Yes.

13 Q Okay. And under where she has heading
14 where it says, "More common," you agree
15 that there is on Exhibit 12 a list that
16 says "More common." Do you see that?

17 A I do.

18 Q But then I want you to look at on Exhibit
19 12, there is one that says, "Incidence
20 not known."

21 A Correct.

22 Q Would you agree that on Ms. Gurry's list,
23 she has removed that heading that says,
24 "Incidence not known"?

25 A Yes.

1 MS. GURRY: Objection. You
2 don't know when I took this from the website.
3 And you said you took that yesterday, was it?
4 So websites can change. The source can
5 change. So that would need to be looked into.

6 MS. SCALISE: We can
7 definitely do that.

8 Q But again, you would agree that on
9 Exhibit 11, right here we have the list
10 that says, "Weight gain." The next one
11 says "Abdominal cramping and/or burning
12 severe."

13 So what's missing is the heading that
14 says, "Incidence not known," would you
15 agree with that?

16 A I see.

17 Q Do you agree that that's not on there?

18 A I see the difference.

19 Q Okay. No, on Exhibit 11, do you see that
20 there is a heading that Ms. Gurry wrote
21 that says, "Side effects." But do you
22 see in Exhibit 12, the heading is
23 actually "Incidence not known." Do you
24 see that?

25 A I see.

1 Q And then on Exhibit 11, she's got some
2 documents or some headings. Do you agree
3 that those headings and the way that they
4 appear are different than what is in
5 Exhibit 12?

6 A I see the difference.

7 Q Okay. So based on that, do you agree
8 that you really can't look at Exhibit 11
9 to say whether or not these truly are
10 side effects from the medication?

11 A I'd have to compare it to the medical
12 literature that I use.

13 Q But, again, in your education, experience
14 and training, the most common, or at
15 least the major side effects with the
16 Kenalog injection would be pain, atrophy
17 or discoloration, not all of the
18 different things that are enumerated in
19 Defendant's Exhibit 11?

20 A What we are saying is common and other
21 things that do occur. That doesn't mean
22 they are not part of that.

23 Q Okay. For a medication to receive FDA
24 approval, is it required by the
25 manufacturer to list every side effect

1 that any person in the clinical trial
2 ever had?

3 A Actually, from what I have seen, yes.

4 Q Okay. It be mean just because it's
5 listed, that that truly is a side effect
6 from a specific drug?

7 A But if you look at the way pharmaceutical
8 companies do their studies, if somebody
9 has any kind of side effect, even if it's
10 one side effect, they have to list it.

11 If somebody has conjunctivitis , if
12 somebody falls, they say "falls."

13 Anything has to be listed. If there is
14 depression. If somebody has suicidal
15 ideation. They have to put all of that
16 on there.

17 Q Okay. That could be just because that
18 particular one patient happened to have
19 that event, not necessarily from the
20 medication, but the fact that they got
21 that, the manufacturer is required to
22 list it, correct?

23 A They are required to list any adverse
24 effects that the people that do the study
25 note.

1 Q But it's not saying necessarily that that
2 is a causal relationship between the fall
3 and the medication, correct?

4 A That's what the FDA demands.

5 Q The FDA demands that they list it, but
6 there is not a determination that that
7 specifically is a cause, correct?

8 A Of course you can say that, but that
9 doesn't mean it's not. Because usually
10 we find out if, as we say, it comes out
11 in the wash when it goes for general
12 distribution.

13 Q And do you agree that, for example,
14 nausea is a side effect of lots of
15 different medications?

16 A Correct.

17 Q And, in fact, if you look at the
18 different lists that is on Defendant's
19 Exhibit 11, those would be side effects
20 that you could see with lots of other
21 medications, correct?

22 A Correct.

23 Q And are you aware that Ms. Gurry was also
24 on Metformin at the same time that she
25 had this injection?

1 A She was prescribed it at the time.

2 Q And you are aware that those side effects
3 of Metformin, most of those that are
4 listed by this drugs.com that she has
5 referenced, are very similar to the ones
6 for Kenalog?

7 A It's possible.

8 Q Were you, also, aware that she was on
9 Acyclovir?

10 A I wasn't aware she was using that.

11 Q Okay. And, in fact, can that also cause
12 many of the same symptomatology that she
13 is listing on Exhibit 11?

14 A It's possible.

15 Q All right. Before we get into all of
16 your opinions, let's take a break for a
17 second. I would caution you that in
18 South Carolina now that your deposition
19 has started, you are not able to talk to
20 Ms. Gurry or anyone about the case, about
21 your opinions, your testimony. Do you
22 understand that?

23 A I do.

24 Q So you are on your own until the end of
25 the day.

1 A Thank you.

2 (Whereupon, a brief recess was
3 taken.)

4 Q Doctor, when we left off, we were going
5 to now get into your opinions in this
6 case and what I'm interested in is where
7 you contend there were breaches of the
8 standard of care.

9 How do you define standard of care?

10 A It's what an average physician or
11 provider in the community, the activities
12 that are common to the profession.
13 Because it's really no longer a local
14 issue anymore. It's really national
15 what's common to the profession in
16 general.

17 Q So if somebody does something that's not
18 common, do you contend that's the breach
19 of the standard of care?

20 A Especially if it leads to harm.

21 Q Okay. Does it always have to lead to
22 harm?

23 A There are a lot of things, like
24 medications, that are prescribed that are
25 not FDA-approved indications, but they

1 are used that way, and that's not
2 considered to be below the standard of
3 care until it causes harm.

4 Q And do you agree that medical providers
5 can disagree with regard to opinions as
6 to what is the standard of care and what
7 isn't?

8 A They can agree, but that really doesn't
9 relate to reality. Because just because
10 it's your opinion it may not be
11 convenient, but we have to deal with
12 what's the best and safest for patient
13 care.

14 Q But do you agree that experts, and
15 clearly, you have been experienced as
16 being an expert witness, do you agree
17 that expert witnesses can disagree as to
18 whether or not standard of care has been
19 breached?

20 A They do all the time.

21 Q Yeah. Otherwise, we wouldn't have
22 lawsuits, correct?

23 A Correct.

24 Q In evaluating information, how do you
25 determine what is accurate versus

1 inaccurate?

2 A Could you define what you are saying?

3 Q Sure. Like if you have, for example, in
4 this case, you have got Ms. Gurry saying,
5 "Shannon Hussey said X," and then Shannon
6 Hussey says, "No, I didn't say X," how do
7 you determine which one to believe?

8 A I have to determine what the final result
9 was.

10 Q So do you base you're results oriented?

11 A I'm very results oriented. But, you
12 know, if somebody is hesitant to have a
13 procedure done if they would know in
14 advance that there is a potential for an
15 adverse effect, that would be a breach,
16 especially if it actually leads to
17 an adverse effect.

18 Q All right. Do you have any opinions as
19 to breaches of the standard of care on
20 the part of Dr. Richard Hussey?

21 A I don't think he actually did anything.

22 Q So you have no opinions as to breach of
23 standard of care on his part, correct?

24 A I could not see that he was active in
25 this.

1 Q I just want to make sure I'm clear.

2 So when we go to trial, you are not
3 going to get on the witness stand and
4 say, "Dr. Hussey breached the standard of
5 care by X, Y Z"?

6 A I saw nothing that Dr. Hussey did.

7 Q The answer is yes, you are not going to
8 say that he breached some standard of
9 care, correct?

10 A Correct. As far as I can tell, I could
11 find nothing that he breached it with.

12 Q Okay. The next one is the actual
13 practice itself.

14 Are there any practice breaches of
15 the standard of care that you found?

16 A I think the only breach in the standard
17 of care was the provider, Ms. Hussey.

18 Q Again, just so it's clear on the record,
19 at trial, you are not going to give
20 an opinion that there was some breach of
21 the standard of care on the part of the
22 practice, correct?

23 A I couldn't see that there was anything
24 related to the practice as such.

25 Q So is that a yes, you are not going to

1 say that?

2 A Yes.

3 Q Okay. Thank you.

4 So the only breaches of the standard
5 of care that you found were on the part
6 of Shannon Hussey, correct?

7 A Correct.

8 Q And are you able to list for me what the
9 breaches are, and then we can go through
10 that? Or how would you like to describe
11 what the breaches of the standard of care
12 are?

13 A I can start by listing and you will
14 probably have to cue me in about other
15 things that I may have missed.

16 Q Okay.

17 A I think the primary one is lack of
18 informed consent. She did not tell
19 Ms. Gurry that she would experience any
20 adverse effects, such as pain, such as
21 possibility of distortion of the wound
22 site, atrophy. Those are the primary
23 ones.

24 Q Okay. Is it your contention that pain,
25 as well as the possibility of distortion

1 of the wound site or atrophy were
2 required to be told to the plaintiff?

3 A I think if the plaintiff had any
4 indication that any of those would have
5 occurred, she would have not allowed the
6 procedure to go forward.

7 Q You are great at evading answers. Let me
8 go back to my original question.

9 My question was, is it your
10 contention that the standard of care
11 requires a medical provider to tell a
12 patient that side effects or risk of a
13 procedure, such as an intralesional
14 injection, include pain, or the
15 possibility of distortion of a wound
16 site/atrophy?

17 A Correct.

18 Q And is there anything that you are
19 relying on to say that that is the
20 standard of care, as far as those two
21 different things, pain, as well as the
22 possibility of distortion of the wound
23 site, that those are required to be told
24 to a patient for an intralesional steroid
25 injection?

1 A Patients need to know in advance that the
2 primary goal of the procedure is to
3 soften the tissue, and there will be some
4 atrophy. But if the patient had an idea
5 that there would be excessive atrophy,
6 they wouldn't allow the procedure to go
7 forward.

8 Q What are you basing that on that the
9 patient, and I assume you are meaning
10 Ms. Gurry, would not allow the procedure
11 to have gone forward if she had been
12 aware of atrophy?

13 A She had stated that in multiple
14 documents.

15 Q And these are documents that she has sent
16 to you that are in Exhibit 1?

17 A Correct. But any time you are dealing
18 with a patient, it makes no difference
19 what procedure you do with them. You
20 need to discuss with them what's going to
21 happen, and there is the possibility that
22 X, Y and Z can occur.

23 If you notice that a patient has any
24 hesitation about any of those potential
25 things, in all likelihood, you shouldn't

1 do the procedure. Not that they would
2 allow you to, but you shouldn't do it.

3 Q Before I get more into that, are there
4 any other breaches of the standard of
5 care?

6 A Yes. I feel that excessive
7 concentration was injected into the wound
8 site, deep in the wound site.

9 Q Any other opinions?

10 A Well, an excessive concentration of the
11 corticosteroid was injected and it led to
12 this. If there wasn't, if the right
13 amount of injection was used, then you
14 wouldn't have this result.

15 Q Any other opinions?

16 A No. I feel those are all what resulted
17 in the adverse effect.

18 Q Okay. Let's talk, then, about
19 intralesional steroids. As part of that
20 curriculum that you are teaching
21 dermatology residents, is there a section
22 in there on intralesional steroids?

23 A No. Just to know that they will learn
24 how to do it.

25 Q So is that something that you during the

1 residency training teach them how to do?

2 A Yes.

3 Q Tell me then what you teach about
4 intralesional steroids.

5 A The way to inject it, the concentration
6 to inject it, and what your objectives
7 are and what to avoid.

8 Q So I'm a first year resident. What do
9 you teach me?

10 A Okay. First of all, it really depends on
11 the thickness of the scar. If it's a
12 thin scar with minimal hypertrophy, you
13 inject just subcutaneously into the
14 dermis just enough to get a bleb.
15 Probably no more than 2.5 milligrams per
16 cc of corticosteroid and probably per
17 site only a drop of corticosteroid.

18 Q I'm sorry. Say that again, what you said
19 about the 2.5?

20 A 2.5 milligrams per cc in a very thin
21 scar, and you shouldn't inject more than
22 a drop at each site in the subcutaneous
23 -- into the dermis. Into the dermis.
24 Not subcutaneous tissue. You don't want
25 to do it into the epidermis because that

1 could lead too much thinning and lead to
2 necrosis.

3 Q So if it's not a minimally thick scar,
4 what is the next thing to do?

5 A If it's a thicker scar?

6 Q Yes, sir.

7 A If it's a thicker scar, you use a higher
8 concentration, but the same technique.
9 Only one drop into each site into the
10 dermis until you see a blanching of the
11 skin, if that much, or if the skin raises
12 up slightly.

13 Q And the concentration, how do you
14 determine the concentration?

15 A It depends on the thickness of the scar.
16 If it's a minimally thick scar, it's 2.5
17 milligrams per cc. If it's a moderately
18 thick scar, 5 milligrams per cc.

19 Q Where do you go to obtain these values?

20 A Experience.

21 Q So would you agree that there is nothing
22 in writing that says 2.5 milligrams
23 versus the 5 milligrams?

24 A Correct. There may be, but those are
25 used as guidelines.

1 Q So would you agree, then, that there are
2 other providers that might use different
3 amounts per cc?

4 A Sure. But it also depends on the
5 thickness of the scar.

6 Q So is it based on clinical judgment at
7 the time as to how much to inject?

8 A It's a matter of good sense. How thick
9 is the scar? If it's a minimally thick
10 scar, you don't want to inject too much.
11 For the concentration you don't want to
12 inject too much volume.

13 Q So again, I would rely on the clinical
14 judgment of the medical provider at the
15 time, correct?

16 A Correct.

17 Q And as far as we were talking about
18 intralesional steroid, is there another
19 name or trade name of the intralesional
20 steroid?

21 A The most common one used is
22 Triamcinolone.

23 Q Does it go by a trade name of Kenalog?

24 A That's a name.

25 Q Brand name. Is that the brand name for

1 that?

2 A That is one of the brand names.

3 Q Is Kenalog a brand that you use?

4 A Yes.

5 Q I have seen where it says Kenalog 10,
6 Kenalog 40. Is there any difference in
7 those?

8 A One is 10 milligrams per cc. The other
9 is 40 milligrams per cc.

10 Q Okay. And for a scar, can you use
11 Kenalog 10 and/or Kenalog 40?

12 A It depends on the way you are going to
13 dilute it.

14 Q Explain that to me.

15 A If it's a thin scar, you want to dilute
16 it to 2.5 milligrams per cc. If it's a
17 thicker scarring, you would use 5
18 milligrams per cc. But if it's a bolus
19 keloid, you can go up to 10 milligrams
20 per cc.

21 Q And how is the Kenalog diluted?

22 A It's diluted with normal saline.

23 Q Do you agree that even when the Kenalog
24 is appropriately diluted with normal
25 saline, that can still cause a little bit

1 of pain when it's being injected?

2 A It can.

3 Q And then as far as, I guess, on either
4 one of our exhibits, looking on Exhibit
5 5, can you show me where on Exhibit 5
6 where the needle is inserting the
7 Kenalog?

8 A Just under the epidermis.

9 Q Can you use this marker and kind of show
10 us the area where it's going to be
11 inserted. And this is on Exhibit 5.

12 A Into the dermis. You really don't want
13 to do it into the epidermis unless the
14 epidermis is really thick. You could
15 even do it here. It really depends.
16 It's a clinical decision based on the
17 thickness of the scar.

18 Q All right. And you have used this kind
19 of reddish pen on Exhibit 5 to draw kind
20 of two dots. And you were explaining the
21 lower dot is in the dermis area, and then
22 the upper dot is somewhere in the
23 epidermis. And it would all depend on
24 clinical decision and clinical judgment
25 at the time as to exactly where the

1 Kenalog is injected, correct?

2 A It depends on the thickness of the scar.

3 Q But again, that depends on clinical
4 judgment determining the thickness of the
5 scar?

6 A Correct.

7 Q So how is the thickness of the scar
8 determined?

9 A By experience.

10 Q Is there a size of needle that is
11 typically used in this injection?

12 A Most people use a 30-gauge needle.

13 Q And you also said that you teach the
14 residents about the objectives of the
15 intralesional steroids. What are the
16 objectives?

17 A To soften the scar but avoid atrophy.

18 Q Can there still be some atrophy even when
19 Kenalog is appropriately used and
20 injected?

21 A That's the definition. You are going to
22 cause atrophy of the scar. You are going
23 to soften the scar.

24 Q Okay. So by softening the scar, and
25 maybe as a lay person I'm not using the

1 right words, with atrophy is that always
2 going to mean softening or does that also
3 mean depression?

4 A You want to avoid a depression. That's a
5 catastrophe. That's a disaster.

6 Q So when you are explaining about the
7 informed consent and talking about the
8 possibility of atrophy, that's something
9 that you want, correct?

10 A There is gradations of it. You are
11 really not getting atrophy. You are
12 softening the scar.

13 If you've gotten to the point of
14 causing a gully, then you have had an
15 adverse reaction. You have caused a
16 problem that was not necessary.

17 Q How quickly would you expect to see
18 atrophy if an injection of Kenalog was
19 done improperly?

20 A It depends on the concentration. If
21 excessive concentration is used, then you
22 would see it occurring in about a week
23 starting and then it would progress.

24 Q For how long?

25 A How long would it progress?

1 Q Yes, sir.

2 A Probably at least a month. You would see
3 continued atrophy of the subcutaneous
4 tissue.

5 Q Where do you get that information to base
6 it that it would start in about a week
7 and progress for about a month?

8 A Clinical experience. The key is to avoid
9 using excessive concentration and
10 excessive volume in a place you shouldn't
11 be doing the injection.

12 Q What would be the indications to use
13 an intralesional steroid?

14 A To soften the scar.

15 Q How about if a scar is pulling or there
16 is tension on the scar? Would that be a
17 reason to use intralesional steroids?

18 A I don't think it's necessary.

19 Q If there is tension on a scar, will that
20 cause a scar to worsen?

21 A It will soften over time with the
22 remodeling of the underlying tissue.

23 Q So is it your testimony, then, that
24 pulling or tension on the scar is not an
25 indication for intralesional steroid?

1 A It's not necessary.

2 Q I hear you saying it's not necessary, but
3 are you saying that's not an indication?

4 A Correct. I don't think it's an
5 indication. The scar will loosen up over
6 time. There is something called the
7 modulus of elasticity. Over time the
8 tension forces on the skin will decrease,
9 and therefore, there will be less
10 sensation of tension.

11 Q And I believe we talked about earlier in
12 Dr. Masessa's operative report where he
13 described inelasticity of her skin. What
14 causes inelasticity?

15 A That's fairly common on legs, actually.
16 Especially worse below the knee. There
17 is a lot of inelasticity below the knee.
18 But it depends on --it's an individual
19 factor of matter.

20 Q So what causes the inelasticity on the
21 thigh?

22 A What's causing the skin to be tight?

23 Q Yes, sir.

24 A It could be that if the person is very
25 fit.

1 Q Meaning less fat, correct?

2 A Less fat is one factor.

3 Q What are the other factors?

4 A I think I'd really be getting into an
5 area that I can't give you a lot of good
6 factual information about.

7 Certainly, a person who is very fit,
8 good muscle tone. Things like that.

9 Q How about for hypertrophic scarring,
10 would that be a reason for intralesional
11 steroid?

12 A Yes.

13 Q And what is a hypertrophic scar?

14 A A thick scar. A scar that's thicker than
15 usual. There is an increase in
16 fibroblastic proliferation. Actually,
17 the scar rises up and expands over the
18 site past the actual excision site.

19 Q And in this case, what is your
20 understanding as to the indication for
21 the Kenalog injection?

22 A For a hypertrophic scar?

23 Q No, sir. With regard to Ms. Gurry?

24 A I don't think she had one.

25 Q So is your opinion and your contention

1 that there was no indication at all for
2 Kenalog to be injected into Ms. Gurry on
3 May 3rd, 2016?

4 A Correct. I don't think there was any
5 indication at the time of that visit.

6 Q And you would agree that you were not
7 present for that visit, correct?

8 A Correct.

9 - - - - -

10 (Defendant's Exhibit 13
11 marked for identification.)

12 - - - - -

13 Q I will show you what have I have marked
14 as Defendant's Exhibit 13, which, as I'm
15 sure, you have seen, correct?

16 A I have.

17 Q And do you see you've got the one that
18 shows the wording. Do you see where it's
19 described as a hypertrophic scar of
20 approximately 7 centimeters on the body
21 diagram?

22 A Yeah, I see it.

23 Q Okay. And then do you also see under
24 number three at the bottom, it says,
25 "Intralesional steroid to decrease

1 hypertrophy"?

2 A I do.

3 Q But you disagree with Ms. Hussey that
4 there was a hypertrophic scar?

5 A Yes.

6 Q What is the basis for that?

7 A It's based on the photos that I saw. And
8 there is no logic in needing to do
9 an injection so early in the healing
10 process. Absolutely no reasoning at all.

11 Q Okay. And is there a particular photo
12 that you are referencing to say that
13 there was no hypertrophy?

14 A In all of these photos I don't see any
15 hypertrophy. I could show you these.

16 Q I'm going to mark as Exhibit 14 these
17 pictures you are referencing.

18 - - - - -

19 (Defendant's Exhibit 14
20 marked for identification.)

21 - - - - -

22 Q So it's your contention that these photos
23 on Exhibit 14 do not show any evidence of
24 hypertrophy?

25 A No. I think these are adequately,

1 healing scars. I think they were fine.

2 I think time would be the best treatment
3 for these kind of scars.

4 Q And again, you are relying on Ms. Gurry
5 to have not altered the photos and to
6 have correctly put the dates beside them,
7 correct?

8 A Correct.

9 Q So if there was some alteration to the
10 photo or if the date is incorrect, that
11 would then change your opinion?

12 A I cannot attest to alterations of photos.

13 Q So you are not going to say because you
14 have not seen the original photos
15 themselves, correct?

16 A All I see is all I see.

17 Q Which is Exhibit 14?

18 A Correct.

19 Q Also, looking back at Exhibit 13, which
20 is the office visit of May 3rd, 2016, do
21 you see under the third line at the top,
22 it says, "Feels scar pulling. Feels
23 sutures are still in scar."

24 Do you see that?

25 A Yeah.

1 Q Is it your testimony that neither the
2 fact that the scar was pulling, or the
3 fact that there was a suture in the scar,
4 neither of those would be a reason for an
5 intralesional steroid?

6 A No indication at all.

7 Q Okay. You talked the informed consent,
8 and you said that there was no informed
9 consent. But do you see on Exhibit 13,
10 it says "Side effects reviewed"?

11 A Yeah.

12 Q So how do you, then, determine whether
13 side effects were reviewed or not
14 reviewed?

15 A Just because it's written doesn't mean it
16 occurred, but you don't know because it's
17 a situation in which two people say two
18 different things.

19 Q So how do you as an expert determine
20 which one to believe?

21 A Well, all I can tell you is it really
22 doesn't matter in this case because the
23 results speak for themselves.

24 And other thing that is really an
25 important thing with this issue is you

1 need to be able to read your patient.
2 And if you look at Ms. Gurry, you know
3 she has a very high aesthetic acuity.
4 She's very sensitive about all of these
5 issues. If you know her, you can read
6 her. It just takes a second to read her.
7 You would know you don't want to be doing
8 anything invasive in her unless it's a
9 hundred percent necessary. I mean, it's
10 loud and clear to me.

11 And I think Ms. Hussey made a
12 catastrophic error in not being able to
13 read her patient, knowing there are some
14 things you do not do procedures on.

15 Q Okay. Going back to the informed
16 consent, do you agree that the informed
17 consent can be oral and it doesn't have
18 to be in writing?

19 A Correct.

20 Q And based on the information that
21 Ms. Gurry has provided you and in some of
22 her statements, do you agree that at
23 least in the information she's told to
24 you, that as the injection started, that
25 she felt some pain? Do you recall that?

1 A I do.

2 Q All right. And did Ms. Gurry say, "Stop,
3 don't do anything more"?

4 A Not that I know of.

5 Q So, in fact, even if allegedly Ms. Hussey
6 had not said anything or warned her that
7 this could be painful, do you agree that
8 Ms. Gurry still opted to continue with
9 the injection even if it was painful?

10 A She didn't say anything. But you also
11 know in dealing with patients, that
12 sometimes things may be going wrong, the
13 patient knows something is going wrong
14 but they won't say anything because they
15 are in a state of shock.

16 Q Do you have any evidence that Ms. Gurry
17 was in a state of shock on May the 3rd,
18 2016?

19 A I do not.

20 Q Okay. But again, if truly hearing that
21 this was going to be painful would have
22 stopped her from having this injection,
23 do you agree that based on the
24 information she has provided to you that
25 as it started, as it was painful she

1 didn't tell anybody to stop?

2 A Correct.

3 Q Okay. So, in fact, she would have still
4 proceeded with the injection even if she
5 had been told it was painful?

6 A Could you repeat that?

7 Q Sure. It's my understanding from your
8 testimony that you don't believe informed
9 consent was given, correct?

10 A I think that is totally correct based on
11 the nature of the patient.

12 Q But we do know based on Ms. Gurry's own
13 admission through the documents that she
14 has given to you, that as this injection
15 started, she thought it was painful, but
16 yet, she still allowed it to proceed,
17 correct?

18 A That happened.

19 Q All right. So wouldn't you agree that
20 even if she had been told by Shannon
21 Hussey that this could be painful, that
22 she would have still proceeded with the
23 injection?

24 A No. We are talking about to two totally
25 separate things.

1 Q And how is that separate?

2 A On is if she was told -- she had said
3 many times -- if she was told she knew
4 there would be side effects such as pain,
5 she wouldn't have allowed that to occur.

6 Q But we know from her own documents that
7 she sent to you that she experienced pain
8 and she didn't make it stop, correct?

9 A That's correct. But this is not unusual.
10 Some people are just in a state of kind
11 of shock or not knowing how to respond.
12 This is not unusual at all. I have seen
13 it a lot of times where people won't say
14 no because their voice is gone for that
15 time.

16 Q All right. And as far as the atrophy, I
17 think you have explained that given the
18 correct amount of injection, typically
19 you are not going to see a deep
20 depression or anything as to what
21 Ms. Gurry currently experienced, correct?

22 A Correct.

23 Q So you would agree, then, that if she had
24 been told there could be some atrophy,
25 that you have no evidence that she would

1 have said, "No, I don't want to have it
2 because there might be a little bit of a
3 scar thing," correct?

4 A There is no evidence.

5 Q Let's talk with your opinion with regard
6 to the concentration. What is your
7 understanding as to the amount of Kenalog
8 that Ms. Hussey injected?

9 A The amount of Kenalog injected, according
10 to her documentation, was 3.3 milligrams
11 per cc. Approximately, it would have
12 been 3.3 milligrams per cc.

13 Q Okay. And you are basing that on Exhibit
14 13?

15 A I think it was the Interrogatory. I'm
16 just trying to see. There is not enough
17 information here. It would have to be
18 the Interrogatory.

19 Q So you don't see at the bottom where it
20 says, "TAC 0.3 percent"?

21 A At the bottom you say? Oh, yeah. I say
22 0.3. Yeah, I see that. I'm sorry. But
23 the clearer explanation was in the
24 Interrogatory.

25 Q Okay. But your testimony is 3.3 was too

1 much. It should have been 2.5?

2 A I doubt if that was the truth. I really
3 do.

4 Q Why do you doubt that?

5 A I have never seen such a catastrophic
6 result if the correct concentration and
7 correct volume were administered. Never.

8 Q So, in essence, you are saying the thing
9 speaks for itself? The fact that she has
10 this injury, it must mean Shannon Hussey
11 something wrong?

12 A Is that called Res ipsa loquitur?

13 Q Yes. So is that your contention?

14 A Yes.

15 Q So the fact of how it looks like now, it
16 has to mean that Shannon did something
17 wrong?

18 A Correct.

19 Q But if, in fact, she did administer 3.3
20 milligrams per cc, would that be an
21 appropriate amount for a hypertrophic
22 scar?

23 A It would be an appropriate amount if it
24 was injected properly. But I think a
25 higher concentration was -- what I see

1 there is when you see all of the systemic
2 side effects and everything like that,
3 I'm more inclined to think of 40
4 milligrams totally injected into the
5 area.

6 Q What I want to know is at least based on
7 how she has it documented, would that be
8 an appropriate amount to inject into a
9 hypertrophic scar?

10 A That would be an appropriate
11 concentration into a hypertrophic scar,
12 which this wasn't.

13 Q And with that appropriate amount to
14 inject, would you agree that you would
15 not expect to see any type of atrophy,
16 certainly not to the extent of what
17 Ms. Gurry has?

18 A Yeah. You wouldn't expect to see it if
19 it was appropriately administered with
20 the right concentration with the correct
21 volume in the correct location.

22 Q All right. And as far as the location,
23 do you have any evidence that it was not
24 appropriately administered into the
25 correct location?

1 A The only evidence is the result.

2 Q But as far as how Ms. Hussey has
3 described how she did that injection,
4 that would be an appropriate method and
5 location as to how she injected it?

6 A Well, she really didn't say where she
7 injected it. That's one problem.

8 So when you see what's written down,
9 yeah, I could see that would be
10 acceptable, but I don't believe it.

11 Q How many times have you injected Kenalog
12 into a scar?

13 A How many times?

14 Q Yes, sir.

15 A Hundreds, if not thousands of times.

16 Q And during all of those times that you
17 have injected Kenalog, have you ever
18 heard any atrophy or depression?

19 A Thank God, no.

20 Q So none at all? It's skin has always
21 remained the same surface level as the
22 surrounding skin?

23 A I've always been conservative when it
24 comes to injecting.

25 Q So is the answer no, you have never had

1 any depressions?

2 A I have never had any depressions. Thank
3 goodness.

4 Q So you would agree with me, then, that a
5 depression would be very rare to have
6 with a Kenalog injection?

7 A It's a major adverse effect.

8 Q But is it rare?

9 A It's infrequent. But you can't say it's
10 not going to happen when an improper
11 amount of concentration of medication is
12 injected also improperly with the
13 improper volume of medication.

14 Q Okay. So again, let me go back to that.
15 If it was injected properly in the
16 properly location, the properly volume,
17 et cetera, all that you said, but if it
18 as proper, then you would not expect to
19 see atrophy, correct?

20 A Correct. And she used one cc from what I
21 saw. One cc. Even with what I saw, if
22 it would have occurred the way she says
23 it happened, it was too much to inject.
24 Way too much. Excessive. Even with the
25 proper concentration.

1 Q And how is that too much to inject?

2 A When you see the location and the areas
3 that were injected, if you were going to
4 inject the area, you would only inject a
5 small area of the scar. A procedure that
6 was totally unnecessary because that
7 would have resolved by itself over the
8 next year.

9 Q How about the pulling of the skin?

10 A It doesn't matter. It doesn't matter.

11 Q Could the pulling of the skin have
12 actually, or at least the pulling
13 sensation, could that have been the
14 sutures from the epidermis and dermal
15 layers actually coming apart?

16 A No. If it would come apart, you would
17 feel a relaxation. You would feel
18 relaxation, not pulling. No, that
19 definitely would never have happened.

20 Pulling means that you are going
21 through the process of wound healing, and
22 that would have resolved over time just
23 by itself by doing nothing.

24 Q And if Ms. Hussey had determined, "Hey, I
25 put too much," is there a way to retract

1 it back?

2 A No.

3 Q So once it's there, the damage is done?

4 A You've got it. Anything else you inject
5 would only magnify the degree of damage.

6 If you injected anything else, you'd
7 probably end up with necrosis, which
8 would be another major disaster.

9 Q So why would it not cause necrosis here?

10 A Because if you inject too much into the
11 epidermis, you are increasing the risk of
12 necrosis. If you injected into the
13 dermis the proper amount, the proper
14 concentration, you are not going to get
15 necrosis.

16 Q But if you inject too much and/or an
17 improper concentration, wouldn't you have
18 necrosis?

19 A If it's too superficial into the
20 epidermis and you are getting it leaching
21 through the surrounding tissue.

22 Q Okay. If it's not an epidermal layer but
23 it's in the dermal, aren't you going to
24 have necrosis there?

25 A If you inject too much, too high a

1 concentration, you could. But it's based
2 on a person who knows what they are doing
3 who does it correctly.

4 Q It's my understanding your testimony is
5 Ms. Hussey injected too much, too high of
6 a concentration, wrong location, all of
7 that. So that's what I'm trying to find
8 out is where is the necrosis?

9 A There wasn't any.

10 Q So why would there not be necrosis if
11 truly this is too much and/or the wrong
12 concentration?

13 A If you are injecting deep into the skin,
14 into the deep dermis, subcutaneous fat,
15 then you are having the medication being
16 directed throughout, which could go into
17 blood vessels, lymphatic vessels,
18 anything else imaginable.

19 Basically necrosis usually results
20 from a circulation being disturbed. If
21 you cut off the circulation one way or
22 another, the tissue dies.

23 Q So you would agree there is no evidence
24 of any necrosis here?

25 A No.

1 Q No, there is?

2 A No, there is not any evidence of
3 necrosis.

4 Q And there is no evidence of the injection
5 being down into the lymphatics?

6 A Well, something is going to go into the
7 lymphatics if you inject it deeply.

8 Q But is there any evidence this injection
9 was a deep injection?

10 A There was evidence that it was injected
11 improperly, which is deeper than it
12 probably should have been.

13 Q So looking at Exhibit 5, can you give
14 an opinion as to where this injection was
15 located?

16 A I can't give you an opinion, but I can
17 tell you it was injected in the wrong
18 place, too high of volume, too high of
19 concentration, because the result speaks
20 for itself.

21 Q So again, getting back to the fact she
22 has got what she has now, there was
23 something going on wrong by nurse Hussey?

24 A There was no problem prior to the
25 injections. After the injection,

1 everything went wrong. It became a
2 catastrophic event.

3 Q What are you basing that on, that after
4 this injection, quote, "Everything went
5 wrong"?

6 A There was no problem. The wound was
7 healing perfectly naturally prior to the
8 injection. After the injection, atrophy
9 started to occur. She had systemic side
10 effects. A lot of the systemic side
11 effects are comparable to the results of
12 corticosteroid.

13 Q That's why I asked if you had read the
14 endocrinologist, Ms. LaRochelle's
15 deposition, and you said you had not?

16 A Correct.

17 Q Her testimony is none of the side effects
18 that Ms. Gurry has were caused by this
19 intralesional steroid. So I'm wondering
20 --

21 MS. GURRY: Objection.
22 That's not properly stated. Objection.

23 Q So would you agree you would have to
24 defer to an endocrinologist as to whether
25 the side effects were related to an

1 intralesional a injection?

2 A No. What I would have to do is read the
3 deposition of the endocrinologist so I
4 know all the facts rather than just
5 conjecture from a few snippets in
6 sentences.

7 Q But even with that, you would have to be
8 deferring to what she said, correct, or
9 any endocrinologist?

10 A I would only defer to what
11 endocrinologist knows, but that doesn't
12 mean I may not find fault with what they
13 say because I need to be able to say -- I
14 need to see the entire picture of what
15 the endocrinologist said.

16 Q As a dermatologist, do you have the
17 education and experience and training to
18 even comment on those topics?

19 A You are asking me to compare what the
20 endocrinologist is saying and I can't
21 make any comment on what the
22 endocrinologist said because I don't have
23 information.

24 Q Okay. That's what I want to know.
25 Ms. Gurry is claiming lots of different

1 things that occurred to her as a result
2 of this injection. That's what I'm
3 wondering. Do you have the experience,
4 education and training to give legal
5 opinions and medical opinions as to
6 whether those results were due to this
7 injection versus something else?

8 A It is not uncommon for a lot of --

9 Q Yes or no?

10 A I can't say no because it is not uncommon
11 for her side effects, a lot of the side
12 effects to be associated with the adverse
13 effect of a corticosteroid systemically
14 administered.

15 Q I guess that's key. Your opinion is this
16 was a systemic corticosteroid or a local
17 corticosteroid?

18 A It was locally injected but it was
19 systemically experienced.

20 Q And explain to me what you mean by that.

21 A Well, she did have local effect because
22 it was injected too deep or with too high
23 of a concentration, too high of a volume.
24 That goes to say that this would be more
25 into the blood and lymphatic vessels, and

1 therefore, you would have a systemic
2 effect.

3 It's just like if you give somebody
4 an injection into a muscle, that's a
5 local injection; however, you are getting
6 a systemic effect.

7 Q And this is where I need to know whether
8 you can give opinion testimony on this or
9 if that needs to be deferred.

10 The question is, how quickly would
11 you see a systemic effect from a
12 corticosteroid?

13 A Well, my experience with -- I give a lot
14 of injectable corticosteroids in muscle.
15 I do that five, six times a week. And
16 normally, I will tell my patient they
17 will see the results of that within 48
18 hours.

19 Q And how long does is that going to last?

20 A A month.

21 Q But after a month, they should not be
22 having any more systemic side effects
23 from that corticosteroid that's been
24 injected into the muscle?

25 A But they will be feeling that in the --

1 Q Is that yes or no?

2 A You are going to have to repeat that
3 question.

4 MS. SCALISE: Would you
5 read it back to him, please.

6 (Record read.)

7 A Yes, they can. Because I've had people
8 have the effects of corticosteroids for
9 at least two months.

10 Q Well, that's my next question. In your
11 opinion, the maximum amount of time that
12 someone should experience side effects
13 from an excessive dose of corticosteroids
14 is, at most, two months or three months?

15 A I can't say that. Because there can be
16 associated structural changes which may
17 have long-lasting effects.

18 Q What type of associated structural
19 changes are you referring to?

20 A We are talking about blood sugar changes
21 for sure, changes in bone exacerbating
22 bony defects or problems. Similar things
23 to that.

24 Q Have any of your patients ever
25 experienced any side effects from

1 corticosteroids greater than two or three
2 months after an injection?

3 A Yes. When they had bony destruction, it
4 make them lose a few inches of height.

5 Q How many patients would that have been?

6 A It could have been about three.

7 Q And in those patients, the only long-term
8 effect you saw or experienced by those
9 patient was that they lost a few inches
10 of height?

11 A And problems with hips. Those are the
12 only ones I can remember.

13 Q Have you seen in any of the medical
14 records you have been provided that any
15 medical provider has said Ms. Gurry has
16 experienced a loss in height or any with
17 her hips as a result of this particular
18 intralesional steroid injection?

19 A I don't recall any medical provider. I
20 can't think of any medical provider at
21 this moment.

22 Q I will also submit to you that
23 Dr. LaRoche testified as far as
24 osteopenia, that that was genetic for
25 Ms. Gurry and not related to the

1 intralesional steroids. Do you have any
2 reason to dispute that or doubt that?

3 A It's not my area of expertise, but I
4 would want a third opinion.

5 Q Okay. But again, you would not be able
6 to offer that kind of opinion, correct?

7 A Correct.

8 Q As far as thyroid and effects on the
9 thyroid, would you agree you would not be
10 educated, trained or experienced to offer
11 opinions as to whether this intralesional
12 steroid injection affected her thyroid?

13 A Correct.

14 Q And the same thing, you would have no
15 experience, education or training to
16 offer any opinions as to whether this
17 affected her adrenal gland?

18 A It's not my opinion.

19 MS. GURRY: Well, I'm going
20 to leave. It's fine to continue on. Great to
21 meet you.

22 MS. SCALISE: So you are
23 leaving?

24 MS. GURRY: Yeah, I am.

25 MS. SCALISE: You are

1 leaving the deposition?

2 MS. GURRY: I apologize.

3 MS. SCALISE: Okay. I want
4 to make sure it's clear on the record that
5 this is your expert deposition and you are
6 going to leave the deposition?

7 MS. GURRY: I feel
8 confident. I'd like to stay, but I need to
9 get back to my business. I didn't think that
10 it was going go into all of this. Great to
11 meet you, doctor.

12 Q Also, as far as an iliotibial band and
13 any effects on that, is it also fair to
14 say that you cannot offer any opinions
15 because you have no education, experience
16 or training as to whether an
17 intralesional steroid injection would
18 affect an iliotibial band?

19 A It's not my experience.

20 Q So you are not going to offer any
21 opinions, correct?

22 A I cannot.

23 Q Doctor, also, I believe you were sent an
24 evaluation that she had by a
25 psychiatrist. Did you see that?

1 A I did.

2 Q And did you see where he documented how
3 she was obsessing about this scar?

4 A I never saw the words "obsessing" about
5 the scar. I never saw that.

6 Q This is Dr. Oduwole. O-D-U-W-O-L-E.

7 A I've got the material here, but it's only
8 three pages and nothing else regarding
9 that. I just see that it's a
10 documentation that she was diagnosed with
11 major depression disorder single episode,
12 generalized anxiety disorder, rule out
13 PTSD, rule out bipolar depression.
14 That's all I have.

15 Q He wanted to rule out bipolar disorder?

16 A Rule out bipolar disorder.

17 Q He prescribed Zoloft, is that correct?

18 A He did prescribe Zoloft.

19 Q I'm not able to find any pharmacy record
20 where she ever got any Zoloft filled.
21 You are not aware that she ever went back
22 to see the psychiatrist, is that fair to
23 say?

24 A I am not aware.

25 Q There are some handwritten psychiatric

1 evaluation records. I'm just going to
2 show you this. One for the record, it's
3 Bates stamp Community Behavioral Health,
4 page 4. And do you see where under
5 "Content of thought," he's got marked
6 "obsession"?

7 A I do.

8 Q Are you aware that Ms. Gurry has
9 metastatic melanoma?

10 A No.

11 Q Are you aware that she had later a lymph
12 node removed that was positive for
13 cancer?

14 A I have no documentation of that at all.

15 Q If she has got cancer in her lymph nodes,
16 how does that affect her life expectancy?

17 A It decreases her life expectancy.

18 Q Are you going to be offering any opinions
19 at trial as to what stage of cancer she
20 has, what life expectancy, anything like
21 that?

22 A No.

23 Q I assume you have treated patients with
24 metastatic melanoma?

25 A Yes.

1 Q Have you found in your experience with
2 those patients that some patients focus
3 on their disease and some don't?

4 A Correct.

5 Q And could it be here in this case that
6 Ms. Gurry is focused on this scar and the
7 atrophy that she has rather than dealing
8 with her metastatic melanoma?

9 A I can't comment on it.

10 Q If Ms. Gurry has, as we saw from the
11 record from her psychiatrist, that she
12 had been prescribed Zoloft, if she is not
13 taking the anti-depressant or
14 anti-anxiety, would that increase someone
15 else's depression and/or anxiety?

16 A I can't comment on that.

17 Q Just because that's outside of your area
18 of expertise?

19 A It is.

20 Q In Exhibit 11, that was the list of
21 various side effects that Ms. Gurry has
22 kind of highlighted in red as things she
23 has experienced. Are you able to say
24 whether any of these are specifically due
25 to the Kenalog injection as compared to

1 any other medical issues she may have?

2 A May I?

3 Q Sure.

4 A No. All I can really comment on
5 specifically is the adverse effect of the
6 injection locally.

7 Q And so that adverse effect was the
8 atrophy that you are referencing?

9 A Yes. And all of the results thereof.

10 Q So what other results thereof are you
11 referencing?

12 A Well, with atrophy, you have loss of
13 subcutaneous tissue and anatomic
14 components in that area.

15 Q What anatomic components in that area are
16 you going to contend were lost or damaged
17 or injured as a result of the Kenalog
18 injection?

19 A A loss of adipose tissue.

20 Q And that's it?

21 A Thinning of the skin.

22 Q Anything else?

23 A No, not right now.

24 Q Okay. As far as that loss of adipose
25 tissue, if she had some of the adipose

1 tissue already lost from the melanoma
2 excision, then you would agree there
3 would be no additional adipose tissue
4 that was lost because of the Kenalog,
5 correct?

6 A There was no indication that she had
7 substantial loss of subcutaneous fat as a
8 result of the procedure. The changes
9 occurred after the injection.

10 Q Are you able to piece together or tell
11 when those changes occurred after the
12 injection?

13 A They began to occur within a week or two.

14 Q What are you basing that on?

15 A I would have to see the photo.

16 Q Let me mark it as Exhibit 15.

17 - - - - -

18 (Defendant's Exhibit 15
19 marked for identification.)

20 - - - - -

21 Q I will show you what we marked as Exhibit
22 15. Is that what you are referencing?

23 A Yes. I really can't say too much with
24 May 14th, but certainly, in July and
25 August it's really obvious.

1 Q What I wondered is in looking on Exhibit
2 15, the photo at the top, she has marked
3 it as saying, "The day after the
4 injection," and that this supposedly was
5 taken on May the 4th, 2016. And just
6 looking at that photo, does it appear
7 that there was an excessive amount of
8 Kenalog injected based on just the photo
9 itself?

10 A I can't make that opinion based on the
11 photo itself, the way I see it.

12 Q Okay. So you can't say one way or the
13 other whether it's excessive or whether
14 it's an appropriate amount?

15 A The way the photo appears to me, I can't
16 make a judgment.

17 Q So what do you mean by that?

18 A I don't see a lot of changes. But on May
19 14th, I see what begins to look like
20 stria, S-T-R-I-A, and more prominent
21 blood vessels.

22 Q Wouldn't that also depend on the lighting
23 of that particular photo as to whether
24 you see blood vessels or not?

25 A I can only make that opinion based on

1 what I see with this. I can't comment on
2 photographic technique.

3 Q So even with the photo on May 14th, would
4 it also depend on what kind of lighting
5 was used when that photo was taken as to
6 what you see or don't see, correct?

7 A I can't make a comment on photographic
8 technique. I'm not an expert in that.

9 Q But even as far as May 14th, do you agree
10 that there is nothing about that photo
11 that would indicate some excessive amount
12 of Kenalog had been injected?

13 A I can't make that judgment right now with
14 just what I see. It's just not clear
15 enough to me.

16 Q Okay. But would it be consistent with
17 the amount that Ms. Hussey is claiming
18 she injected, would that be consistent
19 with how that would be appear 11 days
20 after an injection?

21 A I can't make a comment on that. I can
22 say that if this was done tangentially,
23 the photo on May 14th, then I probably
24 could make a better opinion.

25 Q What do you mean if it was done

1 tangentially?

2 A Instead of looking down at the side, I'd
3 have a much better idea of what's really
4 happening if I'm looking at it this way.
5 If I'm looking at it this way, I can't
6 make a judgment. I could hypothesize
7 anything at that point.

8 Q Just for purposes of our transcript, you
9 are saying that if, in essence, Ms. Gurry
10 was laying down and you could look
11 basically over and above that site, you
12 could give an opinion, but simply based
13 on the photos and the way they are taken,
14 you can't give an opinion one way or
15 another?

16 A Not with the May 14th photo.

17 Q And were you aware on Defendant's Exhibit
18 13, that it looks like the patient called
19 Myrtle Beach Dermatology, and that
20 Dr. Hussey had asked her to come in for
21 an evaluation?

22 A I was aware of that.

23 Q Okay. And are you aware that she did not
24 come in for the evaluation?

25 A I'm aware of that.

1 Q Okay. Has she explained or said to you
2 why she did not come in for that
3 evaluation?

4 A No.

5 Q Are you aware that she did not see any
6 kind of medical provider until the middle
7 of June? I think it was June 16th, 2016,
8 which was over six weeks later?

9 A I don't have the date. What was the
10 provider?

11 Q Saria, S-A-R-I-A, Almo, A-L-M-O. She's a
12 physician assistant.

13 A I've got it somewhere. I remember she
14 saw a provider Alamo.

15 Q Okay. I guess based on your
16 interaction that you have had with
17 Ms. Gurry if truly she were having all of
18 these complaints from the time of the
19 injection forward, would you have
20 expected based on your interactions with
21 her, that she would have sought some kind
22 of interaction or evaluation by medical
23 providers to see what was going on?

24 A That's why she saw provider Alamo, is
25 that correct?

1 Q That's six weeks later. If, truly, she
2 is having all of these issues from the
3 beginning, wouldn't you have expected her
4 to have gone to some medical provider to
5 see what was causing all of this?

6 A I would have expected it, yes.

7 Q Kind of with the advent of the Internet,
8 have you had patients who read things on
9 the Internet and basically self-diagnose
10 themselves?

11 A Always.

12 Q Do you believe in any way of this, that
13 Ms. Gurry has gone on the Internet and
14 basically convinced herself that what
15 issues she has were all related to that
16 Kenalog injection?

17 A I can't make that opinion.

18 Q Just one way or the other you cannot say?

19 A I cannot say.

20 Q And other than the localized issues that
21 you discussed, which was the atrophy and
22 the loss of subcutaneous tissue, is it
23 fair to say you are not going to come to
24 trial and say that the injection caused
25 any other issues or problems for

1 Ms. Gurry?

2 A Systemically?

3 Q Other than this atrophy and this loss of
4 subcutaneous tissue?

5 A I think that would be what I would
6 probably be the most comfortable to
7 discuss.

8 Q At trial you are not going to give
9 an opinion that the injection caused
10 anything else other than atrophy and loss
11 of subcutaneous tissue?

12 A That's what I'm going to say.

13 Q Thank you.

14 As far as now that she has this issue
15 that you have evaluated and looked at
16 this morning, is there anything that can
17 be done for that area on her thigh?

18 A Sure.

19 Q What can be done?

20 A Scar revision, excise the surrounding
21 tissues, injecting fatty tissue, fat
22 transplantation. I think that's all.

23 Q And are you aware that she went to a
24 plastic surgeon who made that
25 recommendation, but yet, she hasn't had

1 it done?

2 A I'm not aware of that.

3 Q Okay. Has she said why she hasn't had
4 this done?

5 A I'm not aware of any of that.

6 Q I think it's fair to say you haven't been
7 provided with any of her pretreatment
8 records to show what kind of medical
9 issues she had prior to the injection,
10 correct?

11 A All I have is what's in here.

12 Q Okay. But nothing prior to that? I've
13 got three volumes of records, which you
14 agree is significantly more than what you
15 have been provided, correct?

16 A Correct.

17 Q If, in fact, hypothetically, the
18 epidermal and dermal layers separated
19 underneath this suture line, would you
20 agree that that could explain why she has
21 this depression in her leg?

22 A I don't think so.

23 Q So with those circumstances that wouldn't
24 explain this?

25 A It would have happened before the

1 injection.

2 Q Have you had any instances where a
3 patient has had some type of excision in
4 their leg where a section of the leg has
5 been removed, including the epidermis
6 around dermal layers, that, then, have
7 gone onto cause a depression in the leg?

8 A No. The only time I have ever seen
9 depressions in the leg is when somebody
10 had a graft.

11 Q How much have you been paid thus far from
12 this case?

13 A \$2,500 from Ms. Gurry and \$2,500 from
14 you.

15 Q My \$2,500 was the charge that you had for
16 your deposition?

17 A Correct.

18 Q And as far as the \$2,500 that you charged
19 Ms. Gurry, what all did that encompass?

20 A Evaluation of records and communication.

21 Q Has there been any additional work done
22 since you have, I guess used up that
23 \$2,500 retainer? Has there been any time
24 you haven't billed her for?

25 A I have not billed additional time.

1 Q How much additional time do you have on
2 this case?

3 A I think it's maxed out. And there is no
4 additional time as of yet.

5 Q Meaning that the \$2,500, that has covered
6 everything for Ms. Gurry up until coming
7 into your deposition?

8 A It has.

9 Q For trial how much do you charge to
10 travel to South Carolina for trial?

11 A \$500 an hour port to port.

12 Q Let's say you leave at 4:00 on one day
13 and you get to Conway, you testify that
14 next day, and then you come back. Is it
15 from the time you leave on one day until
16 the time you get back to your house?

17 A Correct.

18 Q One thing, doctor. If you change, alter,
19 amendment, add to any of your opinions,
20 will you agree to let me know about that
21 prior to trial?

22 A Of course.

23 Q Do you agree that it's only fair for my
24 clients if we go into that courtroom,
25 that I know all of your opinions?

1 A Correct.

2 Q Have we discussed all of your opinions
3 in this case?

4 A Yes.

5 Q Okay. So is there any question that I
6 have asked you that you haven't
7 understood or you haven't fully answered?

8 A We have discussed all of my opinions up
9 to this point. However, if new
10 information comes to light, then my
11 opinion can change.

12 Q Okay. That's what I wanted to know. So
13 if you do review new information, or you
14 are just sitting there at your house and
15 you think of new opinions, will you let
16 me know so that I can re-depose you on
17 that?

18 A Yes.

19 Q And typically, I would say let the other
20 party know so they can let me know, but
21 because of the circumstances we are
22 involved in, it would probably be best if
23 you let me and Ms. Gurry know at the same
24 time just so she's not having to try to
25 track me down to let me know that you

1 have no opinions.

2 A It's my obligation that I funnel it
3 through her.

4 Q Yes. You funnel to her what your new
5 opinions are, and I'm just going to have
6 to trust that she's going to let me know
7 what the new opinions are prior to us
8 going to the courtroom.

9 A I would just feel uncomfortable breaching
10 protocol.

11 Q This is just an unusual case.

12 Have there been any other cases where
13 you have had a pro se plaintiff?

14 A Oh, yeah.

15 Q How many other pro se plaintiffs have you
16 taken?

17 A This is the third one. The first one
18 ended in trial in northern Kentucky.
19 Florence, Kentucky.

20 Q What was that case about?

21 A A woman, who had a misdiagnosed or
22 failure to diagnosis a basal cell
23 carcinoma. Yeah, that's what it was
24 about.

25 And then I had another one recently,

1 a gentleman was wanting to act as his own
2 attorney regarding a bad result
3 cosmetically, but I backed out of that
4 one because I didn't feel that I could
5 get along with the client.

6 Q With regard to this one case in Kentucky
7 that went to trial for the pro se person,
8 what was the verdict in that one?

9 A It was found for the defense.

10 Q I believe that you were also sent the
11 affidavits of my experts. She's not
12 taken any depositions yet, but they are
13 Dr. Bibb, a Dr. Purvis, who are both
14 dermatologists, and then I had a
15 Dr. Mikol, who is an orthopedic. Do you
16 recall reading those?

17 A I received the ones from Bibb and Purvis,
18 not from Mikol.

19 Q The one for, I think Dr. Bibb and
20 Dr. Purvis, did you read in those where
21 they found that Shannon Hussey met the
22 appropriate standard of care?

23 A That was their opinion.

24 Q Yes, sir. And did you, also, see where
25 they did not believe that informed

1 consent needed to be given for this
2 injection?

3 A I read that.

4 Q But you disagree?

5 A I feel there should be at least a verbal
6 informing of informed consent.

7 Q Just so I'm clear, I'm like the patient,
8 and you are going to give me an
9 intralesional steroid injection. To give
10 me informed consent, what would you say
11 to be in compliance with the standard of
12 care?

13 A I would say if we are talking about
14 injecting into a scar, I would say
15 normally you are going to feel some
16 discomfort. The objective of this is to
17 soften and flatten the scar. There is a
18 slight possibility that there may be
19 excessive thinning of the skin and
20 flattening of the skin. But I think
21 that's pretty much all I would say.

22 Q So the thinning and flattening of the
23 skin, does that imply a depression?

24 A No, absolutely not. We want to avoid
25 that at all costs. Because patients will

1 tell me if that occurs, "This isn't what
2 I wanted."

3 Q And so you would agree that even doing
4 things correctly and appropriately,
5 sometimes bad things happen to patients,
6 correct?

7 A Yes. And I think really the most
8 important thing in patient care that
9 every physician will learn is to read
10 your patient. Certain people should not
11 have procedures done.

12 Q So what about Ms. Gurry would cause
13 someone not to do a procedure?

14 A Just by talking to her you see she has
15 what we call a high aesthetic acuity.
16 She's very sensitive to her total body
17 and its appearance. And as a result, you
18 shouldn't do a procedure on somebody like
19 that unless you feel highly comfortable
20 that you can give the results you are
21 suggesting you can give. In those kinds
22 of cases, if you have the slightest
23 hesitation, it's better to refer to
24 another person.

25 Q Is it possible that Shannon Hussey gave

1 an appropriate amount in the correct
2 location using the correct technique, and
3 for whatever reason, Ms. Gurry just had a
4 very bad outcome from it?

5 A I can't see it.

6 Q So you think it had to have been she did
7 something improper?

8 A The result was so egregious, just so
9 excessive, that if it was injected
10 properly, you wouldn't get that result.
11 The result was horrible, especially in an
12 individual with a high aesthetic acuity.

13 Q Doctor, do you have any relatives that
14 live in South Carolina?

15 A No, Ma'am.

16 Q Have you ever been arrested or had any
17 kind of criminal history?

18 A In South Carolina?

19 Q Anywhere?

20 A No, not that I know of. No.

21 Q No DUI, no bad checks?

22 A No, I don't do that.

23 Q How about have you had to seek treatment
24 for any drug or alcohol counseling?

25 A No, Ma'am.

1 Q Any psychological or psychiatric
2 counseling?

3 A Yeah. I see a therapist on a regular
4 basis. But, you know, nothing in terms
5 of mental illness or anything like that.

6 Q Do you agree, doctor, that good experts
7 can disagree on the appropriate course of
8 treatment for a patient?

9 A Yes.

10 Q Do you agree that a bad outcome doesn't
11 necessarily mean that the medical
12 provider was negligent?

13 A Correct. Except in this case.

14 Q Do you agree that the occurrence of an
15 injury is not proof of medical
16 negligence?

17 A Correct. Except in this case.

18 Q Do you agree that you can't judge a
19 medical provider in light of what
20 hindsight might reveal?

21 A When you say "Judge a provider," what do
22 you mean?

23 Q Do you agree that as an expert, you have
24 an inherent hindsight bias?

25 A Of course. We all do.

1 Q And so are you, then, able to go back and
2 look at the information available to a
3 medical provider and give an opinion
4 based on the information they had at the
5 time?

6 A Sure, I do. But this case is so obvious,
7 that the records do not sync with the
8 final result.

9 Q So because of that, even Ms. Hussey has
10 documented in the record on May 3rd, 2016
11 why she gave the intralesional steroid
12 injection, and the amount that she gave,
13 you contend that that was incorrect, an
14 that there is no way that she gave that
15 amount?

16 A I totally agree with that. It couldn't
17 have happened.

18 Q Are you going to offer any criticisms as
19 to Shannon Hussey's education, experience
20 or training?

21 A I can't offer any information about that.

22 Q Do you agree that the standard of care
23 requires a medical provider to act
24 reasonably?

25 A Yes.

1 Q And do you agree the standard of care
2 does not require perfection?

3 A Correct.

4 Q Do you agree that the standard of care
5 allows for judgment calls?

6 A Sure. But not in this case.

7 Q I think that's all I have. Thank you,
8 sir.

9 A My pleasure.

10 Q Just to be clear, so we have gone over
11 all of your opinions that, at least as of
12 the information that you have been
13 provided to date that you are going to
14 express at the trial in this case?

15 A These are my opinions to date. Except if
16 new information becomes available, my
17 opinion at that time will change. And I
18 will notify Ms. Gurry to notify you.

19 Q Perfect. Thank you, sir.

20 A Thank you. And I really would like a
21 copy, please. I will read and sign. I
22 just have to. Thank you.

23 (Deposition concluded at 2:30 p.m.)

24 (Signature is not waived.)

25

EXAMINATION INDEX

SCHILD M. WIKAS, D.O.
BY MS. SCALISE 3

REQUESTED INFORMATION INDEX
(No Information Requested)

EXHIBIT INDEX

		MAR
Defendant's Exhibit		
1	Binder Notebook	4
2	Email Correspondence between Dr. Wikas and Ms. Gurry	5
3	January 27, 2016 Visit Note (Bates 24 005-009)	24
4	Diagram	26
5	Digram 28	
6	Testimony History of Dr. Wikas	55
7	November 11, 2016 MRI Scan Image	67
8	PET/CT Scan Images Before and After Date of Loss	67
9	Affidavit of Kent Carson, M.D.	75
10	Affidavit of Kent Carson, M.D. with Additional Sentence, "I do not intend to testify at a deposition or trial on this case."	75
11	Kenalog-10 (Triamcinolone) Injection Side Effects. (In Red Tara Gurry's Side Effects.)	77

EXHIBIT INDEX (continued)

12	Kenalog-10 Side Effects	80
13	May 3, 2016 Myrtle Beach Dermatology Medical Record Tara Gurry (Bates Hussey0021)	104
14	Melanoma Removal Incision Scar (Healthy Normal Healing Scar)	105
15	Day After Injection; May 4, 2016	133

KENALOG[®]-10 INJECTION **(triamcinolone acetonide injectable suspension, USP)**

NOT FOR USE IN NEONATES
CONTAINS BENZYL ALCOHOL

For Intra-articular or Intralesional Use Only

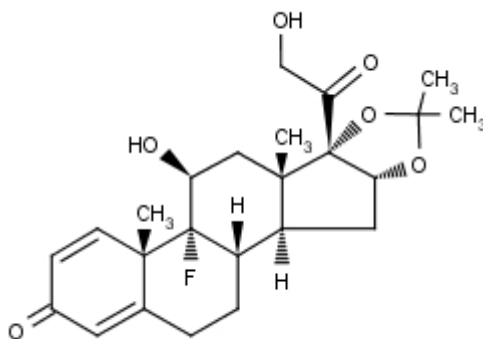
**NOT FOR INTRAVENOUS, INTRAMUSCULAR, INTRAOCULAR, EPIDURAL, OR
INTRATHECAL USE**

DESCRIPTION

Kenalog[®]-10 Injection (triamcinolone acetonide injectable suspension, USP) is triamcinolone acetonide, a synthetic glucocorticoid corticosteroid with marked anti-inflammatory action, in a sterile aqueous suspension suitable for intralesional and intra-articular injection. THIS FORMULATION IS SUITABLE FOR INTRA-ARTICULAR AND INTRALESIONAL USE ONLY.

Each mL of the sterile aqueous suspension provides 10 mg triamcinolone acetonide, with 0.66% sodium chloride for isotonicity, 0.99% (w/v) benzyl alcohol as a preservative, 0.63% carboxymethylcellulose sodium, and 0.04% polysorbate 80. Sodium hydroxide or hydrochloric acid may have been added to adjust pH between 5.0 and 7.5. At the time of manufacture, the air in the container is replaced by nitrogen.

The chemical name for triamcinolone acetonide is 9-Fluoro-11 β ,16 α ,17,21-tetrahydroxy-pregna-1,4-diene-3,20-dione cyclic 16,17-acetal with acetone. Its structural formula is:



MW 434.50

CLINICAL PHARMACOLOGY

Glucocorticoids, naturally occurring and synthetic, are adrenocortical steroids that are readily absorbed from the gastrointestinal tract.

Naturally occurring glucocorticoids (hydrocortisone and cortisone), which also have salt-retaining properties, are used as replacement therapy in adrenocortical deficiency states. Synthetic analogs such as triamcinolone are primarily used for their anti-inflammatory effects in disorders of many organ systems.

INDICATIONS AND USAGE

The intra-articular or soft tissue administration of Kenalog-10 Injection (triamcinolone acetonide injectable suspension, USP) is indicated as adjunctive therapy for short-term administration (to tide the patient over an acute episode or exacerbation) in acute gouty arthritis, acute and subacute bursitis, acute nonspecific tenosynovitis, epicondylitis, rheumatoid arthritis, synovitis of osteoarthritis.

The intralesional administration of Kenalog-10 Injection is indicated for alopecia areata; discoid lupus erythematosus; keloids; localized hypertrophic, infiltrated, inflammatory lesions of granuloma annulare, lichen planus, lichen simplex chronicus (neurodermatitis), and psoriatic plaques; necrobiosis lipoidica diabetorum. Kenalog-10 Injection may also be useful in cystic tumors of an aponeurosis or tendon (ganglia).

CONTRAINDICATIONS

Kenalog-10 Injection is contraindicated in patients who are hypersensitive to any components of this product (see **WARNINGS: General**).

Intramuscular corticosteroid preparations are contraindicated for idiopathic thrombocytopenic purpura.

WARNINGS

Serious Neurologic Adverse Reactions with Epidural Administration

Serious neurologic events, some resulting in death, have been reported with epidural injection of corticosteroids (see **WARNINGS: Neurologic**). Specific events reported include, but are not limited to, spinal cord infarction, paraplegia, quadriplegia, cortical blindness, and stroke. These serious neurologic events have been reported with and without use of fluoroscopy. The safety and effectiveness of epidural administration of corticosteroids have not been established, and corticosteroids are not approved for this use.

General

Exposure to excessive amounts of benzyl alcohol has been associated with toxicity (hypotension, metabolic acidosis), particularly in neonates, and an increased incidence of kernicterus, particularly in small preterm infants. There have been rare reports of deaths, primarily in preterm infants, associated with exposure to excessive amounts of benzyl alcohol. The amount of benzyl alcohol from medications is usually considered negligible compared to that received in flush solutions containing benzyl alcohol. Administration of high dosages of medications containing this preservative must take into account the total amount of benzyl alcohol administered. The amount of benzyl alcohol at which toxicity may occur is not known. If the patient requires more than the recommended dosages or other medications containing this preservative, the practitioner must consider the daily metabolic load of benzyl alcohol from these combined sources (see **PRECAUTIONS: Pediatric Use**).

Because Kenalog-10 Injection (triamcinolone acetonide injectable suspension, USP) is a suspension, it should *not* be administered intravenously. Strict aseptic technique is mandatory.

Rare instances of anaphylaxis have occurred in patients receiving corticosteroid therapy (see **ADVERSE REACTIONS**). Cases of serious anaphylaxis, including death, have been reported

in individuals receiving triamcinolone acetonide injection, regardless of the route of administration.

Increased dosage of rapidly acting corticosteroids is indicated in patients on corticosteroid therapy subjected to any unusual stress before, during, and after the stressful situation.

Kenalog-10 Injection is a long-acting preparation, and is *not* suitable for use in acute stress situations.

Results from one multicenter, randomized, placebo-controlled study with methylprednisolone hemisuccinate, an intravenous corticosteroid, showed an increase in early (at 2 weeks) and late (at 6 months) mortality in patients with cranial trauma who were determined not to have other clear indications for corticosteroid treatment. High doses of systemic corticosteroids, including Kenalog-10 Injection, should not be used for the treatment of traumatic brain injury.

Cardio-Renal

Average and large doses of corticosteroids can cause elevation of blood pressure, salt and water retention, and increased excretion of potassium. These effects are less likely to occur with the synthetic derivatives except when they are used in large doses. Dietary salt restriction and potassium supplementation may be necessary. All corticosteroids increase calcium excretion.

Literature reports suggest an apparent association between use of corticosteroids and left ventricular free wall rupture after a recent myocardial infarction; therefore, therapy with corticosteroids should be used with great caution in these patients.

Endocrine

Corticosteroids can produce reversible hypothalamic-pituitary adrenal (HPA) axis suppression with the potential for glucocorticosteroid insufficiency after withdrawal of treatment.

Metabolic clearance of corticosteroids is decreased in hypothyroid patients and increased in hyperthyroid patients. Changes in thyroid status of the patient may necessitate adjustment in dosage.

Infections

General

Patients who are on corticosteroids are more susceptible to infections than are healthy individuals. There may be decreased resistance and inability to localize infection when corticosteroids are used. Infection with any pathogen (viral, bacterial, fungal, protozoan, or helminthic) in any location of the body may be associated with the use of corticosteroids alone or in combination with other immunosuppressive agents. These infections may be mild to severe. With increasing doses of corticosteroids, the rate of occurrence of infectious complications increases. Corticosteroids may also mask some signs of current infection.

Fungal Infections

Corticosteroids may exacerbate systemic fungal infections and therefore should not be used in the presence of such infections unless they are needed to control drug reactions. There have been cases reported in which concomitant use of amphotericin B and hydrocortisone was followed by cardiac enlargement and congestive heart failure (see **PRECAUTIONS: Drug Interactions:** *Amphotericin B injection and potassium-depleting agents*).

Special Pathogens

Latent disease may be activated or there may be an exacerbation of intercurrent infections due to pathogens, including those caused by *Amoeba*, *Candida*, *Cryptococcus*, *Mycobacterium*, *Nocardia*, *Pneumocystis*, or *Toxoplasma*.

It is recommended that latent amebiasis or active amebiasis be ruled out before initiating corticosteroid therapy in any patient who has spent time in the tropics or in any patient with unexplained diarrhea.

Similarly, corticosteroids should be used with great care in patients with known or suspected *Strongyloides* (threadworm) infestation. In such patients, corticosteroid-induced immunosuppression may lead to *Strongyloides* hyperinfection and dissemination with widespread larval migration, often accompanied by severe enterocolitis and potentially fatal gram-negative septicemia.

Corticosteroids should not be used in cerebral malaria.

Tuberculosis

If corticosteroids are indicated in patients with latent tuberculosis or tuberculin reactivity, close observation is necessary as reactivation of the disease may occur. During prolonged corticosteroid therapy, these patients should receive chemoprophylaxis.

Vaccination

Administration of live or live, attenuated vaccines is contraindicated in patients receiving immunosuppressive doses of corticosteroids. Killed or inactivated vaccines may be administered. However, the response to such vaccines cannot be predicted. Immunization procedures may be undertaken in patients who are receiving corticosteroids as replacement therapy, *e.g.*, for Addison's disease.

Viral Infections

Chicken pox and measles can have a more serious or even fatal course in pediatric and adult patients on corticosteroids. In pediatric and adult patients who have not had these diseases, particular care should be taken to avoid exposure. The contribution of the underlying disease and/or prior corticosteroid treatment to the risk is also not known. If exposed to chicken pox, prophylaxis with varicella zoster immune globulin (VZIG) may be indicated. If exposed to measles, prophylaxis with immunoglobulin (IG) may be indicated. (See the respective package inserts for complete VZIG and IG prescribing information.) If chicken pox develops, treatment with antiviral agents should be considered.

Neurologic

Epidural and intrathecal administration of this product is not recommended. Reports of serious medical events, including death, have been associated with epidural and intrathecal routes of corticosteroid administration (see **ADVERSE REACTIONS: Gastrointestinal and Neurologic/Psychiatric**).

Ophthalmic

Use of corticosteroids may produce posterior subcapsular cataracts, glaucoma with possible damage to the optic nerves, and may enhance the establishment of secondary ocular infections due to bacteria, fungi, or viruses. The use of oral corticosteroids is not recommended in the treatment of optic neuritis and may lead to an increase in the risk of new episodes. Corticosteroids should not be used in active ocular herpes simplex.

Adequate studies to demonstrate the safety of Kenalog Injection use by intratubinal, subconjunctival, sub-Tenons, retrobulbar, and intraocular (intravitreal) injections have not been performed. Endophthalmitis, eye inflammation, increased intraocular pressure, and visual disturbances including vision loss have been reported with intravitreal administration. Administration of Kenalog Injection intraocularly or into the nasal turbinates is not recommended.

Intraocular injection of corticosteroid formulations containing benzyl alcohol, such as Kenalog Injection, is not recommended because of potential toxicity from the benzyl alcohol.

PRECAUTIONS

General

This product, like many other steroid formulations, is sensitive to heat. Therefore, it should not be autoclaved when it is desirable to sterilize the exterior of the vial.

The lowest possible dose of corticosteroid should be used to control the condition under treatment. When reduction in dosage is possible, the reduction should be gradual.

Since complications of treatment with glucocorticoids are dependent on the size of the dose and the duration of treatment, a risk/benefit decision must be made in each individual case as to dose and duration of treatment and as to whether daily or intermittent therapy should be used.

Kaposi's sarcoma has been reported to occur in patients receiving corticosteroid therapy, most often for chronic conditions. Discontinuation of corticosteroids may result in clinical improvement.

Cardio-Renal

As sodium retention with resultant edema and potassium loss may occur in patients receiving corticosteroids, these agents should be used with caution in patients with congestive heart failure, hypertension, or renal insufficiency.

Endocrine

Drug-induced secondary adrenocortical insufficiency may be minimized by gradual reduction of dosage. This type of relative insufficiency may persist for months after discontinuation of therapy; therefore, in any situation of stress occurring during that period, hormone therapy

should be reinstituted. Since mineralocorticoid secretion may be impaired, salt and/or a mineralocorticoid should be administered concurrently.

Gastrointestinal

Steroids should be used with caution in active or latent peptic ulcers, diverticulitis, fresh intestinal anastomoses, and nonspecific ulcerative colitis, since they may increase the risk of a perforation.

Signs of peritoneal irritation following gastrointestinal perforation in patients receiving corticosteroids may be minimal or absent.

There is an enhanced effect of corticosteroids in patients with cirrhosis.

Intra-Articular and Soft Tissue Administration

Intra-articularly injected corticosteroids may be systemically absorbed.

Appropriate examination of any joint fluid present is necessary to exclude a septic process.

A marked increase in pain accompanied by local swelling, further restriction of joint motion, fever, and malaise are suggestive of septic arthritis. If this complication occurs and the diagnosis of sepsis is confirmed, appropriate antimicrobial therapy should be instituted.

Injection of a steroid into an infected site is to be avoided. Local injection of a steroid into a previously infected joint is not usually recommended.

Corticosteroid injection into unstable joints is generally not recommended.

Intra-articular injection may result in damage to joint tissues (see **ADVERSE REACTIONS: Musculoskeletal**).

Musculoskeletal

Corticosteroids decrease bone formation and increase bone resorption both through their effect on calcium regulation (*i.e.*, decreasing absorption and increasing excretion) and inhibition of osteoblast function. This, together with a decrease in the protein matrix of the bone secondary to an increase in protein catabolism, and reduced sex hormone production, may lead to inhibition of bone growth in pediatric patients and the development of osteoporosis at any age.

Special consideration should be given to patients at increased risk of osteoporosis (*i.e.*, postmenopausal women) before initiating corticosteroid therapy.

Neuro-Psychiatric

Although controlled clinical trials have shown corticosteroids to be effective in speeding the resolution of acute exacerbations of multiple sclerosis, they do not show that they affect the ultimate outcome or natural history of the disease. The studies do show that relatively high doses of corticosteroids are necessary to demonstrate a significant effect. (See **DOSAGE AND ADMINISTRATION**.)

An acute myopathy has been observed with the use of high doses of corticosteroids, most often occurring in patients with disorders of neuromuscular transmission (*e.g.*, myasthenia gravis), or in patients receiving concomitant therapy with neuromuscular blocking drugs (*e.g.*, pancuronium). This acute myopathy is generalized, may involve ocular and respiratory muscles, and may result in quadriparesis. Elevation of creatinine kinase may occur. Clinical improvement or recovery after stopping corticosteroids may require weeks to years.

Psychiatric derangements may appear when corticosteroids are used, ranging from euphoria, insomnia, mood swings, personality changes, and severe depression to frank psychotic manifestations. Also, existing emotional instability or psychotic tendencies may be aggravated by corticosteroids.

Ophthalmic

Intraocular pressure may become elevated in some individuals. If steroid therapy is continued for more than 6 weeks, intraocular pressure should be monitored.

Information for Patients

Patients should be warned not to discontinue the use of corticosteroids abruptly or without medical supervision, to advise any medical attendants that they are taking corticosteroids, and to seek medical advice at once should they develop fever or other signs of infection.

Persons who are on corticosteroids should be warned to avoid exposure to chicken pox or measles. Patients should also be advised that if they are exposed, medical advice should be sought without delay.

Drug Interactions

Aminoglutethimide: Aminoglutethimide may lead to a loss of corticosteroid-induced adrenal suppression.

Amphotericin B injection and potassium-depleting agents: When corticosteroids are administered concomitantly with potassium-depleting agents (*i.e.*, amphotericin B, diuretics), patients should be observed closely for development of hypokalemia. There have been cases reported in which concomitant use of amphotericin B and hydrocortisone was followed by cardiac enlargement and congestive heart failure.

Antibiotics: Macrolide antibiotics have been reported to cause a significant decrease in corticosteroid clearance.

Anticholinesterases: Concomitant use of anticholinesterase agents and corticosteroids may produce severe weakness in patients with myasthenia gravis. If possible, anticholinesterase agents should be withdrawn at least 24 hours before initiating corticosteroid therapy.

Anticoagulants, oral: Coadministration of corticosteroids and warfarin usually results in inhibition of response to warfarin, although there have been some conflicting reports. Therefore, coagulation indices should be monitored frequently to maintain the desired anticoagulant effect.

Antidiabetics: Because corticosteroids may increase blood glucose concentrations, dosage adjustments of antidiabetic agents may be required.

Antitubercular drugs: Serum concentrations of isoniazid may be decreased.

Cholestyramine: Cholestyramine may increase the clearance of corticosteroids.

Cyclosporine: Increased activity of both cyclosporine and corticosteroids may occur when the two are used concurrently. Convulsions have been reported with this concurrent use.

CYP3A4 inhibitors: Triamcinolone acetonide is a substrate of CYP3A4. Ketoconazole has been reported to decrease the metabolism of certain corticosteroids by up to 60%, leading to an increased risk of corticosteroid side effects. Co-administration of other strong CYP3A4 inhibitors (e.g., ritonavir, atazanavir, clarithromycin, indinavir, itraconazole, nefazodone, nelfinavir, saquinavir, telithromycin, cobicistat-containing products) with Kenalog-10 Injection may cause increased plasma concentration of triamcinolone leading to adverse reactions. (See

ADVERSE REACTIONS.) During postmarketing use, there have been reports of clinically significant drug interactions in patients receiving triamcinolone acetonide and strong CYP3A4 inhibitors (e.g., ritonavir). (See **WARNINGS, Endocrine** and **PRECAUTIONS, Endocrine**.) Consider the benefit-risk of concomitant use and monitor for systemic corticosteroid side effects

Digitalis glycosides: Patients on digitalis glycosides may be at increased risk of arrhythmias due to hypokalemia.

Estrogens, including oral contraceptives: Estrogens may decrease the hepatic metabolism of certain corticosteroids, thereby increasing their effect.

Hepatic enzyme inducers (e.g., barbiturates, phenytoin, carbamazepine, rifampin): Drugs which induce hepatic microsomal drug metabolizing enzyme activity may enhance the metabolism of corticosteroids and require that the dosage of the corticosteroid be increased.

Nonsteroidal anti-inflammatory drugs (NSAIDs): Concomitant use of aspirin (or other nonsteroidal anti-inflammatory drugs) and corticosteroids increases the risk of gastrointestinal side effects. Aspirin should be used cautiously in conjunction with corticosteroids in hypoprothrombinemia. The clearance of salicylates may be increased with concurrent use of corticosteroids.

Skin tests: Corticosteroids may suppress reactions to skin tests.

Vaccines: Patients on prolonged corticosteroid therapy may exhibit a diminished response to toxoids and live or inactivated vaccines due to inhibition of antibody response. Corticosteroids may also potentiate the replication of some organisms contained in live attenuated vaccines. Routine administration of vaccines or toxoids should be deferred until corticosteroid therapy is discontinued if possible (see **WARNINGS: Infections: Vaccination**).

Carcinogenesis, Mutagenesis, Impairment of Fertility

No adequate studies have been conducted in animals to determine whether corticosteroids have a potential for carcinogenesis or mutagenesis.

Steroids may increase or decrease motility and number of spermatozoa in some patients.

Pregnancy

Teratogenic Effects: Pregnancy Category C

Corticosteroids have been shown to be teratogenic in many species when given in doses equivalent to the human dose. Animal studies in which corticosteroids have been given to pregnant mice, rats, and rabbits have yielded an increased incidence of cleft palate in the offspring. There are no adequate and well-controlled studies in pregnant women. Corticosteroids should be used during pregnancy only if the potential benefit justifies the potential risk to the fetus. Infants born to mothers who have received corticosteroids during pregnancy should be carefully observed for signs of hypoadrenalism.

Nursing Mothers

Systemically administered corticosteroids appear in human milk and could suppress growth, interfere with endogenous corticosteroid production, or cause other untoward effects. Caution should be exercised when corticosteroids are administered to a nursing woman.

Pediatric Use

This product contains benzyl alcohol as a preservative. Benzyl alcohol, a component of this product, has been associated with serious adverse events and death, particularly in pediatric patients. The “gasping syndrome” (characterized by central nervous system depression, metabolic acidosis, gasping respirations, and high levels of benzyl alcohol and its metabolites found in the blood and urine) has been associated with benzyl alcohol dosages >99 mg/kg/day in neonates and low-birth-weight neonates. Additional symptoms may include gradual neurological deterioration, seizures, intracranial hemorrhage, hematologic abnormalities, skin breakdown, hepatic and renal failure, hypotension, bradycardia, and cardiovascular collapse. Although normal therapeutic doses of this product deliver amounts of benzyl alcohol that are substantially lower than those reported in association with the “gasping syndrome,” the minimum amount of benzyl alcohol at which toxicity may occur is not known. Premature and low-birth-weight infants, as well as patients receiving high dosages, may be more likely to develop toxicity. Practitioners administering this and other medications containing benzyl alcohol should consider the combined daily metabolic load of benzyl alcohol from all sources.

The efficacy and safety of corticosteroids in the pediatric population are based on the well-established course of effect of corticosteroids which is similar in pediatric and adult populations. Published studies provide evidence of efficacy and safety in pediatric patients for

the treatment of nephrotic syndrome (>2 years of age), and aggressive lymphomas and leukemias (>1 month of age). Other indications for pediatric use of corticosteroids, *e.g.*, severe asthma and wheezing, are based on adequate and well-controlled trials conducted in adults, on the premises that the course of the diseases and their pathophysiology are considered to be substantially similar in both populations.

The adverse effects of corticosteroids in pediatric patients are similar to those in adults (see **ADVERSE REACTIONS**). Like adults, pediatric patients should be carefully observed with frequent measurements of blood pressure, weight, height, intraocular pressure, and clinical evaluation for the presence of infection, psychosocial disturbances, thromboembolism, peptic ulcers, cataracts, and osteoporosis. Pediatric patients who are treated with corticosteroids by any route, including systemically administered corticosteroids, may experience a decrease in their growth velocity. This negative impact of corticosteroids on growth has been observed at low systemic doses and in the absence of laboratory evidence of HPA axis suppression (*i.e.*, cosyntropin stimulation and basal cortisol plasma levels). Growth velocity may therefore be a more sensitive indicator of systemic corticosteroid exposure in pediatric patients than some commonly used tests of HPA axis function. The linear growth of pediatric patients treated with corticosteroids should be monitored, and the potential growth effects of prolonged treatment should be weighed against clinical benefits obtained and the availability of treatment alternatives. In order to minimize the potential growth effects of corticosteroids, pediatric patients should be *titrated* to the lowest effective dose.

Geriatric Use

No overall differences in safety or effectiveness were observed between elderly subjects and younger subjects, and other reported clinical experience has not identified differences in responses between the elderly and younger patients, but greater sensitivity of some older individuals cannot be ruled out.

ADVERSE REACTIONS

(listed alphabetically under each subsection)

The following adverse reactions may be associated with corticosteroid therapy:

Allergic reactions: Anaphylaxis including death, angioedema.

Cardiovascular: Bradycardia, cardiac arrest, cardiac arrhythmias, cardiac enlargement, circulatory collapse, congestive heart failure, fat embolism, hypertension, hypertrophic cardiomyopathy in premature infants, myocardial rupture following recent myocardial infarction (see **WARNINGS**), pulmonary edema, syncope, tachycardia, thromboembolism, thrombophlebitis, vasculitis.

Dermatologic: Acne, allergic dermatitis, cutaneous and subcutaneous atrophy, dry scaly skin, ecchymoses and petechiae, edema, erythema, hyperpigmentation, hypopigmentation, impaired wound healing, increased sweating, lupus erythematosus-like lesions, purpura, rash, sterile abscess, striae, suppressed reactions to skin tests, thin fragile skin, thinning scalp hair, urticaria.

Endocrine: Decreased carbohydrate and glucose tolerance, development of cushingoid state, glycosuria, hirsutism, hypertrichosis, increased requirements for insulin or oral hypoglycemic agents in diabetes, manifestations of latent diabetes mellitus, menstrual irregularities, postmenopausal vaginal hemorrhage, secondary adrenocortical and pituitary unresponsiveness (particularly in times of stress, as in trauma, surgery, or illness), suppression of growth in pediatric patients.

Fluid and electrolyte disturbances: Congestive heart failure in susceptible patients, fluid retention, hypokalemic alkalosis, potassium loss, sodium retention.

Gastrointestinal: Abdominal distention, bowel/bladder dysfunction (after intrathecal administration [see **WARNINGS: Neurologic**]), elevation in serum liver enzyme levels (usually reversible upon discontinuation), hepatomegaly, increased appetite, nausea, pancreatitis, peptic ulcer with possible perforation and hemorrhage, perforation of the small and large intestine (particularly in patients with inflammatory bowel disease), ulcerative esophagitis.

Metabolic: Negative nitrogen balance due to protein catabolism.

Musculoskeletal: Aseptic necrosis of femoral and humeral heads, calcinosis (following intra-articular or intralesional use), Charcot-like arthropathy, loss of muscle mass, muscle weakness, osteoporosis, pathologic fracture of long bones, post injection flare (following intra-articular use), steroid myopathy, tendon rupture, vertebral compression fractures.

Neurologic/Psychiatric: Convulsions, depression, emotional instability, euphoria, headache, increased intracranial pressure with papilledema (pseudotumor cerebri) usually following discontinuation of treatment, insomnia, mood swings, neuritis, neuropathy, paresthesia,

personality changes, psychiatric disorders, vertigo. Arachnoiditis, meningitis, paraparesis/paraplegia, and sensory disturbances have occurred after intrathecal administration. Spinal cord infarction, paraplegia, quadriplegia, cortical blindness, and stroke (including brainstem) have been reported after epidural administration of corticosteroids (see **WARNINGS: Serious Neurologic Adverse Reactions with Epidural Administration** and **WARNINGS: Neurologic**).

Ophthalmic: Exophthalmos, glaucoma, increased intraocular pressure, posterior subcapsular cataracts, rare instances of blindness associated with periocular injections.

Other: Abnormal fat deposits, decreased resistance to infection, hiccups, increased or decreased motility and number of spermatozoa, malaise, moon face, weight gain.

OVERDOSAGE

Treatment of acute overdose is by supportive and symptomatic therapy. For chronic overdose in the face of severe disease requiring continuous steroid therapy, the dosage of the corticosteroid may be reduced only temporarily, or alternate day treatment may be introduced.

DOSAGE AND ADMINISTRATION

General

NOTE: CONTAINS BENZYL ALCOHOL (see PRECAUTIONS).

IT SHOULD BE EMPHASIZED THAT DOSAGE REQUIREMENTS ARE VARIABLE AND MUST BE INDIVIDUALIZED ON THE BASIS OF THE DISEASE UNDER TREATMENT AND THE RESPONSE OF THE PATIENT. After a favorable response is noted, the proper maintenance dosage should be determined by decreasing the initial drug dosage in small decrements at appropriate time intervals until the lowest dosage which will maintain an adequate clinical response is reached. Situations which may make dosage adjustments necessary are changes in clinical status secondary to remissions or exacerbations in the disease process, the patient's individual drug responsiveness, and the effect of patient exposure to stressful situations not directly related to the disease entity under treatment. In this latter situation it may be necessary to increase the dosage of the corticosteroid for a period of time consistent with the patient's condition. If after long-term therapy the drug is to be stopped, it is recommended that it be withdrawn gradually rather than abruptly.

In pediatric patients, the initial dose of triamcinolone may vary depending on the specific disease entity being treated. The range of initial doses is 0.11 to 1.6 mg/kg/day in 3 or 4 divided doses (3.2 to 48 mg/m²bsa/day).

For the purpose of comparison, the following is the equivalent milligram dosage of the various glucocorticoids:

Cortisone, 25	Triamcinolone, 4
Hydrocortisone, 20	Paramethasone, 2
Prednisolone, 5	Betamethasone, 0.75
Prednisone, 5	Dexamethasone, 0.75
Methylprednisolone, 4	

These dose relationships apply only to oral or intravenous administration of these compounds. When these substances or their derivatives are injected intramuscularly or into joint spaces, their relative properties may be greatly altered.

Intra-Articular Administration

Dosage

The initial dose of Kenalog-10 Injection for intra-articular administration may vary from 2.5 mg to 5 mg for smaller joints and from 5 mg to 15 mg for larger joints, depending on the specific disease entity being treated. Single injections into several joints, up to a total of 20 mg or more, have been given.

Intralesional

For intralesional administration, the initial dose per injection site will vary depending on the specific disease entity and lesion being treated. The site of injection and volume of injection should be carefully considered due to the potential for cutaneous atrophy.

Multiple sites separated by one centimeter or more may be injected, keeping in mind that the greater the *total* volume employed the more corticosteroid becomes available for systemic absorption and systemic effects. Such injections may be repeated, if necessary, at weekly or less frequent intervals.

Localization of Doses

The lower dosages in the initial dosage range of triamcinolone acetonide may produce the desired effect when the corticosteroid is administered to provide a localized concentration. The site and volume of the injection should be carefully considered when triamcinolone acetonide is administered for this purpose.

Administration

STRICT ASEPTIC TECHNIQUE IS MANDATORY. The vial should be shaken before use to ensure a uniform suspension. Prior to withdrawal, the suspension should be inspected for clumping or granular appearance (agglomeration). An agglomerated product results from exposure to freezing temperatures and should not be used. After withdrawal, inject without delay to prevent settling in the syringe.

Injection Technique

For treatment of joints, the usual intra-articular injection technique should be followed. If an excessive amount of synovial fluid is present in the joint, some, but not all, should be aspirated to aid in the relief of pain and to prevent undue dilution of the steroid.

With intra-articular administration, prior use of a local anesthetic may often be desirable. Care should be taken with this kind of injection, particularly in the deltoid region, to avoid injecting the suspension into the tissues surrounding the site, since this may lead to tissue atrophy.

In treating acute nonspecific tenosynovitis, care should be taken to ensure that the injection of Kenalog-10 Injection is made into the tendon sheath rather than the tendon substance. Epicondylitis may be treated by infiltrating the preparation into the area of greatest tenderness.

Intralesional

For treatment of dermal lesions, Kenalog-10 Injection should be injected directly into the lesion, *i.e.*, intradermally or subcutaneously. For accuracy of dosage measurement and ease of administration, it is preferable to employ a tuberculin syringe and a small-bore needle (23-25 gauge). Ethyl chloride spray may be used to alleviate the discomfort of the injection.

HOW SUPPLIED

Kenalog[®]-10 Injection (triamcinolone acetonide injectable suspension, USP) is supplied in 5 mL multiple-dose vials (NDC 0003-0494-20) providing 10 mg triamcinolone acetonide per mL.

Storage

Store at controlled room temperature, 20° to 25°C (68° to 77°F); protect from temperatures below 20°C (68°F). Store vial in carton to protect from light. Store vial upright.

Bristol-Myers Squibb Company
Princeton, NJ 08543 USA

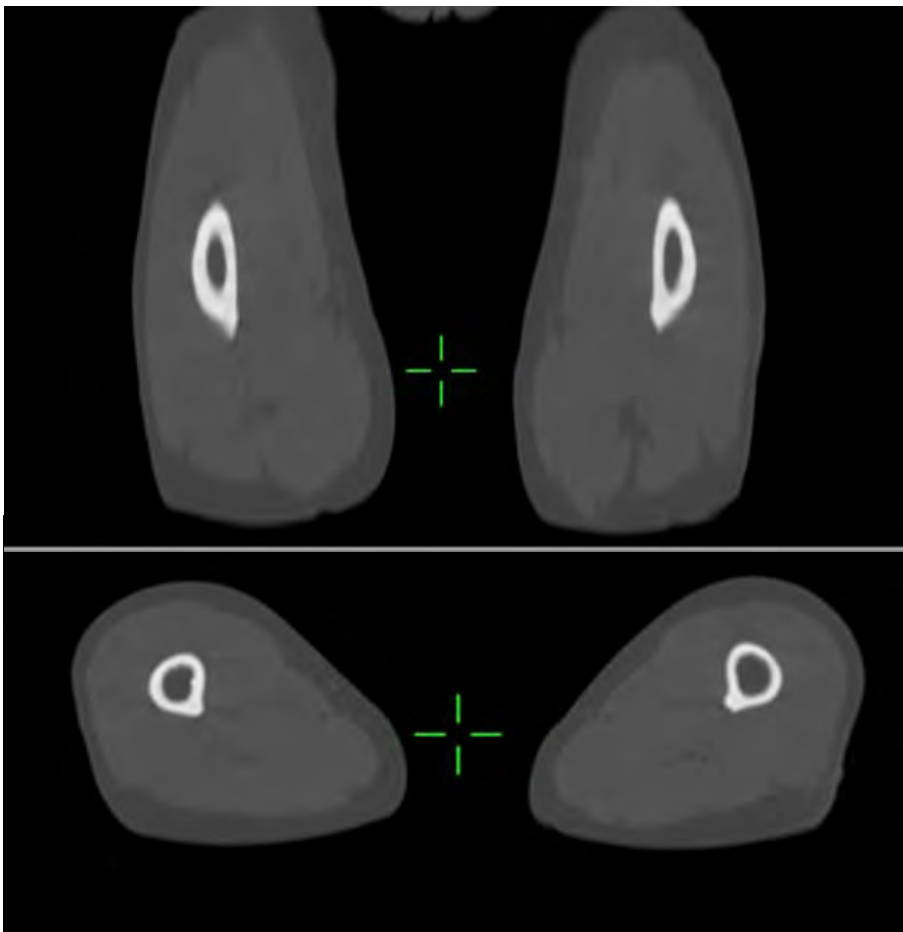
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Revised: June 2018

**PET/CT SCAN IMAGES
Before and After Injection**

PET/CT SCAN
February 25, 2016

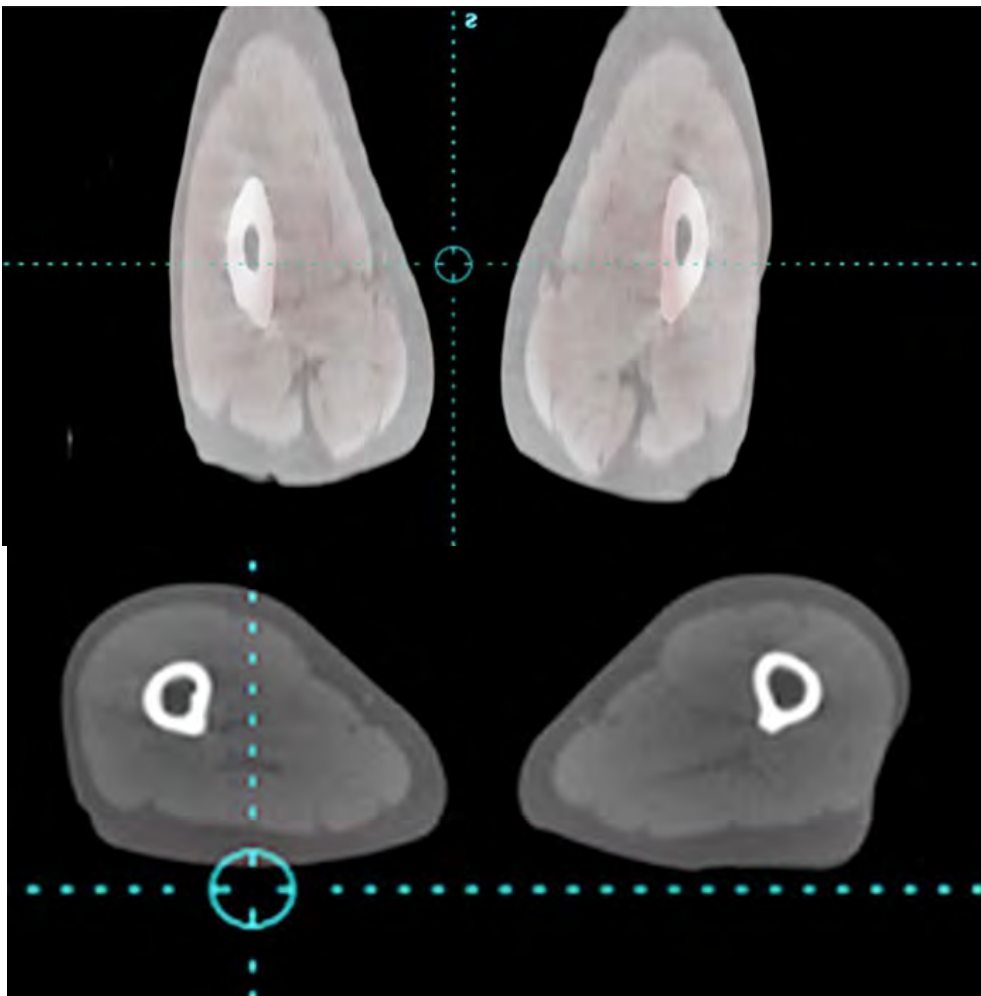
The WLE Surgery was just a month prior and incision site is healing well.



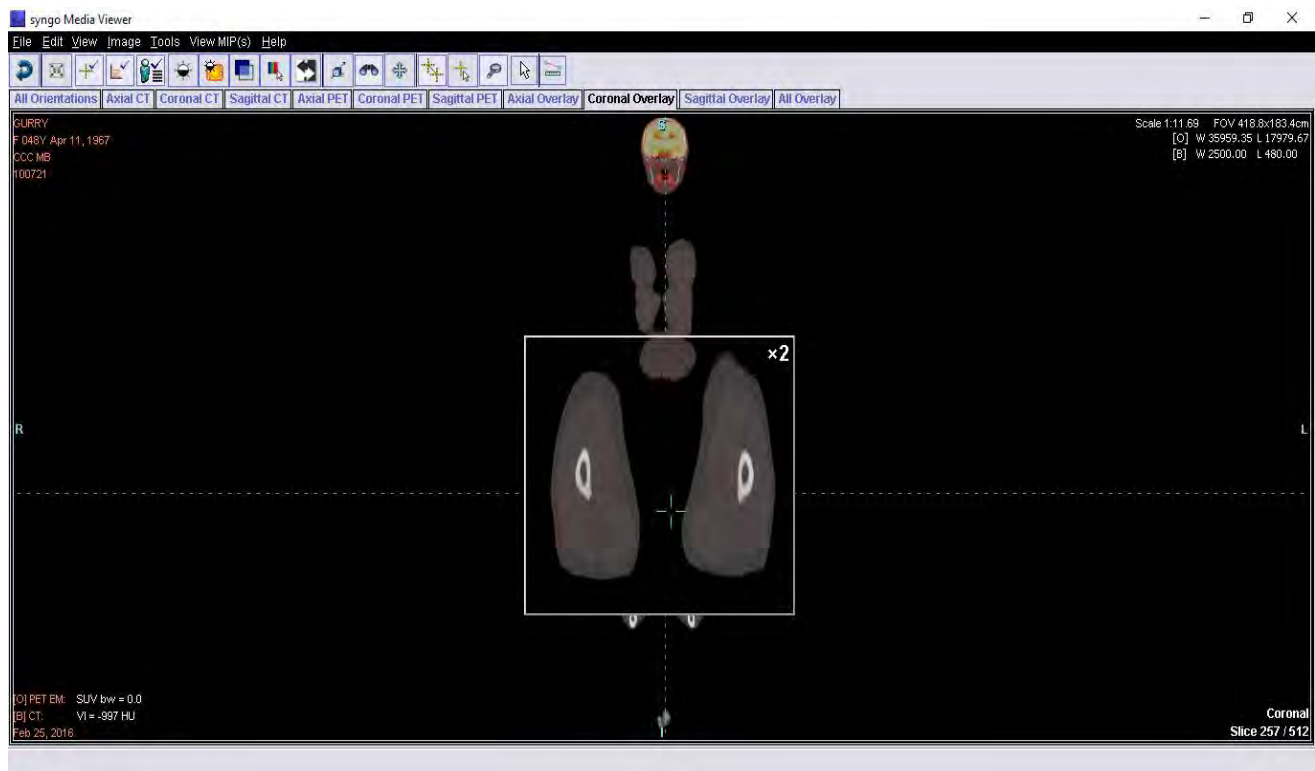
Injection May 3, 2016

PET/CT SCAN
September 21, 2016

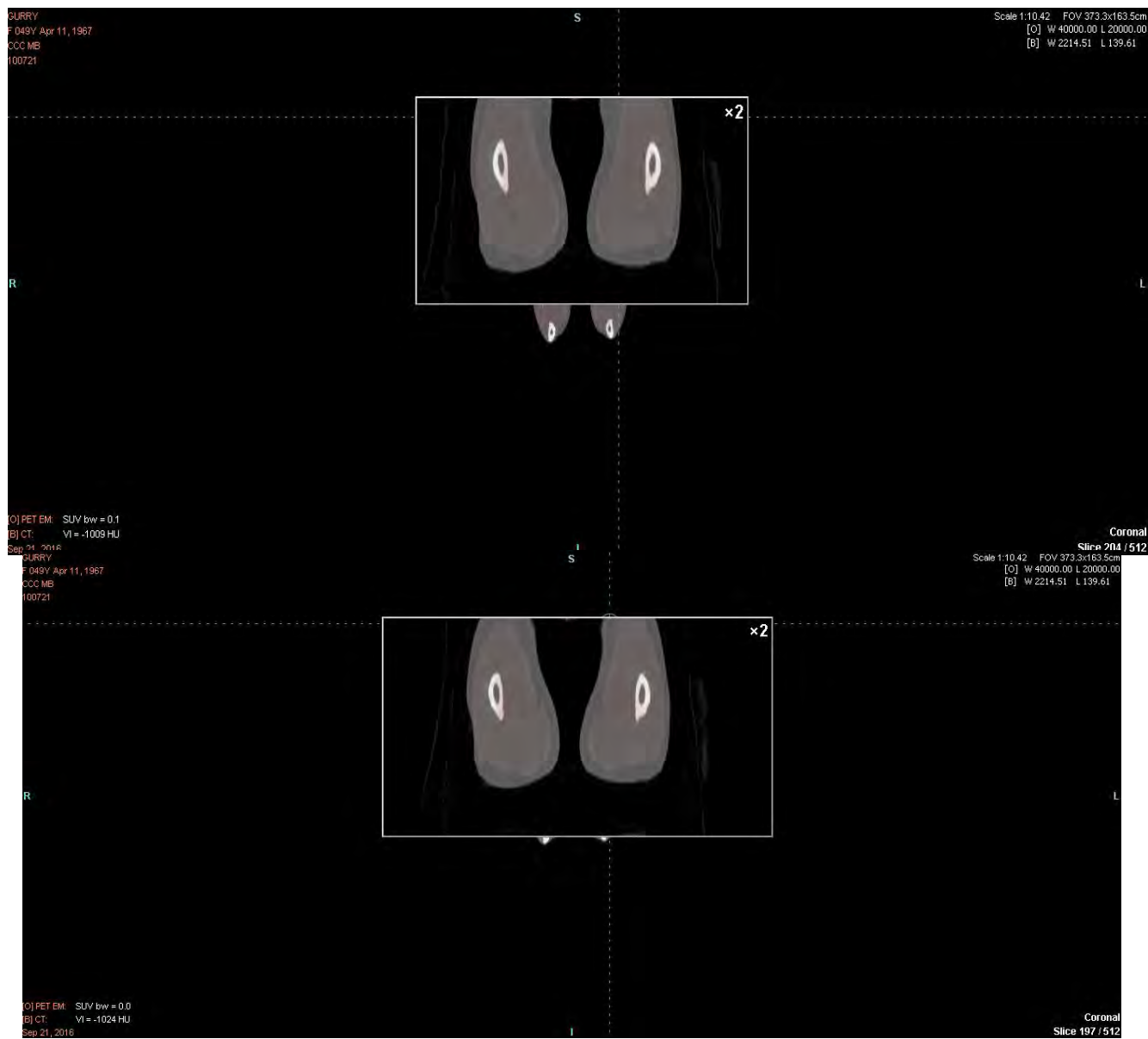
Severe Subcutaneous Tissue Loss
Destroying nerve fibers,
veins, fat, skin, hair follicles,
sweat glands, lymph vessels
and thinning iliotibial band.



Tara Gurry's PET/CT - First Scan 2/25/16 Just 1 month after Surgery



PET/CT Scan After Injection on 9/21/16 with Severe Subcutaneous Tissue Loss Destroying nerves, veins, fat, skin, hair follicles, sweat glands, lymph vessels and thinning iliotibial band.



PLAINTIFF EXHIBIT
#3

May 4, 2016



PLAINTIFF EXHIBIT
#4

May 14, 2016





PLAINTIFF EXHIBIT

May 30, 2016

#5

PLAINTIFF EXHIBIT

#6

July 31, 2016



PLAINTIFF EXHIBIT

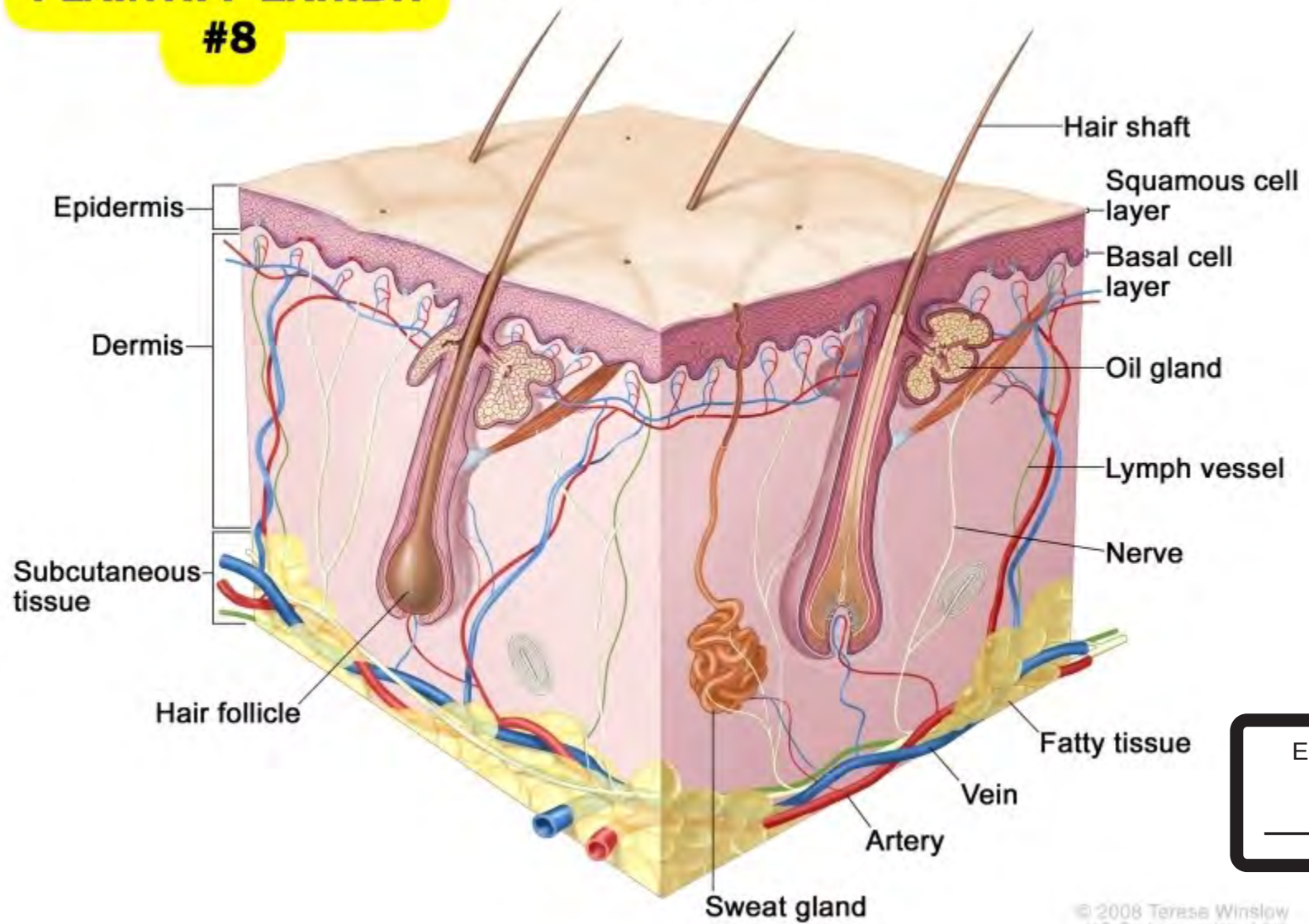
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178

07/26/2017

**PLAINTIFF EXHIBIT
#8**

Anatomy of the Skin



EXHIBIT

10

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PLAINTIFF EXHIBIT

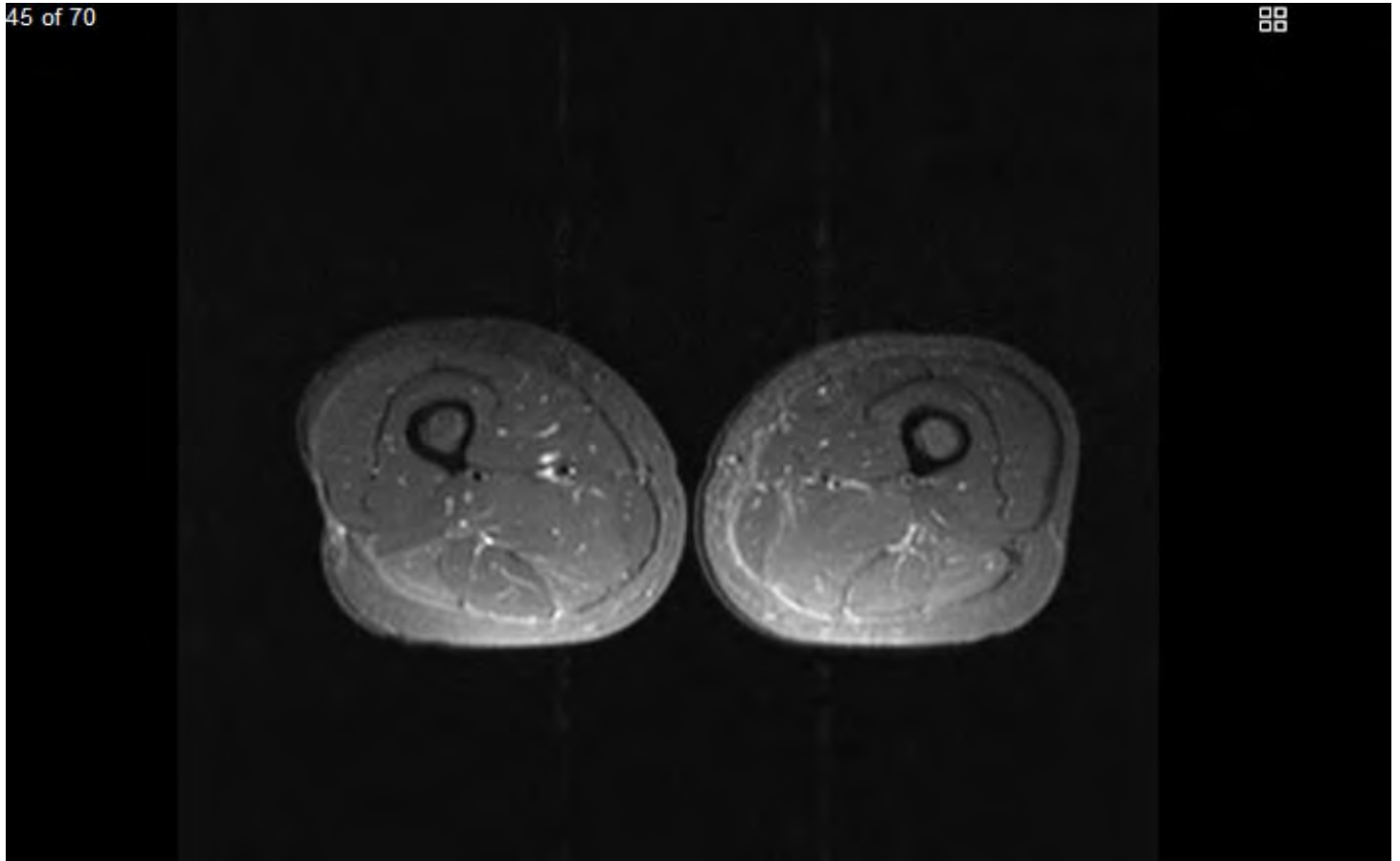
#11

Barely visible scar from one groin lymph node removed 2/2018
Cell phone picture taken 6/18/21



Tara Gurry's MRI - 11/17/16 - 6 Months after Injection

**Major subcutaneous atrophy so deep and wide it damages iliotibial band causing chronic pain
Diagnoses: IT Band Syndrome and Snapping Hip Syndrome**

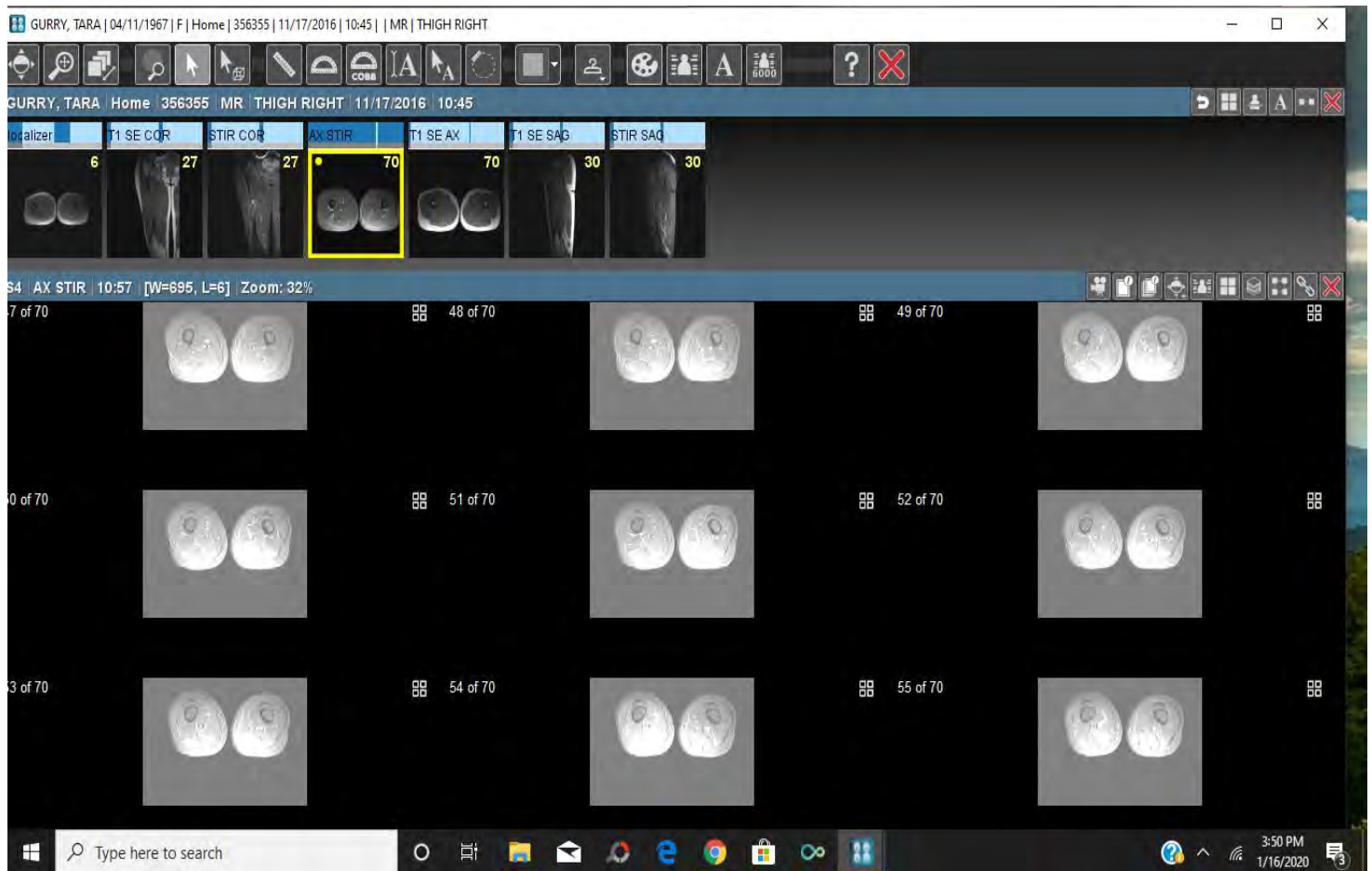


Right thigh has major atrophy with subcutaneous tissue gone all the way down to IT Band thinning and damaging it , causing chronic pain and physical impairment. It is easy to see iliotibial band on the left outer thigh, it is the dark thick line around the muscle, it is not visible on right injured thigh.

*** Right thigh is on left as this is direct screenshot from MRI CD.**

Tara Gurry's MRI - 11/17/16 Screenshot from MRI CD

Orthopedic Doctor Diagnosis IT Band Syndrome Doctor of Physical Therapy Diagnosis Snapping Hip Syndrome



1 concentration, you could. But it's based
2 on a person who knows what they are doing
3 who does it correctly.

4 Q It's my understanding your testimony is
5 Ms. Hussey injected too much, too high of
6 a concentration, wrong location, all of
7 that. So that's what I'm trying to find
8 out is where is the necrosis?

9 A There wasn't any.

10 Q So why would there not be necrosis if
11 truly this is too much and/or the wrong
12 concentration?

13 A If you are injecting deep into the skin,
14 into the deep dermis, subcutaneous fat,
15 then you are having the medication being
16 directed throughout, which could go into
17 blood vessels, lymphatic vessels,
18 anything else imaginable.

19 Basically necrosis usually results
20 from a circulation being disturbed. If
21 you cut off the circulation one way or
22 another, the tissue dies.

23 Q So you would agree there is no evidence
24 of any necrosis here?

25 A No.

EXHIBIT

13

1 Q No, there is?

2 A No, there is not any evidence of
3 necrosis.

4 Q And there is no evidence of the injection
5 being down into the lymphatics?

6 A Well, something is going to go into the
7 lymphatics if you inject it deeply.

8 Q But is there any evidence this injection
9 was a deep injection?

10 A There was evidence that it was injected
11 improperly, which is deeper than it
12 probably should have been.

13 Q So looking at Exhibit 5, can you give
14 an opinion as to where this injection was
15 located?

16 A I can't give you an opinion, but I can
17 tell you it was injected in the wrong
18 place, too high of volume, too high of
19 concentration, because the result speaks
20 for itself.

21 Q So again, getting back to the fact she
22 has got what she has now, there was
23 something going on wrong by nurse Hussey?

24 A There was no problem prior to the
25 injections. After the injection,

1 everything went wrong. It became a
2 catastrophic event.

3 Q What are you basing that on, that after
4 this injection, quote, "Everything went
5 wrong"?

6 A There was no problem. The wound was
7 healing perfectly naturally prior to the
8 injection. After the injection, atrophy
9 started to occur. She had systemic side
10 effects. A lot of the systemic side
11 effects are comparable to the results of
12 corticosteroid.

13 Q That's why I asked if you had read the
14 endocrinologist, Ms. LaRochelle's
15 deposition, and you said you had not?

16 A Correct.

17 Q Her testimony is none of the side effects
18 that Ms. Gurry has were caused by this
19 intralesional steroid. So I'm wondering
20 --

21 MS. GURRY: Objection.
22 That's not properly stated. Objection.

23 Q So would you agree you would have to
24 defer to an endocrinologist as to whether
25 the side effects were related to an

1 intralesional a injection?

2 A No. What I would have to do is read the
3 deposition of the endocrinologist so I
4 know all the facts rather than just
5 conjecture from a few snippets in
6 sentences.

7 Q But even with that, you would have to be
8 deferring to what she said, correct, or
9 any endocrinologist?

10 A I would only defer to what
11 endocrinologist knows, but that doesn't
12 mean I may not find fault with what they
13 say because I need to be able to say -- I
14 need to see the entire picture of what
15 the endocrinologist said.

16 Q As a dermatologist, do you have the
17 education and experience and training to
18 even comment on those topics?

19 A You are asking me to compare what the
20 endocrinologist is saying and I can't
21 make any comment on what the
22 endocrinologist said because I don't have
23 information.

24 Q Okay. That's what I want to know.
25 Ms. Gurry is claiming lots of different

1 things that occurred to her as a result
2 of this injection. That's what I'm
3 wondering. Do you have the experience,
4 education and training to give legal
5 opinions and medical opinions as to
6 whether those results were due to this
7 injection versus something else?

8 A It is not uncommon for a lot of --

9 Q Yes or no?

10 A I can't say no because it is not uncommon
11 for her side effects, a lot of the side
12 effects to be associated with the adverse
13 effect of a corticosteroid systemically
14 administered.

15 Q I guess that's key. Your opinion is this
16 was a systemic corticosteroid or a local
17 corticosteroid?

18 A It was locally injected but it was
19 systemically experienced.

20 Q And explain to me what you mean by that.

21 A Well, she did have local effect because
22 it was injected too deep or with too high
23 of a concentration, too high of a volume.
24 That goes to say that this would be more
25 into the blood and lymphatic vessels, and

1 therefore, you would have a systemic
2 effect.

3 It's just like if you give somebody
4 an injection into a muscle, that's a
5 local injection; however, you are getting
6 a systemic effect.

7 Q And this is where I need to know whether
8 you can give opinion testimony on this or
9 if that needs to be deferred.

10 The question is, how quickly would
11 you see a systemic effect from a
12 corticosteroid?

13 A Well, my experience with -- I give a lot
14 of injectable corticosteroids in muscle.
15 I do that five, six times a week. And
16 normally, I will tell my patient they
17 will see the results of that within 48
18 hours.

19 Q And how long does is that going to last?

20 A A month.

21 Q But after a month, they should not be
22 having any more systemic side effects
23 from that corticosteroid that's been
24 injected into the muscle?

25 A But they will be feeling that in the --

1 Q Is that yes or no?

2 A You are going to have to repeat that
3 question.

4 MS. SCALISE: Would you
5 read it back to him, please.

6 (Record read.)

7 A Yes, they can. Because I've had people
8 have the effects of corticosteroids for
9 at least two months.

10 Q Well, that's my next question. In your
11 opinion, the maximum amount of time that
12 someone should experience side effects
13 from an excessive dose of corticosteroids
14 is, at most, two months or three months?

15 A I can't say that. Because there can be
16 associated structural changes which may
17 have long-lasting effects.

18 Q What type of associated structural
19 changes are you referring to?

20 A We are talking about blood sugar changes
21 for sure, changes in bone exacerbating
22 bony defects or problems. Similar things
23 to that.

24 Q Have any of your patients ever
25 experienced any side effects from

1 corticosteroids greater than two or three
2 months after an injection?

3 A Yes. When they had bony destruction, it
4 make them lose a few inches of height.

5 Q How many patients would that have been?

6 A It could have been about three.

7 Q And in those patients, the only long-term
8 effect you saw or experienced by those
9 patient was that they lost a few inches
10 of height?

11 A And problems with hips. Those are the
12 only ones I can remember.

13 Q Have you seen in any of the medical
14 records you have been provided that any
15 medical provider has said Ms. Gurry has
16 experienced a loss in height or any with
17 her hips as a result of this particular
18 intralesional steroid injection?

19 A I don't recall any medical provider. I
20 can't think of any medical provider at
21 this moment.

22 Q I will also submit to you that
23 Dr. LaRoche testified as far as
24 osteopenia, that that was genetic for
25 Ms. Gurry and not related to the

AFFIDAVIT of Schield M. Wikas DO

Documents Examined:

1. Summary Document
2. Photos April 27, 2016, April 11, 2016, March 7, 2016, May 4, 2016, May 14, 2016, July 13, 2016, August 8, 2016, August 10, 2016.
3. PET-CT SCAN IMAGES
Before February 25, 2016. After: September 21, 2016.
4. MRI SCAN IMAGE November 11, 2016
5. Photo Depicting 5 inch Scar
6. Statement of Elizabeth Sherertz MD Charlotte DERMATOLOGY
7. Clinical Notes Myrtle Beach Dermatology May 3, 2016
8. Affidavit Tara Gurry
9. Affidavit Dr. Kent Carson
10. Clinical Notes January 25, 2016 Misty Seawright NP
11. Clinical Notes/Pathology January 27, 2016 Dr. Joseph Masessa
12. Clinical Notes/Pathology Dr. Joseph Masessa
13. Consultation Letter Coastal Cancer Center February 19, 2016 Justin Markow DO
14. Coastal Cancer Center PET-CT February 25, 2016
15. Clinical Notes Kenneth Warrick MD January 13, 2016
16. Clinical Notes Coastal Cancer Center March 3, 2016 Justin Markow MD March 3, 2016, September 12, 2016
17. Coastal Cancer Center Whole Body PET-CT September 21, 2016
18. Coastal Cancer Center September 23, 2016 Dr. Emily Touloukian DO October 14, 2016
- 19 Charlotte Dermatology Dr. Elizabeth Sherertz June 6, 2016, July 27, 2016, September 6, 2016, November 21, 2016

20. Clinical Notes Dr. Chris Boggs July 22, 2016, September 2, 2016, September 30, 2016, October 25, 2016
20. Progressive Physical Therapy August 19, 2016, September 1, 2016, August 26, 2018, August 19, 2016, August 28, 2018
21. Strand Orthopedics Dr. Brian Blair November 1, 2017
22. Carolina Orthopedics Dr. Brian Blair November 1, 2017
23. Psychiatric Evaluation May 9, 2017
24. Comprehensive Behavioral Health Services August 8, 2016
25. Shannon Hussey Discovery Responses

My name is Schield M Wikas DO. I am a clinical dermatologist in practice since 1984. My CV is attached documenting my credentials and clinical experience. I am also the program director of an ACGME accredited dermatology residency since 1990. I have evaluated all of the above documents. I have not examined Tara Gully in person. I feel that all of the above documents allow me to make an opinion regarding the care Ms. Tara Gurry by FNP, Shannon Hussey on May 3, 2016. In addition, I have read and am in agreement with the statements and opinions in the affidavit of Dr. Ken Carson.

Tara Gurry had a malignant melanoma, Clark's level 4, on her right thigh surgically removed by wide local excision on January 27, 2016. On May 3, 2016 Tara Gurry had a scheduled appointment with FNP Shannon Hussey for a routine skin check. After the skin check, Shannon Hussey looked at the incision site and stated, "I have something that'll make that look better. I do it all the time." The incision site on the right thigh was documented by photographs April 27, 2016, April 11, 2016 and March 7, 2016 as having a length of 5 inches long. The postsurgical incision site on the right thigh prior to injection of corticosteroid as documented by photographs was healing normally and did not appear to have any significant hypertrophic scarring. According to the photograph, prior to the injection of corticosteroid there was no need for injection of corticosteroid. With time, in most individuals, these incisions heal normally with adequate patient satisfaction. According to the clinical notes of FNP Shannon Hussey on May 3, 2016 there was a hypertrophic scar of approximately 7 cm. There was no signed informed consent form prior to any injection. Shannon Hussey NP injected a "full syringe" into the scar site with triamcinolone acetonide (Kenalog). This caused continuing pain during the injection with no explanation as to potential for adverse effects. After the injection, according to Tara Gurry's sworn testimony:

"I was in pain, felt horrible and was very ill for 72 hours. This illness lasted 2 weeks, including nausea, chills, racing heartbeat, cramps, body aches, headaches, insomnia and my menstrual cycle started May 4 and lasted 3 weeks. The injection sites were painful and atrophy began within 24 hours and just got worse over several months, accompanied with severe leg pain including knee and hip. I had to stop running, golfing, and doing many activities I love. Nurse Hussey told me nothing of what to expect. I trusted her and her "medical advice" of "it'll make it look better", although I never complained how it

looked as it was only 13 weeks from surgery and it was healing fine, pictures show this. I would have never allowed her to touch me with that if I knew one side effect, even if she just told me it would hurt. I would have said no."

Subsequent to the injections, there was massive atrophy documented by the imaging of September 21, 2016 with damaged and retracted tissue including skin, subcutaneous tissue with destroyed nerve fibers, veins, fat, skin, hair follicles, sweat glands, lymph vessels and iliotibial band. A subsequent MRI dated November 11 2016 documented severe subcutaneous and cutaneous nerve loss. There was atrophy and destruction of iliotibial band.

In the Discovery Responses of FNP Shannon Hussey, "Defendant administered intralesional Kenalog in order to lessen the tension in the scar, which was evidenced by the Plaintiff's complaint of a pulling sensation and due to hypertrophic scarring. Thinning scar tissue with Kenalog is an appropriate treatment for thick or tight scar tissue as well as hypertrophic scar tissue." Ms. Gurry had mentioned to the defendant at the beginning of the appointment that she could feel a couple of stitches (noted on May 3 record in complaint) still at incision site. Normally, when a patient complains that they "feel" stitches in the healing scar but the stitches cannot be seen, it would be most appropriate to allow the stitches to dissolve; if the stitches are visualized, they can be removed or allowed to "spit" naturally. Injection of massive amount of corticosteroid is an inappropriate remedy for this situation.

Prior to the injections of triamcinolone into the local wide excision site on the right thigh, Tara Gurry had been an elite athlete. She had been a fitness instructor and yoga teacher for nearly 2 decades. She had participated in triathlons, marathons and speed skating events as well as golf, ~~by~~ yoga and cycling. She participated in 3 marathons including the Boston Marathon.

After the Kenalog injection, she had horrible headaches. She had subsequent diagnosis of osteopenia, osteoarthritis in the right hip documented by MRI with associated hip clicks when she walks; she may need a hip replacement in the future. As a result of the triamcinolone injection, she has had major muscle loss with some fat gain. She has been diagnosed with iliotibial band syndrome in addition to stiffness, tenderness, constant hip, knee, and leg pain. She has been unable to participate in the athletic activities in which she had previously excelled. Since the corticosteroid injection, she has been diagnosed by a psychiatrist with Major Depression Single Episode and general anxiety. The medical treatments, medication and physical therapy as well as counseling have not improved her life to the pre-injection status physically or emotionally. The results of the injections were catastrophic. The injections have caused a total life change for Tara Gurry. The results of the corticosteroid injection into the right thigh by FNP Shannon Hussey have been documented by multiple imaging procedures.

Through my education and experience I am aware of the standard of care when injecting corticosteroids into hypertrophic scars. I do not believe that Tara Gurry had a hypertrophic scar on May 3, 2016. The

photograph of the scar on the right thigh prior to May 3, 2016 showed a scar that was quite adequately healing with no indication of the hypertrophic changes or keloid changes. Therefore, I believe that the corticosteroid injected into the right thigh incision site of Tara Gurry was unnecessary. There is no documentation of any verbal or written consent prior to the procedure. Ms. Gurry had stated that if she knew that there was any potential adverse effects of the injection even pain she would not allow the procedure to go forward. Shannon Hussey had stated:

"The Kenalog was diluted with normal saline. Defendant utilized a 3 cc syringe and pulled up to 1 cc of Kenalog 10. Defendant then drew up normal saline into the syringe to the 3 cc line (in essence adding 2 cc of saline to the syringe). Defendant then changed the needle to a 30-gauge subcutaneous needle. Defendant superficially injected Kenalog along the length of the scar, not into the muscle, with the angle of the needle being close to parallel to the skin. Defendant documented that she gave approximately 1 cc which equates to approximately 3 mg of Kenalog in total. The remaining 2 cc of diluted Kenalog in the syringe would have been discarded."

#2> All of the imaging documentation substantiates that Ms. Gurry did not have a wound dehiscence but had a severe atrophic event comparable to an implosion. There was no splitting open of the wound which is the definition of dehiscence. There was massive atrophy/dissolution of the underlying structures. There is absolutely no evidence that the wound split apart. All imaging documents that there was dissolution of the underlying subcutaneous tissues including destruction of the iliotibial band. Shannon Hussey's narration of the preparation and injection of the corticosteroid is not plausible. The destruction of underlying tissue was too massive in the scenario that she presents. After the injection, the symptoms experienced by Ms. Gurry would be associated with much higher doses of corticosteroid.

<#1

#3> Tara Gurry was injected with excessive volume and/or excessive concentration of corticosteroid with inappropriate technique. It is my opinion to a reasonable degree of medical and scientific certainty that FNP Shannon Hussey fell below the standard of care by doing a procedure that was unnecessary and inappropriate. As a result of this unnecessary and inappropriate procedure, Tara Gurry has sustained significant physical harm with limitation of her physical activities and resulting emotional distress.

I depose to the affidavit in good faith conscientiously believing its contents to be true and correct.

Schield M. Wikas

Schield M. Wikas DO

I, the undersigned Notary Public, do hereby witness the affiant subscribed and SWORN to before me this 7 day of June, 2019.

Georgia J. Hartswick
NOTARY OF PUBLIC for the STATE of OHIO

My Commission Expires:

8/14/22





PENGAD 800-631-6989
EXHIBIT
Defendant
1

June 28, 2019



EXHIBIT
Defendant
2

PENGAD 800-631-6869

June 28, 2019

STATE OF SOUTH CAROLINA) IN THE COURT OF COMMON PLEAS

COUNTY OF HORRY) 2018-CP-26-05438

TARA GURRY,)
)
Plaintiff,) **Transcript of Record**
) (Motion Hearing)
vs.)
) June 28, 2021
MYRTLE BEACH DERMATOLOGY,)
LLC, SHANNON HUSSEY, AND)
RICHARD HUSSEY, M.D.,)
)
Defendant.)

B E F O R E:

Honorable Benjamin H. Culbertson
Horry County Courthouse
Conway, South Carolina

A P P E A R A N C E S:

Tara Gurry, Esquire
Pro Se Plaintiff

Marian W. Scalise, Esquire
Lydia L. McGee, Esquire
Attorneys for Defendants

Kay H. Richardson
Circuit Court Reporter

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JUNE 28, 2021

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Motions	3
Certificate of Court Reporter	61

E X H I B I T S

No.

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(No exhibits were marked or admitted.)

1 **JUNE 28, 2021**

2 **ON THE RECORD - 12:06 P.M.**

3 THE COURT: All right. This is case 2018-CP-26-05438,
4 Tara Gurry v. Myrtle Beach Dermatology, LLC, Shannon Hussey,
5 and Richard Hussey, M.D.

6 All right. What pretrial motions do we have?

7 MS. SCALISE: Your Honor, may it please the Court, I'm
8 Marian Scalise, and Lydia McGee, we represent the defendants.
9 As part of our pretrial brief, we have filed a number of
10 motions in limine. I believe that there are in total, I
11 believe it's like 17 of those. In particular, I don't know if
12 you want to just go through each one or how would you like to
13 do that?

14 THE COURT: Well, let me ask you this, are there -- I've
15 got the defendants' motions in limine, so are there any
16 pretrial motions from the plaintiff?

17 MS. GURRY: Your Honor, I actually have an objection to
18 these motion in limines. I was just handed these this
19 morning. I was just handed these as well as the defendants'
20 pretrial brief. It's my first time seeing all of these. I
21 was given no -- not told that I was gonna be received these,
22 and again I've had no time to look -- I've looked through
23 them, somewhat, some of them I'm fine with, but there are
24 several of them that I'm not. So, I would like to ask either
25 a continuance or -- there's objections that I just will not

1 agree to and I don't have enough time to respond properly,
2 because I have not received those before.

3 THE COURT: All right.

4 MS. GURRY: So, I have every right to do that. So, I've
5 prepared myself very well for this case. I've done the
6 research. I've educated myself, and I'm allowed to get a fair
7 trial and not to have stacks of papers given to me on the day
8 of trial.

9 THE COURT: All right. Do you have any pretrial motions?

10 MS. GURRY: They're basically addressed in her motions,
11 so ---

12 THE COURT: All right. So, everything -- you don't have
13 anything aside from what she's got?

14 MS. GURRY: A few, but again ---

15 THE COURT: Well, that's what I'm asking you. I need to
16 know what motions do you have?

17 MS. GURRY: It's -- they're all addressed here.

18 THE COURT: Okay. Ms. Scalise, what about the notice?

19 MS. SCALISE: Well, Your Honor, as to that, under the
20 rules, I don't think that there's any requirement for a motion
21 in limine to be served in advance. Under Rule 16 for pretrial
22 procedures, under 16(C) it says at or prior to a pretrial
23 hearing, counsel for each party shall provide to the judge a
24 uniform brief containing different matters. One of that
25 includes any legal issues involved and applicable law, causes

1 of action, et cetera. With motions in limine, they are
2 generally construed as a pretrial motion that is heard at the
3 time of trial. I'm not aware of any requirement that we have
4 to serve those in advance or provide any time. These are all
5 issues that have been in this case since the beginning. I
6 don't know that there's any new issues.

7 THE COURT: All right.

8 MS. SCALISE: So, we do oppose a continuance.

9 THE COURT: All right. Well, if that's what the rules
10 say, then we'll go forward with them. Now, are any of these
11 motions dispositive or any of the others?

12 MS. SCALISE: They could be, Your Honor.

13 THE COURT: All right. Well, then let's kind of take
14 them in the order -- in that order.

15 MS. SCALISE: Yes, sir, Your Honor.

16 THE COURT: All right.

17 MS. GURRY: Excuse me, Your Honor?

18 THE COURT: Yes.

19 MS. GURRY: There also was included defendants' pretrial
20 brief.

21 THE COURT: Right.

22 MS. GURRY: Stating the concise nonargumentative
23 statement of the facts of this case. There's several -- I've
24 written some notes here, statements that are absolutely not
25 true that can be verified.

1 THE COURT: Okay. Well, those -- all that is is that's
2 just short summary to let me, as the Judge, know what the case
3 is about.

4 MS. GURRY: Is this filed and on the record?

5 THE COURT: It's -- I don't think that it's filed, no.

6 MS. SCALISE: It's not filed.

7 THE COURT: And it doesn't go to the jury. All it is
8 it's just a piece of information for me to know who the
9 witnesses are, what they're ---

10 MS. GURRY: Okay, but there's -- and there's many false
11 statements on it, so I'd like to go ahead and address that.

12 THE COURT: Well, it -- there's no need to address it
13 because the jury is not gonna hear that statement. All right?

14 MS. GURRY: I would then like to, if we're gonna end up
15 moving forward, yes, some of my motions in limine, there's a
16 few that ---

17 THE COURT: I thought you said all of your motions were
18 tied up in hers?

19 MS. GURRY: Well, I notice that there's one that's not.

20 THE COURT: All right. What motion do you have?

21 MS. GURRY: Include evidence that the corticosteroid
22 Kenalog -- do you want me to read that ---

23 THE COURT: What is your motion?

24 MS. GURRY: My motion in limine, so there's several --
25 there's about five, six -- again, some of them are mentioned

1 here but there's about three of them that are not.

2 THE COURT: All right. What's the first motion in
3 limine?

4 MS. GURRY: Okay. Include testimony from Dr. Wikas about
5 the side effects of Kenalog and the Kenalog package insert ---

6 THE COURT: All right. A motion in limine is generally a
7 pretrial motion to suppress some type of evidence or
8 testimony.

9 MS. GURRY: Okay, correct, but I also read that it was to
10 include as well.

11 THE COURT: I've never had one -- is it to include? I've
12 never heard a motion in limine to include.

13 MS. GURRY: Okay. Well, we'll -- we'll be able to get
14 to, I think, get to it when we go over her motions.

15 THE COURT: All right. Anything else?

16 MS. GURRY: And, I'm sorry, I do see one other thing,
17 Your Honor; I'm sorry.

18 THE COURT: All right.

19 MS. GURRY: Exclude any testimony or documents, pictures
20 related to the accusations from Marian Scalise and/or defense
21 counsel that plaintiff doctored or altered documents or
22 pictures to mislead evidence or facts in this case.

23 THE COURT: Wait a minute. Say that -- read that to me
24 again, ma'am.

25 MS. GURRY: Exclude any testimony and/or documents,

1 pictures, et cetera, related to the accusations from defense
2 counsel that plaintiff doctored and/or altered documents or
3 pictures to mislead evidence and/or facts in the case.

4 THE COURT: All right. Ms. Scalise, let me hear from you
5 on that.

6 MS. SCALISE: Yes, sir, Your Honor. On that, when the
7 plaintiff's expert was originally disposed in his discovery
8 deposition, we learned that some of the documents that
9 Plaintiff had produced to him were actually doctored
10 documents. In essence, there was an affidavit from another
11 expert which she had deleted a sentence that basically read: I
12 am not going to be offering any opinion with regard to any
13 deposition or trial testimony. So, we just brought that up in
14 that expert's deposition.

15 Another one was she had gone online and printed ---

16 THE COURT: She being...

17 MS. SCALISE: I'm sorry. Being the pro se plaintiff.

18 THE COURT: All right.

19 MS. SCALISE: --- had printed some side effects of
20 Kenalog, but when you actually went to the document itself
21 online it was taken -- she had changed headings, she had moved
22 things around. And so, we brought that up in her expert's
23 deposition. I think that we actually have a motion basically
24 just cautioning her that she cannot use any evidence at trial
25 that has been doctored or has been altered in any manner.

1 Hopefully, she would not be doing that, so I don't think that
2 it would come to an issue here at trial so long as she doesn't
3 produce anything that's doctored. And it would just be that
4 before she tries to introduce some evidence, we would just
5 want to look at that and make sure our copy is the same as
6 what she is producing.

7 THE COURT: All right. Ms. Gurry, anything in reply?

8 MS. GURRY: Yes, Your Honor. The affidavit was -- as a
9 pro se plaintiff, I just want to go ahead and let you know
10 that it's very difficult as a pro se plaintiff to obtain the
11 services of an expert witness. Dr. Carson, a dermatologist,
12 he was the first expert that I retained. And he wrote an
13 affidavit, and at the time -- and this was the beginning of
14 litigation -- I thought that the affidavit would suffice for
15 the expert witness, what's needed, and then he told me he was
16 moving to Europe and that he wasn't gonna be able to testify,
17 so he put it into -- he put that one sentence into his
18 affidavit. I do not intend to testify at a deposition or
19 trial of the case. Then I went ahead and secure the services
20 of my expert witness now, Dr. Wikas. And when I forwarded him
21 the affidavit, I took out that one sentence. I know now,
22 obviously, it's a mistake. This is my first time doing
23 anything like this, but I didn't want to, again, getting back
24 to the fact that it was so hard for me to obtain a expert
25 witness, I didn't want that to have it not move forth with our

1 services, so that was -- Marian brought that up at Dr. Wikas'
2 deposition and, again, I did not alter the affidavit with the
3 facts and his testimony.

4 And then the other document that she's referring to is --
5 and again, I'm kind of new with working with pdfs and whatnot
6 and copying them, and this was back maybe like three years
7 ago. And so, what I did, when I found -- I found a website
8 that had Kenalog side effects, and I thought it was gonna be
9 very helpful, and I copied and pasted from the website onto a
10 pdf form, so there were a few headlines that didn't go ahead
11 and make it to my document. And, but right after the headline
12 of what the document was about, I put source with the actual
13 website; so, total transparency there. So, I would just like
14 the Court to know that.

15 THE COURT: All right.

16 MS. GURRY: Thank you.

17 THE COURT: All right. Ms. Gurry, I'm gonna deny your
18 motion in limine. All that means is that I cannot rule as a
19 matter of law that it's inadmissible. It may be
20 objectionable, but when they try to introduce it, raise your
21 objection then and then I'll address it, because at this point
22 in time, I can't say that as a matter of law it's totally
23 inadmissible. I'll have to wait until they attempt to present
24 it, why they're presenting it, and what the circumstances are,
25 and then I'll make a ruling. Okay?

1 MS. GURRY: But I object to that because it's prejudicial
2 over probative value. I mean, if the jurors hear that I went
3 ahead and -- the way how she explains it, they'll go ahead and
4 think that I've done dishonest things, where I just went ahead
5 and explained to you ---

6 THE COURT: But I can't rule as a matter of law that it's
7 inadmissible. I mean, certainly, if you and your expert's
8 testimony is based upon any false document, then it might come
9 in. If the issue never comes up, then it won't come up or if
10 they try to use it where it's irrelevant, then raise your
11 objection and I'll sustain your objection.

12 MS. GURRY: Okay. Neither of these are being brought
13 forth into evidence, anyhow, so there shouldn't be a problem
14 with that.

15 THE COURT: Ma'am, I'm just ruling on your motion; that's
16 all I can do is to decide whether or not as a matter of law
17 the evidence ---

18 MS. GURRY: Okay. Well, then I'll explain to the jurors
19 about that.

20 THE COURT: --- is inadmissible.

21 All right? Anything else from the plaintiff?

22 MS. GURRY: Not at this time.

23 THE COURT: All right.

24 Ms. Scalise, now what have you got?

25 MS. SCALISE: Yes, sir, Your Honor. May it please the

1 Court, we filed a motion in limine to challenge, limit, or
2 exclude Dr. Schield Wikas' testimony. Dr. Schield is the
3 plaintiff's expert in this case. We took a ---

4 THE COURT: Dr. Schield?

5 MS. SCALISE: Yes, sir. S-C-H-I-E-L-D, Wikas, W-I-K-A-S.

6 THE COURT: Okay. All right.

7 MS. SCALISE: This past Monday, we took a de bene esse
8 trial deposition that was videotaped of Dr. Wikas. He
9 testified that the concentration and volume of an
10 intralesional steroid injection that was documented by Nurse
11 Practitioner Hussey in the medical record that met the
12 standard of care and was appropriate, and any resulting
13 depression or atrophy was not a foreseeable outcome of that
14 injection. So, then he relied on a different theory. He said
15 on a res ipsa loquitur that the thing speaks for itself. And
16 he opined that the resulting depression and atrophy that she
17 has on her leg must mean that Nurse Practitioner Hussey did
18 something wrong. And so what he claims is, I don't know for
19 sure, but I think maybe it was excessive concentration,
20 excessive volume, and/or an improper location where this
21 injection took place. But despite his claims, he had no
22 literature whatsoever that supported his theories. He agreed
23 that this was purely a hypothesis and speculation as to
24 causation. And, under the Court's gatekeeping function, we
25 contend that the Court should exclude Dr. Wikas as an expert.

1 As far as kind of a background with regard to these
2 facts, back on January the 27th of 2016, the plaintiff had a
3 malignant melanoma on her right thigh that was excised by a
4 different dermatologist, a Dr. Joseph Masessa. This procedure
5 resulted in a 7.5 centimeter width, 1 centimeter depth of mass
6 that was excised from her leg. Then the resulting skin and
7 tissue was then sewn together resulting in a 16-centimeter
8 scar. This procedure in and of itself left here with a
9 significant scar. She ended up coming to the defendants'
10 office on February the 22nd, 2016 for a routine checkup.
11 Shannon Hussey at that visit documented that the excision scar
12 had central erythema and some mild oozing. And then the
13 patient returned to see Nurse Practitioner Hussey on May the
14 3rd of 2016 for this routine follow-up, because if you have
15 malignant melanoma, you have to have skin checks to see
16 whether there's any recurrence. So, she came to see Nurse
17 Practitioner Hussey, and Nurse Practitioner described in the
18 record that this scar was hypertrophic, which means it was
19 thickened, it was abnormal, and she also documented that the
20 plaintiff described it as having a pulling sensation and/or
21 the feeling of stitches in it. As part of her discussion with
22 the plaintiff, an intralesional steroid injection of Kenalog
23 was recommended. The plaintiff consented to that. And then,
24 Shannon Hussey then proceeded with injecting along the length
25 of that scar with this intralesional steroid. The records

1 show that she injected about 1 cc of a 3.3 milligram dose of
2 Kenalog. After this visit, the plaintiff has contended that
3 her whole life changed, and she has had systemic side effects
4 as a result of this Kenalog injection so much so that she had
5 three-week menstrual cycle, she had nausea, chills, racing
6 heartbeat, cramps, insomnia, headaches, that this caused
7 atrophy or significant depression in her thigh, that she can
8 no longer run or do any other kind of activities, and that now
9 she claims she has bone loss, wasting of her muscles,
10 hypothyroidism, adrenal fatigue, prominence of her veins,
11 depression, anxiety, PTSD, nightmares, et cetera.

12 MS. GURRY: Excuse me, I just -- I'm sorry, Your Honor.
13 Do I go ahead and object as this is moving along?

14 THE COURT: No. I'll give you an opportunity.

15 MS. GURRY: Thank you, Your Honor.

16 THE COURT: All right. Go ahead.

17 MS. SCALISE: She then continued to see medical --
18 different medical providers for these different claims. Then
19 on September the 27th of 2018, she filed a summons and
20 complaint against the defendants alleging cross negligence and
21 claiming that Nurse Practitioner Hussey has caused all of
22 these injuries that she has. Now, to support her claim, she
23 has identified this Dr. Wikas as her expert witness. We
24 originally deposed him on June the 28th of 2019, and then
25 again this past Monday on June the 21st, we took the de bene

1 esse videotaped trial deposition.

2 Your Honor, under Rule 702 of the South Carolina Rules of
3 Evidence, if scientific, technical, or other specialized
4 knowledge will assist the trier of fact to understand the
5 evidence or to determine a fact in issue, a witness qualified
6 as an expert by knowledge, skill, experience, training, or
7 education may testify in the form of an opinion or otherwise.
8 So, to determine admissibility of the expert opinion under
9 Rule 702, the Court is gatekeeper and must be satisfied that
10 this opinion testimony meets all three of the following
11 requirements: First, the Trial Court must find that the
12 subject matter is beyond the ordinary knowledge of the jury,
13 thus requiring an expert to explain this matter to the jury;
14 second, the expert need not be a specialist in the particular
15 branch or field, but the Trial Court must find that this
16 proffered expert has acquired the requisite knowledge and
17 skill to qualify as an expert; then finally, the Court must
18 evaluate the substance of that testimony and determine whether
19 it's reliable. And this is based on *Watson v. Ford Motor*
20 *Company*, 699 S.E.2d 169, holding that in executing its
21 gatekeeping duties, the Trial Court must make these three key
22 preliminary findings which are fundamental to Rule 702 before
23 the jury may consider expert testimony. In South Carolina,
24 the key case is *State v. Council*, 515 S.E.2d 508, and that
25 that particular court talked about how the Trial Court should

1 analyze the *State v. Jones* factors to determine reliability
2 and, if the evidence is admissible under Rule 702, then the
3 Trial Judge has to determine if its probative value is
4 outweighed by the prejudicial effect under a Rule 403
5 analysis. Then, once all of that analysis is done and the
6 evidence is admitted, then the jury may give it such weight as
7 it deems appropriate.

8 Your Honor, we contend that it's crucial that this Court
9 fulfill its *Watson* gatekeeping function to ensure that this
10 plaintiff's expert actually satisfies the criteria of Rule
11 702. And, the Court must ensure that Dr. Wikas does have the
12 requisite knowledge and skill to qualify as an expert and that
13 his opinion is based upon reliable medicine or science. The
14 gatekeeping function is critical due to the weight given by --
15 given to experts by a jury, so therefore the Court has to
16 recognize that due to the difficulty of evaluating the
17 testimony, expert witnesses have the potential to be both
18 powerful but also quite misleading. And as our Supreme Court
19 has reiterated time and again, reliability is the central
20 feature of a Rule 702 admissibility. And, the familiar tenet
21 of evidence law that a continuing challenge to evidence goes
22 to weight, not admissibility. Our Courts have said has never
23 been intended to supplant the gatekeeping role of the Trial
24 Court in the first instance in accessing this admissibility of
25 expert testimony, including that professional threshold

1 determination over liability.

2 In a medical malpractice case, expert opinion is
3 generally required. The plaintiff must demonstrate and prove
4 -- and provide evidence that through an expert witness of a
5 generally recognized and accepted practices and procedures be
6 followed of the average competent practitioners in the
7 defendant's field of medicine under the same or similar
8 circumstances, and that the defendant departed from those
9 recognized and generally accepted standards.

10 Plaintiff also has to establish that the defendant's
11 departure was the proximate cause of the plaintiff's alleged
12 injuries and damages. So, while plaintiff is pro se, she
13 still bears that burden of proof and must establish this
14 through expert testimony to prevail in a medical malpractice
15 action. A medical malpractice action, of course, requires a
16 greater showing than just generic allegations and conjecture,
17 and the admissibility of expert opinion requires more scrutiny
18 that admissibility of other evidence.

19 So, Your Honor, our first point is that Dr. Wikas does
20 not have experience or training outside of the field of
21 dermatology, which renders him unable to -- and not qualified
22 to render any opinions outside of the realm of dermatology.

23 Under 702, that expert has to have particular knowledge,
24 skill, experience, training, or education, and the test under
25 *Watson* is a relative one that is dependent on the particular

1 witness' reference to the subject. In *Watson*, the Court found
2 that the Trial Court had erred in qualifying a plaintiff's
3 expert witness as an expert in automobile cruise control
4 systems. And the Court noted that while the plaintiff's
5 expert may've been qualified as an expert in some automobile
6 components, there was no evidence to suggest that he had that
7 knowledge, skill, experience, education, or training
8 specifically related to cruise controls. And we find that
9 *Watson* directly controls the facts of this case.

10 In this case, Dr. Wikas was only trained in the field of
11 dermatology. He does not perform the type of melanoma
12 excision the plaintiff had the months prior to this Kenalog
13 injection at issue in this case. Dr. Wikas conceded in his
14 discovery deposition that he is solely going to offer opinion
15 about the plaintiff's alleged atrophy. He was not gonna be
16 offering any opinion about any of these other systemic
17 complaints ---

18 MS. GURRY: I'm sorry. Can you just tell me the page
19 you're on, please?

20 MS. SCALISE: On my brief?

21 MS. GURRY: Yes.

22 MS. SCALISE: Sure; it's page 6.

23 MS. GURRY: Okay, Thank you.

24 MS. SCALISE: And, Your Honor, in case I do forget, we
25 have filed an extensive memorandum and motion that outlines

1 all of what I'm talking about that has the actual caselaw that
2 we are citing as well as exhibits that include these excerpts
3 from the deposition testimony.

4 But, Mr. Wikas, he conceded that he was not gonna be
5 offering any opinions about any of these other systemic claims
6 that the plaintiff has. So, despite him giving that
7 testimony, he is not able to say whether any of the things
8 that the plaintiff alleges she's experienced other than
9 atrophy were caused by the Kenalog injection. He was not the
10 being qualified -- he admitted he was not qualified as an
11 expert in fields of rheumatology, endocrinology, obstetrics
12 and gynecology, orthopedics, or radiology. But yet, the
13 plaintiff proceeded to question him about the impacts of
14 corticosteroids, such as Kenalog, when it's absorbed
15 systemically and about what he was able to interpret from PET
16 scans and CAT scans and MRI scans. We objected in his
17 deposition; we moved to strike that testimony. And now, we
18 assert that this testimony that he has given is purely
19 speculative, not based on any scientific evidence or opinion,
20 and we believe it would be confusing to the jury and cause --
21 misleading them when Dr. Wikas himself testified that the only
22 alleged injury he could comment on was this alleged atrophy.

23 THE COURT: So, he testified as to these other conditions
24 in addition to the atrophy?

25 MS. SCALISE: In his discovery deposition he did not; in

1 his trial deposition, then she asked him a question about all
2 these and he started to say about all these other things even
3 though he had previously said and acknowledged he was not an
4 expert in those.

5 MS. GURRY: Okay. Objection, because this is not
6 correct. So, I need to speak up. Right? Don't you want me
7 to?

8 THE COURT: Not now. I'll give you an opportunity.

9 MS. GURRY: Okay. Thank you, Judge.

10 THE COURT: All right.

11 Go ahead.

12 MS. SCALISE: Additionally, Dr. Wikas testified that if
13 this patient had come to him, he would've referred the patient
14 to a plastic surgeon for that melanoma excision because the
15 depth of the malignant melanoma and how that it required
16 excision. This is particularly important because Dr. Wikas is
17 providing testimony that the Kenalog injection is the only
18 cause of this atrophy and loss of subcutaneous tissue as
19 compared to this loss of tissue being due to the original
20 surgery itself. We assert that Dr. Wikas, because he
21 testified he would refer the plaintiff to a plastic surgeon to
22 perform this, he is unqualified to testify that the atrophy or
23 loss of subcutaneous tissue was of a naturally occurring event
24 with scar stretch from the plaintiff's extensive melanoma
25 excision. For these reasons, we believe he's unqualified to

1 provide opinions as to any alleged injury outside of the
2 atrophy, which would occur as a result of this steroid
3 injection. We'd also contend he's unqualified to opine
4 whether this atrophy was really the natural progression of a
5 post-melanoma excision scar healing. Therefore, for him to
6 assert that Kenalog, rather than this original surgery, is the
7 cause has a great potential to mislead a jury. He would be
8 inclined to give his testimony greater weight just because
9 he's been deemed an expert. So, for that reason, under the
10 Court's gatekeeping function, we contend that Dr. Wikas should
11 be excluded.

12 Additionally, Dr. Wikas offers no opinion on how Nurse
13 Practitioner Hussey most likely breached a standard of care or
14 how that breach was a foreseeable proximate cause of the
15 alleged damages, again, rendering his testimony unreliable.

16 Under the *Oglesby v. General Motors Corporation* case, it
17 says a reliable expert opinion must be based on scientific,
18 technical, or other specialized knowledge, and not on belief
19 or speculation, and inferences must be derived using
20 scientific or other valid methods. An expert's opinion should
21 be excluded when it's based on assumptions which are
22 speculative and not supported by the record. In a medical
23 malpractice action, it is impermissible to speculate that an
24 injury is a result of negligence in the absence of any
25 evidence as to how the medical provider deviated from the

1 standard of care.

2 The Supreme Court in *King* stated that it is well settled
3 that the -- it is stated that the burden rests upon the party
4 to prove negligence, and this burden cannot be met by relying
5 upon the theory that the thing speaks for itself or that the
6 very fact the injury indicates negligence. In order therefore
7 for a plaintiff to recover damages, she has to prove by the
8 greater weight or preponderance of the evidence not only the
9 injury but also that it was caused by the actionable
10 negligence of the defendant. The *Watson* case, again, it's
11 particularly instructive because it was decided that the
12 plaintiff's expert would be excluded and then the Court in
13 South Carolina noted that it does not follow the doctrine of
14 res ipsa loquitur, and that plaintiff's case cannot rely on
15 the fact that an accident occurred just to prove negligence.

16 In *Cooper v. Smith & Nephew*, the -- in the Fourth
17 Circuit, Court of Appeals affirmed a Trial Court's grant of
18 summary judgment dismissing a plaintiff's claim for personal
19 injuries based upon allegedly defective pedicle screw fixation
20 devices to treat spinal injuries. In that case, the
21 plaintiff's expert testified that his determination of whether
22 a device was defective or not was based simply on whether or
23 not the surgery was successful. The Court stated *Daubert*
24 requires more than assertion that if there is a lack of
25 surgical success, there's ipso facto the product defect and

1 hence causation is established. In affirming the Trial
2 Court's ruling, the plaintiff's testimony was unreliable, the
3 Fourth Circuit found that the plaintiff's expert failed to
4 provide any medical evidence as to what caused the injuries
5 rather inferred causation, because the surgery in question
6 ultimately was not successful. Although South Carolina does
7 not explicitly follow *Daubert*, it does require that the
8 expert's testimony is reliable. Just as in *Cooper*, the
9 inability to testify as to proximate cause renders Dr. Wikas'
10 opinion unreliable.

11 It is well settled in our state that when medical
12 testimony is relied upon to show a causal connection between
13 the accident and certain result, it is not sufficient for the
14 doctor to say simply that the ailment in question possibly or
15 might have resulted from the accident. Instead, medical
16 experts must go further and testify that in their professional
17 opinion that the result was -- most probably came from the
18 alleged cause.

19 Now, Dr. Wikas has testified on behalf of a pro se
20 plaintiff on multiple occasions. He admitted to owning expert
21 witness books and attending various expert witness courses.
22 In fact, he admitted attending ten of those courses and owning
23 all these different books on how to be an expert witness. He
24 actually has his own expert witness website. He advertises
25 with a number of expert witness locator services, and has been

1 an expert for the last 20 years. As such, he understands the
2 exacting legal standard required of the medical malpractice
3 expert to testify to a reasonable degree of medical certainty
4 that the injury complained of most probably caused -- was
5 caused by the alleged conduct. So, despite having that
6 foundational knowledge, he never once gave any testimony to a
7 reasonable degree of medical certainty that the Kenalog
8 injected by Nurse Practitioner Hussey is the most probable
9 cause of her atrophy or any other alleged side effects.
10 Additionally, he admitted in the discovery deposition and
11 again in his trial deposition that he understood and
12 acknowledged that his testimony amounted to a res ipsa
13 loquitur argument, which is not acceptable in South Carolina.

14 The question was: So, in essence, you're saying the
15 thing speaks for itself, the fact that she has this injury it
16 must mean Shannon Hussey did something wrong? His answer: Is
17 that called res ipsa loquitur? Question: Yes. So, is that
18 your contention? Answer: Yes. Question: All right.
19 Because I think you explained in your deposition is the thing
20 speaks for itself? Answer: Correct. Question: In fact,
21 it's kind of a legal term res ipsa loquitur, that the fact
22 that there's been an injury, somebody must've done something
23 wrong to have caused that, correct? His answer was: In this
24 case, yes.

25 Moreover, Dr. Wikas testified on multiple occasions that

1 the injury itself is evidence of negligence and an injection
2 in an improper location, or of an improper concentration, or
3 of an improper volume by Shannon Hussey. His testimony was: I
4 felt that Nurse Practitioner Hussey fell below the standard of
5 care because plaintiff had catastrophic thinning of the skin,
6 a depression, accentuation of blood vessels, there was
7 sensitivity to touch, so I felt that her activities were well
8 below the standard of care. He testified: It was my
9 impression that she injected too much corticosteroid, probably
10 too deeply, too high a concentration, too large a volume. He
11 testified: I think the results speak for themselves. I've
12 never seen -- he said: Ms. Hussey said she injected 3.3
13 milligrams of the corticosteroid into the incision site. I've
14 injected that amount of concentration many, many times,
15 literally at least hundreds of times, and I've never seen a
16 wound implode. He testified: The amount Ms. Hussey said she
17 injected really doesn't jive with the results.... He
18 testified: Well, an excessive concentration of the
19 corticosteroid injection was injected and it led to this. If
20 there wasn't, if the right amount of injection was used, then
21 you wouldn't have this result. He testified: Well, all I can
22 tell you is it really doesn't matter in this case, because the
23 result speaks for themselves. And I asked him: So, your
24 opinions as to the cause of her injuries are solely based on
25 the fact that she's got this atrophy, and now you've

1 backtracked and tried to come up with some explanation as to
2 what could have caused that. In essence, the thing speaks for
3 itself; something must've been done wrong? And he said:
4 Correct. I asked him: Because you have no evidence to truly
5 say there was a wrong concentration or the wrong dose or the
6 wrong site, correct? And he said: There's no concrete
7 evidence. I asked him: And so as we've discussed, you've not
8 seen and you're not aware of any literature that supports your
9 opinion, correct? And his answer was: Correct. And you've
10 not performed any testing or any kind of methodology to see if
11 your hypothesis is correct? He said: Correct. He said, I've
12 never seen such as catastrophic result if the correct
13 concentration and correct volume were administered. Never.
14 So, I asked him: So, the fact of how it looks now, it has to
15 mean that Shannon did something wrong? His answer: Yes -- or
16 correct. I asked him: But if in fact she did administer the
17 3.3 milligrams per cc as the record supports, would that be an
18 appropriate amount for a hypertrophic scar. His answer: It
19 would be an appropriate amount if it was injected properly,
20 but I think a higher concentration was -- well, I see there --
21 you see all the systemic side effects -- which again, he
22 testified previously, he couldn't give an opinion to -- and
23 everything like that, I'm more inclined to think of 40
24 milligrams totally injected in the area. I said: What I want
25 to know is at least based on how she's documented, would that

1 be an appropriate amount to inject into a hypertrophic scar?
2 His answer: That would be an appropriate concentration into a
3 hypertrophic scar which this wasn't. I asked him: And would
4 that appropriate amount to inject, would you agree that you
5 would not expect to see any type of atrophy, certainly not to
6 the extent of what Ms. Gurry has? His answer was: Yeah, you
7 wouldn't expect to see it if it was appropriately administered
8 with the right concentration with the correct volume and the
9 correct location. Question: All right. And as far as the
10 location, do you have any evidence that it as not
11 appropriately administered in this correct location? His
12 answer was: The only evidence is the result. I said: So
13 looking at Exhibit 5 -- which was a diagram of some skin --
14 can you give an opinion as to where this injection was
15 located? He said, I can't give you an opinion, but I can tell
16 you it was injected in the wrong place, too high a volume, too
17 high of a concentration because the result speaks for itself.
18 So, again, getting back to the fact that she has got what she
19 has now, there was something going on wrong by Nurse Hussey?
20 His answer: There was no problem prior to the injections.
21 After the injections, everything went wrong and it became a
22 catastrophic event. Then I asked him: Do you agree that a bad
23 outcome doesn't necessarily mean that the medical provider was
24 negligent? He said: Correct, except in this case. I said:
25 You agree that the occurrence of an injury is not proof of

1 medical negligence? He said: Correct, except in this case.

2 Your Honor, Dr. Wikas' testimony is pure supposition as
3 detailed above, he agrees that what Shannon Hussey documented
4 is an appropriate amount. It meets the standard of care. If
5 in fact that's what caused her injury, that's not foreseeable.
6 So, instead, he comes up with these theories of perhaps it was
7 too much of a concentration, too much volume, or the wrong
8 location, only based on how it looks now. But importantly, he
9 testified he had never experienced, never even heard of, never
10 read about an injection given as documented in the medical
11 record, causing the type of atrophy. But similarly, he's
12 never -- he's not aware of any literature that would support
13 if you gave too much of a concentration that would cause it;
14 not aware of any literature that says if you gave it in the
15 wrong amount that would cause this; or if you gave it in the
16 wrong location, it would cause this. There is absolutely no
17 evidence to support any of his opinions by his own admission.
18 He bases his opinion -- we contend that his opinions are
19 outside of the realm of his expertise as far as any systemic
20 side effects, which again demonstrates how speculative his
21 opinions are, which again are unreliable.

22 Dr. Wikas testified that the alleged injury is a logical
23 result of the Kenalog injection but a finding of medical
24 malpractice is not required that the alleged injury be a
25 logical result of the alleged negligent act. Instead, the

1 finding of medical malpractice requires that the expert say to
2 a reasonable degree of medical certainty that the result in
3 question most probably was caused, more likely than not, from
4 the alleged cause. And that is simply not something that he
5 has testified to.

6 Again, I asked him: And you would agree that injecting
7 one CC of 3.3 milligrams of Kenalog it would not be
8 foreseeable that that's going to cause the depression that
9 Tara Gurry has, correct? His answer: Yes. That would not be
10 a natural or probable consequence of injecting the amount of
11 steroid into the scar, correct? His answer was: Correct. It
12 would be highly unusual, would it not? Answer: Correct.
13 Question: Very abnormal, correct? And the answer: Correct.

14 Under the *Eadie v. Krause* case, when an injury complained
15 of is not reasonably foreseeable in the exercise of due care,
16 there is no liability. If the atrophy the plaintiff alleges
17 truly occurred as a result of what Nurse Practitioner injected
18 as reflected in the medical record, that is absolutely an
19 unforeseeable event for which there can be no liability. So,
20 Dr. Wikas has chosen not to believe the medical record, and
21 instead he candidly admitted that, other than the alleged
22 injury itself, he has no direct evidence that anything was
23 done wrong. So, this theory of causation has been rejected by
24 South Carolina courts, and it's this type of speculative
25 testimony that's unreliable and, under the Court's gatekeeping

1 function, should be excluded at trial.

2 Skipping ahead, let's see. Without limiting or
3 abandoning the defendant's theories of causation, we submit
4 that the *Fletcher* case is on point and requires that the Court
5 grant the defendant's motion to exclude Dr. Wikas' testimony
6 as unreliable. In *Fletcher*, the plaintiff had a subclavian
7 bypass surgery. Mr. Fletcher brought a medical malpractice
8 claim alleging that the doctors were negligent in performing
9 the procedure and that she was not properly advised of the
10 risks associated with that procedure. Like the plaintiff in
11 this case, the plaintiff in *Fletcher* testified that she would
12 not have undergone the procedure had she known of the
13 potential risks or side effects. But, during cross-
14 examination, the plaintiff's expert testified that
15 complications could've occurred during this procedure even in
16 the absence of any surgical negligence. As discussed above,
17 Dr. Wikas, he's testified that atrophy and pain are known side
18 effects of Kenalog injection. The expert in *Fletcher*
19 testified: Do you see anything in there, the operative note
20 and the records, that indicate that Dr. Brothers used an
21 improper technique to do this operation? And he answered: No.
22 Similarly, Dr. Wikas testified that the amount Nurse
23 Practitioner Hussey documented that she injected was an
24 appropriate amount, and with that amount, you would not expect
25 to see the significant atrophy and depression.

1 Now, based on the testimony in Fletcher, the Court of
2 Appeals held the following: It said -- Essentially, the
3 plaintiff asks us to conclude that the occurrence of a
4 complication is itself evidence of negligence. However, South
5 Carolina does not recognize the doctrine of res ipsa loquitur.
6 Simply no evidence establishes how the defendants deviated
7 from the standard of care. Unfortunately, two of the risks
8 associated with the procedure did befall the plaintiff.
9 Nevertheless, we as the Court are not permitted to speculate
10 that misfortune was a result of negligence in the absence of
11 any evidence as to how the physicians deviated from the
12 standard of care.

13 And the Court went onto say in *Bowie v. Hearn*, it
14 addressed this point. This case was reversed based on the
15 particular facts presented, but the reasoning employed by the
16 Court of Appeals was found to be instructive by our South
17 Carolina Supreme Court. Bowie sued the physician who
18 delivered him via C-section because he was cut on the check
19 during the procedure resulting in a scar. Bowie's expert
20 testified that the standard of care required the physician not
21 to cut the baby. And in analyzing the sufficiency of his
22 testimony the Court alluded to another oft-cited medical
23 malpractice case, *Cox v. Lund*, and stated under the
24 plaintiff's reasoning in the *Bowie* case the doctors in *Cox*
25 could simply have testified that normally colons are not

1 perforated during colonoscopies, the standard care, therefore,
2 is a doctor should not perforate the colon, and to do so
3 violates the standard of care. Such reasoning would, in
4 effect, make a doctor an insurer of a perfect result in every
5 surgical procedure. And the Supreme Court said a doctor is
6 not an insurer of health and negligence may not be inferred.

7 The Supreme Court said the analysis in *Bowie* is precisely
8 on point with the *Fletcher* case which we also contend is on
9 point here in this case. And the Supreme Court said that we
10 discern no factual basis that would cause a reasoning in that
11 case to be inapplicable to the facts. And they affirmed the
12 circuit court's granting of a directed verdict as the *Fletcher*
13 case presented no evidence, only speculation, that MUSC's
14 agents had deviated from the standard of care.

15 Again, we believe that thus the reasoning in *Fletcher* is
16 on point. Dr. Wikas readily admitted he was relying on the
17 doctrine of res ipsa loquitur to opine that the injury itself
18 demonstrates negligence and so, because of that reasoning, we
19 contend that his testimony should be excluded at trial.

20 Dr. Wikas initially testified that adequate informed
21 consent was not given. However, he then testified that what
22 ultimately occurred with Ms. Gurry would not be something that
23 a medical provider would expect to occur, such as this atrophy
24 and large depression, and such that that would not be a risk
25 that a medical provider would have to advise a patient as part

1 of the informed consent, because it would not be something
2 that would be expected to happen. Instead, he agreed that the
3 medical record documented that there was a discussion about
4 the procedure, that Nurse Practitioner Hussey reviewed the
5 causes, options, the treatment which was recommended, which
6 was the intralesional steroid to decrease the hypertrophy, and
7 that side effects were reviewed. And Dr. Wikas testified that
8 was appropriate.

9 Dr. Wikas conceded that there was no evidence that had
10 the plaintiff been told about the potential for atrophy that
11 she would've chosen not to get the injection. Despite the
12 plaintiff saying she would not have chosen to receive the
13 injection if she knew she was going to experience pain, she
14 did testify that in fact she experienced pain and she never
15 instructed the defendant to stop. So, Dr. Wikas' testimony is
16 speculative, it is unreliable, and the Court under its
17 gatekeeping function should exclude Dr. Wikas as an expert.

18 In totality, his opinions are pure speculation relying
19 solely on the doctrine of res ipsa, which is impermissible
20 under South Carolina law. And it's unreliable under Rule 702
21 of the South Carolina Rules of Evidence and must be excluded.

22 Another ground, Your Honor, is that to be reliable, Dr.
23 Wikas' opinions have to be based upon some type of reliable
24 medicine or science. Our Court in the *White* case and other
25 cases have expressed time and time again that reliability is a

1 central feature of Rule 702 admissibility. And the Court
2 suggested four factors to consider in determining whether
3 scientific evidence is reliable. The first is what is the
4 scientific methodology; the second, what is the peer review;
5 (3) what is the consideration of general acceptance; and (4)
6 is the rate of error of a particular technique. And again, by
7 Dr. Wikas' own testimony, there is no literature that supports
8 his opinion. He didn't perform any testing to see whether his
9 opinions are accurate and whether, in fact, if you put in an
10 excessive amount of steroid, there's gonna be atrophy; or you
11 put in the wrong amount that that's gonna cause this
12 depression that she has; or you put it in the wrong location
13 that's gonna cause that. He acknowledged that he did none of
14 that, whether it be in animal models, anything. He has
15 nothing whatsoever to support his opinions, they are pure
16 speculation in the purest sense.

17 Additionally -- oh, and I'd also like to add that Dr.
18 Wikas gives Kenalog injections, just like Shannon Hussey does,
19 and he has never experienced this kind of results. He's never
20 seen any type of intralesional steroid injection cause an
21 injury like what the plaintiff has. So, again, under Rule 702
22 analysis, his opinions are only speculation. He's failed to
23 provide any research or medical literature to suggest that
24 what he's contending is even a possibility. So, his opinions
25 are wholly unreliable.

1 Then, finally, Your Honor, if the Court were inclined to
2 find Dr. Wikas credible and admissible under Rule 702, we
3 contend that under a 403 analysis, his testimony also should
4 be excluded on the basis of any probative value being
5 outweighed by its prejudicial effect. Again, Dr. Wikas is
6 only trained and qualified to provide opinions in the field of
7 dermatology. And because he's unable and unqualified to
8 provide opinions about any of her other medical issues, any
9 testimony as to the cause of her alleged injuries is pure
10 speculation and not based on scientific opinion or evidence.
11 So, any probative value in allowing him to testify that the
12 Kenalog injection is the sole cause of her injury, when he's
13 unable to provide any opinions about any of her other medical
14 issues would be substantially outweighed by the prejudice to
15 the defendants, it would cause confusion of the issues and
16 would mislead the jury to believe that he is qualified to
17 consider, evaluate, and provide opinions about her illnesses
18 and his testimony that this Kenalog injection is the sole
19 cause of her problems. He is qualified to consider all
20 potential causes of the depression to her leg, and he has
21 evidence to believe that the sole cause was the Kenalog
22 injection. But, again, this whole opinion is based on res
23 ipsa, which we contend is impermissible. And there's no
24 evidence this -- no evidence whatsoever to show that the
25 plaintiff was actually injected with too high of a

1 concentration, too much volume, or an improper location, and
2 he's failed to meet that exacting standard of testifying to a
3 reasonable degree of medical certainty or providing any
4 testimony that is more probable. If the Court were to find
5 that any of his testimony is relevant and admissible under
6 Rule 702, we assert that the probative value in allowing him
7 to give these speculative opinions circumvents the requirement
8 of reliability in Rule 702 was substantially outweighed -- and
9 would be substantially outweighed by the prejudice to the
10 defendants, cause confusion of the issues, misleading the
11 jury.

12 Your Honor, under a Rule 702 and 403 analysis, we contend
13 that Dr. Wikas should be excluded as an expert. His testimony
14 does not meet the requirements under our very strict laws as
15 to what is required for an expert. And under the Court's
16 gatekeeping function, we'd ask that Your Honor exclude him as
17 a witness.

18 Thank you.

19 THE COURT: Thank you.

20 Mr. Gurry?

21 MS. GURRY: Well, first of all, I'd like say, getting
22 back to just because -- can you hear me okay?

23 THE COURT: Yes.

24 MS. GURRY: Getting back to where this all started with
25 the defendants' pretrial brief. There's so many errors on

1 here. Okay. So, this is the information that you've been
2 given to know what this trial is about. Well, there are many
3 errors on here that need to be addressed. I have every right
4 to go ahead and address these properly.

5 Regarding this, things have been cherry-picked out of
6 what she's stating. He, first of all, in his affidavit he
7 stated Tara Gurry was injected with excessive volume,
8 excessive concentration ---

9 MS. SCALISE: Go ahead.

10 MS. GURRY: I'm just stating like -- okay. It's my
11 opinion as a reasonable of medical and scientific certainty
12 that Shannon Hussey fell below the standard of care by doing a
13 procedure that was unnecessary, inappropriate, as a result I
14 sustained injuries. And first of all, too, I need to go ahead
15 and state ---

16 THE COURT: What was that -- what were just reading from?

17 MS. GURRY: Yes. That was his initial -- that was his
18 affidavit, Dr. Wikas' affidavit.

19 THE COURT: Is that contained in his deposition?

20 MS. SCALISE: No, Your Honor.

21 MS. GURRY: It's mentioned in his a -- I mean, there's
22 parts of that ---

23 THE COURT: In his deposition ---

24 MS. GURRY: Parts of that, yes, parts of that -- no, it's
25 not like the actual ---

1 THE COURT: But does his deposition say that in his
2 expert opinion to reasonable degree of medical certainty the
3 ---

4 MS. GURRY: I'll have to ---

5 THE COURT: --- the injuries you sustained were more
6 probably than not the result of a breach of care?

7 MS. GURRY: He said -- I don't know if he said exactly
8 that, but he went ahead and made several statements as to the
9 causation and the breach of -- the breach of this. And -- but
10 before we get into that, I really -- I want to state, too,
11 that this whole thing is based upon that the medical records
12 that Shannon Hussey kept on that day, which I want to let you
13 know, too, were cited by the Board of Nurses for inaccurate
14 records. Okay? That everything that she documented in her
15 records is correct, is proper. That is how she is basing this
16 whole argument on. And there is -- there's no -- there's no
17 way that that could've happened because of the injury that I
18 have, because let me explain to you what this drug does. This
19 drug will -- if someone does have a keloid scar or a raised
20 thick scar tissue, the drug needs to be injected directly into
21 that scar tissue and it will thin it, it will atrophy it, it
22 will waste away. If it's injected into healthy tissue and
23 skin, what's it gonna do? The same thing. I had so much
24 injected into me this dermatologist, who's been practicing for
25 37 years has never seen anything like it in his practice. It

1 was catastrophic. Okay? The drug -- skin anatomy is blood,
2 vessels, the lymph system, part of the lymph system,
3 subcutaneous tissues, the dermis, the epidermis; all this was
4 destroyed. I have pictures that show that. I have a PET-CT
5 scan that shows me after the surgery where my thigh was
6 intact, and then after the injection, about four months later,
7 where I had a huge indentation and subcutaneous tissue was
8 lost. I suffered -- was diagnosed with many things because of
9 this, but just getting to the actual damage of it, it went --
10 the atrophy went all the way down to my IT band. But, getting
11 back to that he did not -- well, I'd like to -- thank you for
12 bearing with me here, it's just all a lot to take in all at
13 once. But, regarding her it speaks for itself, I'm well aware
14 that that is not a doctrine of South Carolina. And Dr. Wikas
15 was not using that as his testimony as to the causation for
16 this. And I'm gonna be here presenting the evidence and facts
17 testimony to go ahead and prove my burden of proof. We're not
18 -- but she continuously cites that as to his reasoning. If I
19 have time to go and look through his deposition -- well, I can
20 tell you right here. I remember I asked him what the breach
21 was and he went ahead and said misdiagnosis. So, I've never
22 had a hypertrophic scar in my life. I was healing
23 beautifully. The pictures show this. My only complaint was I
24 could feel a stitch within the five-inch incision site, I
25 could feel a couple of stitches. That's all I told her. And

1 -- and, so -- I'm sorry; I lost my train of thought. But, so,
2 Dr. Wikas' testimony was that his opinion, his medical opinion
3 was that it was inappropriate, that it was a misdiagnosis, and
4 that she -- the administration was improperly done. There had
5 to be -- there had to be -- he said there was no possible way,
6 it wasn't probable for what she had stated on the medical
7 records to be true. Again, this is a dermatologist with 37
8 years' experience. Like, and what this drug does is it does
9 exactly what happened to me. So, anyway, but just to get back
10 to Dr. Wikas, and then he stated that the informed consent,
11 that he didn't believe that I had the informed consent, did
12 not have the informed consent because I wouldn't have moved
13 forward with this if I knew there were gonna be any side
14 effects. But, again, I was never told of any diagnosis. All
15 she said during this whole appointment -- I wasn't able to
16 give you a trial brief about this -- I didn't know that was
17 part of it. But, all that occurred during this was she said,
18 I have something that will make that look better. I do it all
19 the time. She left the room and returned with a syringe and
20 started injecting. So, again, getting back to Dr. Wikas, he
21 has stated that the breaches are misdiagnosis, informed
22 consent, administration of the drug, and inaccurate medical
23 records. So, just the basis, going off -- I don't know where
24 we've come to the point in reading through her different
25 things that Shannon Hussey's records, medical records, that

1 they're fact. Okay. All the evidence and facts in this case
2 and what happened to me, they're all in the Kenalog package
3 insert. This goes ahead and tells you what the drug is about
4 and what it does and the side effects. Well, the side effects
5 that I encountered that are on my medical records after the
6 injection, they match up to what this drug does. And
7 specifically what we can all see and what the jurors will see,
8 and I'm gonna have them touch my leg as well, the horrendous
9 atrophy and depression that happened to my leg.

10 So, but getting to my expert witness, he did an excellent
11 job and he offered his medical opinion and the causations, and
12 he stated several times -- and I was surprised during the
13 deposition that Marian kept on asking about is it correct that
14 the amount that she injected could not cause this. Well, of
15 course it is because that wasn't what was injected, and that's
16 why he's never seen it before. And as to her citing that
17 there's no medical literature on this, why would there be?
18 Why would you go ahead and harm animals or humans and go ahead
19 and inject so much concentration and undiluted excessive and
20 the dilution of this Kenalog to cause what had happened. I
21 had just turned 49 at the time. I'd been a professional
22 athlete, a yoga instructor, in excellent health with great
23 skin. There's nothing -- I don't have any reactions to
24 anybody, I don't suffer for anything that would cause a
25 reaction to take place other than, again, this is what the

1 drug does. So, regarding Dr. Wikas, excluding him, his
2 testimony is -- there's no reasoning to it. The -- what else
3 did I note here?

4 And again, so now we get to page 5. Dr. Wikas has no
5 experience or training outside of the field of dermatology
6 hereby rendering him not qualified to render any opinions
7 outside the realm of dermatology. I agree. That's fine. But
8 during his testimony, we were going over the package insert --
9 and by the way, he does have pharmaceutical education, and I
10 believe he was a pharmacist years prior to becoming a
11 dermatologist -- and she objected to using the Kenalog package
12 insert, which is medical literature that can be used by an
13 expert witness during a deposition to go ahead and with their
14 expert testimony. And so, she objected to using that, so I
15 had him put aside the Kenalog package insert, and I said, Dr.
16 Wikas, you have enough experience with this drug and your
17 background in pharmacy, let's talk about the drug. What are
18 some of the side effects? He's -- he's able to, as making a
19 statement about the actual package insert. He was making a
20 statement. He was not asserting his opinion outside of the
21 realm of dermatology. He's telling you what this drug does.
22 So, if he says if there's bone loss -- and bone loss is
23 experienced in some of his patients, that there's a -- that's
24 what the drug does. The drug goes ahead and it speeds up
25 osteoclast and slows down osteoblast, so your regular

1 remodeling of the bone, you're not able to -- and I've studied
2 this, I know. And this is -- I'm not an expert, but this is
3 common knowledge that's out there. And this is what this drug
4 does. This drug can be devastating. And again, he's been a
5 dermatologist for 37 years. He's never seen anything like it.
6 It's been catastrophic. This was gross negligence. So, to go
7 ahead and -- what else?

8 And then regarding -- regarding his testimony on the
9 surgery that was done. And yes, he said that if he -- if he
10 had a patient like myself, he would -- he would recommend a
11 plastic surgeon. But, he knows how to read a pathology
12 report, and he went ahead and read the doctor's notes as to
13 the operative procedure, what happened. And they state that
14 he did not cut into the subcutaneous tissue, and that -- and
15 even on the pathology report, where he said, if they had taken
16 out subcutaneous tissue out of me or anything else, it
17 would've been on the pathology report, which it was not.

18 And again, regarding anything about it being going
19 systemically, it's on the package insert, it's on the medical
20 literature that this is what it does. When it tells the
21 healthcare provider how to administer it with doses, it says
22 be very mindful of the concentration that you use and --
23 again, I'm paraphrasing here -- because too much will cause
24 systemic effects.

25 So, to say that he didn't base it on his expert opinion,

1 that it was speculative is not correct. There's -- and Dr.
2 Wikas himself testified that the only alleged injury he could
3 comment on was the plaintiff's alleged atrophy. Well, we went
4 ahead and used, again, the skin anatomy. And before I looked
5 into it, who would've think that there is subcutaneous tissue,
6 that there's nerves, that there's blood vessels, that there's
7 your lymph system, that there's hair follicles, that there's
8 sweat glands. That's all gone in me. That's all gone. This
9 whole side of my leg, a big chunk was taken out. And so, he
10 -- he can testify to skin anatomy. So -- so, you know, the
11 disappearance of that skin anatomy in that area.

12 Dr. Wikas offers no opinion on how Defendant Hussey most
13 likely breached the standard of care or how such breach was
14 the proximate cause of plaintiff's alleged damages therefore
15 rendering his testimony unreliable. As I have stated, and it
16 is in his testimony -- in his deposition testimony, he gave
17 the breaches. The misdiagnosis, he stated and it is true --
18 there was nothing to treat, and I was so -- it was only three
19 months from a major surgery. There was -- a scar matures with
20 time. The defendants will tell you that. Dr. Hussey will
21 tell you that. I mean, this is all science as far as how a
22 scar matures. I have no evidence -- I've never had any
23 problem with irregular scarring. I have since then had a
24 surgery to remove one lymph node of melanoma that went to my
25 groin area. And you can't even see that scar now, and that

1 was two -- three years ago.

2 So -- okay. Again, he's not -- he's giving the
3 causations. And again, she keeps on alluding to that he says
4 it speaks for itself. If we were a state that went ahead and
5 honored that doctrine, then they'd have to be explaining why
6 it did not cause it. I walked into the office happy and
7 healthy, and left harmed and injured. So, he was not relying
8 on that for his opinion. He was just stating it was that bad.
9 I mean, how many negligent cases can you say that that it
10 speaks for itself.

11 And then she said that he's been an expert witness --
12 yeah, he is an expert witness. We all get expert witnesses
13 here. That he has a background in it and the long history. I
14 don't see any problem with that. He did a fine job as my
15 expert. He did go ahead and again give the proper testimony
16 as to his medical and scientific certainty that she fell below
17 the standard of care.

18 I just want to make sure -- you know, she states here she
19 took certain parts of the testimony out. We talked a lot
20 about this and there was a -- there were quite a few questions
21 regarding falling below the standard of care. But, she has
22 here -- she had asked that the injury itself is evidence of
23 negligence and injection had been properly -- Dr. Wikas'
24 testimony was in relevant part -- so, now, she took one of his
25 answers and she's stating that this is -- I felt that Nurse

1 Practitioner Hussey fell below the standard of care because
2 the plaintiff had a catastrophic thinning of the skin and
3 depression, accentuation of blood vessels and they were
4 sensitive to touch, so I felt that her activities were well
5 below the standard of care. But, again, that's one sentence.
6 He went ahead and he states -- we have it in the deposition
7 why it's below the standard of care.

8 And, then she goes on with this questioning, so this was
9 the cross-examination, so -- okay. Your opinion as to the
10 cause of Ms. Gurry's injuries are solely based on the fact
11 that she got this atrophy and now you're backtracking to come
12 up with some explanation as to what could've caused that. In
13 essence, the thing speaks for itself. Something must've gone
14 wrong, correct? Correct. And again, like this is -- he's
15 already stated -- that's already been stated, so we already
16 have that in the record. So, she's asking the question about
17 this and he's saying, yeah, correct, because you have no
18 evidence to truly say that there was a wrong concentration or
19 wrong dose or the wrong site, correct? There's no concrete
20 evidence, like -- but again, it speaks for itself. Like if it
21 was the right concentration, if it was what she said, it
22 would've been fine. So, and as we've discussed, you've not
23 seen or you're not aware of any literature that supports your
24 opinion, correct? Again, why would there be literature on
25 this, because it would harm -- I mean, this is just -- it's a

1 negligence, I mean, how much literature is there on a drug
2 that causes great negligence or -- okay -- up here -- okay.
3 So, again, her questioning, and with the appropriate amount to
4 inject, would you agree that you would not expect to see any
5 type of atrophy -- yeah, you wouldn't expect to see it if it
6 was appropriately administered with the right concentration,
7 with the correct volume, and the correct location. So, again,
8 citing what she states that she did could not have happened;
9 it's not probable.

10 So, I think for right now, I covered -- does the way how
11 it work, Your Honor, we'll be able to talk about it a little
12 bit and go back so make sure if I ---

13 THE COURT: No. She gets to argue, you get to respond,
14 and she gets a brief reply.

15 MS. GURRY: Okay. Okay, let me just -- okay. And, here
16 on page 17, she states Dr. Wikas readily admitted that he was
17 relying on the doctrine of it speaks for itself. I do opine
18 that injury itself demonstrates negligence. So, he was not
19 relying on that doctrine. Again, he went ahead and gave the
20 breaches, the causation. And then the fact that I had said is
21 if there was even gonna be pain with this injection, I
22 wouldn't have gone forward with it. And then for her to cite,
23 because I did feel pain on the first injection, that I didn't
24 stop it. She had already started the procedure, which is --
25 is wasn't my duty -- she was there to take care of me; I

1 didn't have to go ahead and -- I had no idea what was
2 happening because she didn't tell me.

3 Let's see here. Okay. And again, regarding the
4 literature though, not seeing anything to support it, because
5 he hasn't seen anything like that before and it was so
6 catastrophic, that's why you can't find any case studies about
7 this.

8 Okay.

9 THE COURT: All right. Anything in reply?

10 MS. SCALISE: Yes, sir, Your Honor. As Ms. Gurry has
11 explained, her expert has that long history of being an
12 expert. He knows what needs to be said. And while he gave
13 opinions, not a single time did he ever say that his opinions
14 were to a reasonable degree of medical certainty; never said
15 that these were the most probable opinions. So, we contend
16 that she has failed to meet her burden as to having an expert
17 testimony that is supportive, that gets this case to the jury.

18 Additionally, Your Honor, she brought up the fact that
19 the nursing board had an order. The plaintiff actually filed
20 these same allegations against Nurse Practitioner Hussey
21 against the -- with the South Carolina Board of Nursing. They
22 investigated it. The only thing that they found wrong was
23 that as she is walking out the door and Nurse Practitioner
24 Hussey gratuitously writes her a prescription for metformin.
25 They faulted her for not documenting that prescription for

1 metformin. There was zero finding that this was an improper
2 injection, that it was an improper amount, or that this
3 injection caused any harm whatsoever. The only citation was
4 that she didn't document metformin. That was the only thing.

5 As far as her expert, again, she readily agreed there is
6 no literature, which means there's no case reports. I mean,
7 if there is somebody who has gotten an excessive amount, and
8 that's in somehow the Kenalog package insert, well, then Dr.
9 Wikas should have claimed and said that that is literature I'm
10 relying on. Instead, he acknowledges no literature, no case
11 reports, nothing whatsoever that supports his opinions.

12 When she talked about her asking questions of Dr. Wikas
13 about systemic side effects and he gave kind of this general
14 testimony about systemic side effects, he never once said did
15 I give the opinion that her systemic side effects were due to
16 this Kenalog injection. And so again, for any of that
17 testimony to come in about systemic side effects, is only
18 something that's gonna confuse and mislead the jury.

19 And, again, we submit that the reason Dr. Wikas does not
20 understand the cause of this depression in her leg is because
21 he does not do that surgery to remove the 7.5 centimeter mass
22 and that is the natural and -- you know, readily explainable
23 explanation as to why she has this depression in her leg, not
24 the Kenalog injection, but her original cancer melanoma
25 surgery that was done prior to her ever seeing the defendants.

1 We believe that under the Court's gatekeeping function,
2 there is no evidence for the jury to consider Dr. Wikas'
3 testimony. It is simply under a 702 and 403 analysis only to
4 confuse the jury, mislead the jury. His testimony and his
5 opinions are not reliable. He is not an expert that gets her
6 to that jury, and we contend it should be excluded.

7 THE COURT: All right.

8 MS. SCALISE: Thank you, Your Honor.

9 THE COURT: How is this gonna be presented? Is it a
10 video or is it a written deposition?

11 MS. GURRY: Yes, Your Honor.

12 THE COURT: Video?

13 MS. GURRY: Yes, Your Honor.

14 THE COURT: All right. I think what I'm gonna do -- I
15 don't know what it says. You say it's not in there; she says
16 it is. I think I'm just gonna have to review the testimony
17 prior to it being submitted and then make a decision whether
18 or not he is qualified as an expert, whether or not his
19 opinion is based upon a reasonable degree of medical
20 certainty, and then the 403 analysis. So, I'm just gonna have
21 to look at it first before I can say whether or not it goes to
22 a jury.

23 MS. SCALISE: Your Honor, I would ask, you know, with
24 that, I know that there were lots of objections that were made
25 in his deposition that -- would Your Honor be willing to read

1 that and review those, because I do have a videographer that's
2 willing to come and cut, you know, and parcel that video.

3 THE COURT: If that -- if your other motions is based
4 upon objections raised in the deposition, then yeah, when you
5 raise those, I'll go ahead and I'll make those rulings as
6 well. But, I guess, first what I need to do is take a look at
7 it and see if it's proper to come in.

8 I've got -- do we want to -- I don't know -- how long is
9 it, the deposition?

10 MS. SCALISE: I happen to have a transcript of it if you
11 would like to look at that, Your Honor.

12 THE COURT: You've got a written transcript?

13 MS. SCALISE: Yes, sir.

14 MS. GURRY: Your Honor, I actually have the video.

15 THE COURT: Well, y'all tell me, which is gonna be
16 easier, to read it or ---

17 MS. SCALISE: I prefer just to read the testimony.

18 THE COURT: I guess my question is, is do we want to pick
19 the jury at 2 o'clock, or do we want to just have them come
20 back tomorrow morning at 9:30 because we've got enough to do
21 today. Y'all tell me.

22 MS. GURRY: Your Honor, I'd appreciate it if we could do
23 that tomorrow regarding ---

24 THE COURT: What, pick the jury?

25 MS. GURRY: Yes.

1 MS. SCALISE: This is the transcript of his deposition.
2 And I actually put in yellow highlight where there was the
3 objection to see -- Your Honor, to rule on those anyway. But
4 that's his testimony.

5 THE COURT: Okay. Well, let's do this, if this is a
6 agreeable. Let's go ahead and break. Give me an opportunity
7 to look at the deposition of Dr. Wikas. I'm gonna instruct
8 the clerk of court to just tell the jury to come back tomorrow
9 morning at 9:15. Let me take a look at this. Y'all want to
10 come back, say, at 3 o'clock and we'll follow up with the
11 pretrial motions then. Does that sound agreeable?

12 MS. GURRY: Thank you.

13 THE COURT: All right. So, we'll be in recess till 3
14 o'clock.

15 All right. Thank y'all.

16 **RECESS - 1:23 P.M.**

17 *****OFF THE RECORD*****

18 **ON THE RECORD - 2:58 P.M.**

19 THE COURT: All right. I have reviewed the entire
20 transcript of testimony of Schield M. Wikas, W-I-K-A-S, D.O.
21 And I, based upon my review of his testimony, transcript of
22 testimony, I am gonna grant the defendant's motion in limine.
23 His entire opinion as to causation of the injury is based upon
24 the doctrine of res ipsa loquitur which is not recognized by
25 this state. He repeatedly testifies that the plaintiff's

1 condition alone indicates a breach of due care. In other
2 words, the injury is proof of a breach of due care and that's
3 not recognized in South Carolina. He says he has no evidence
4 that there was an excessive concentration of Kenalog given,
5 and because he cannot explain any other reason for the
6 atrophy, that it had to have been because of something that
7 the defendants did. And that's not recognized in South
8 Carolina. That is the classic example of *res ipsa loquitur*,
9 which the state does not recognize.

10 MS. GURRY: He went ahead and made several statements
11 about causation and the breach. I asked him what the breach
12 was and he went ahead and said misdiagnosis, administration of
13 the Kenalog.

14 THE COURT: He said that but he said that his opinion as
15 to why that is a breach is because the condition exists. And
16 that is the definition of *res ipsa loquitur* is the fact that
17 you are finding a breach not because of any evidence that
18 there was an excessive dosage or that there was any evidence
19 of a misdiagnosis but because there is a condition here, that
20 condition in and of itself is a proof of negligence. That's
21 not recognized in South Carolina.

22 MS. GURRY: He stated that -- he stated there was a
23 breach and the reason -- and this drug that was injected into
24 me causes what happens to me, and he made that very clear.
25 Again, that he went ahead and stated it speaks for itself; he

1 said plenty of other -- again, the causation and the breaches
2 were listed -- were said.

3 THE COURT: Yes. That's exactly what he said.

4 MS. GURRY: Right.

5 THE COURT: But he's saying that causation is based upon
6 the existence of an injury. That's *res ipsa loquitur*. That's
7 saying the injury in and of itself is proof of negligence, and
8 that's not recognized in South Carolina.

9 MS. GURRY: So, if he hadn't said that, then -- this is
10 -- if he hadn't said that, then you wouldn't even be talking
11 about this? I don't ---

12 THE COURT: No. If he had said, I have here evidence
13 that ---

14 MS. GURRY: Excuse me, Your Honor.

15 THE COURT: --- that this amount of Kenalog was
16 administered, and that that is an excessive amount of Kenalog,
17 and that because there is evidence of this amount of Kenalog
18 that was given, which I find to be excessive, and that that is
19 a breach of the standard of care, and that I can say to a
20 medical -- reasonable degree of medical certainty that if you
21 give somebody this excessive dosage that it will cause this
22 injury, then that's the testimony you need. You can't say I
23 look at this condition -- I can't explain why the condition is
24 there unless they must've given too much Kenalog or an
25 excessive concentration of Kenalog, even though I have no

1 evidence that they gave an excessive concentration of Kenalog.

2 MS. GURRY: There'd be no way he could have evidence.

3 THE COURT: Well, that's -- and that is -- that happens.
4 That's how the opinions of res ipsa loquitur came before the
5 South Carolina Supreme Court is you had a plaintiff who could
6 not explain their injury ---

7 MS. GURRY: Right.

8 THE COURT: --- but for the fact than an injury existed.
9 And the South Carolina Supreme Court said we recognize that
10 predicament, but we don't recognize it. The burden of proof
11 is on the plaintiff, the plaintiff has to prove a standard of
12 care, a breach of that care, and causation. And you can't say
13 that the injury in and of itself creates the causation or the
14 breach of care.

15 MS. GURRY: He stated several times that she fell below
16 the standard of care, and this was the reason, and ---

17 THE COURT: The reason being because of the injury. He
18 said look at the injury. That means there has to be ---

19 MS. GURRY: The reason -- the breaches again were what I
20 told you, the misdiagnosis, the administration and -- and then
21 ---

22 THE COURT: I mean, that's -- that's just the law. And I
23 -- that's why I took a break and I read the entire transcript,
24 because I was looking anywhere for him to say here is evidence
25 of where the defendants did this, that I find that that was a

1 breach of care, and that that caused your injury.

2 MS. GURRY: He offered his medical opinion as experts do
3 and stated the breaches of the standard of care and stated
4 several times that it was below the standard of care, which he
5 did.

6 THE COURT: That's right.

7 MS. GURRY: And he stated, you know, all that, so -- I'm
8 sorry, you said that -- yeah. I mean as far evidence, there's
9 no -- as far as evidence in medical malpractice cases, that's
10 hard to -- we can't find out the exact amount because -- you
11 know. It's not evidence; I mean, it's his medical opinion.
12 It's his expert opinion.

13 THE COURT: But his opinion was that there was a breach
14 and a causation because the injury exists. He says I don't
15 have any evidence that they breached a standard of care and
16 that the breach was a proximate cause of the injury other than
17 the fact that she has an injury. And the fact that she has an
18 injury indicates they had to have done something wrong,
19 because I can't explain it any other -- I have no other
20 explanation for the injury.

21 MS. GURRY: Well, he did explain it and he said that an
22 excessive amount and ---

23 THE COURT: But, he had no evidence that there was an
24 excessive concentration of the steroid injection.

25 MS. GURRY: The evidence is what happened to me. Okay, I

1 mean, that's ---

2 THE COURT: And I agree with you 100 percent, Ms. Gurry.

3 MS. GURRY: Okay.

4 THE COURT: But what I'm saying is that the doctrine of
5 res ipsa loquitur, which is what you are basically putting
6 forth in this case, is not recognized in South Carolina. Your
7 evidence consists of the fact that have an injury. That in
8 and of itself does not create a duty of care, a breach of
9 care, or a causation of the injury. And that's what res ipsa
10 loquitur says is that the injury in and of itself indicates
11 negligence, and South Carolina doesn't recognize that. Some
12 states do; South Carolina does not. And I'm -- I have to
13 follow South Carolina law that says that that -- well, that's
14 the law and that's what I have to apply in an evidentiary
15 proceeding, and your expert has no testimony to support your
16 conclusion other than by applying the doctrine of res ipsa
17 loquitur.

18 MS. GURRY: But, again, I just don't understand how he
19 explained the breaches, which would be if this was another
20 medical malpractice, hypothetically speaking, if there was a
21 missed diagnosis and something occurred when the person left
22 and they got -- what was injected, what is known to cause this
23 that that even -- one thing that that would go ahead and be --
24 you know, that's the causation and that's what the expert
25 witness is saying. I mean, these breaches have been stated by

1 him that -- I mean, it seems like it's semantics in a way,
2 like. I mean, he already stated the breaches, that she was
3 below the standard of care, that is his medical ---

4 THE COURT: Well, carrying it to an extreme, an extreme
5 example would be cyanide causes death. So, if you have death,
6 then the doctor had to have injected someone with cyanide,
7 without having any other proof of a cyanide injection. That's
8 *res ipsa loquitur*, and the Court does not recognize that.

9 MS. GURRY: Okay. Okay. And that's -- and that's fine
10 and that's a great example because she did go ahead and inject
11 me with Kenalog. As far as the dosage, we have no idea.
12 Enough to do the damage of what Kenalog, the drug, does. And
13 so, therefore, as you stated we have that evidence that she
14 injected me with the drug, and then my leg with all the
15 injuries that are directly from the drug, go ahead and show
16 that. And that's what he said over and over again.

17 THE COURT: What he said over and over again is the only
18 evidence I have is that she injected the appropriate amount,
19 but, because of the injury, that can't be correct.

20 MS. GURRY: No, he went ahead and said that she -- he
21 didn't say she injected the right amount at all, never. He
22 went ahead and said ---

23 THE COURT: Well, he basically said he didn't have any
24 evidence as to what was injected other than ---

25 MS. GURRY: No one would, no one would, but she injected

1 this Kenalog, but the amount of it and whatnot was such that
2 it did what it did to me. So, he didn't go ahead and say what
3 she injected was fine and -- you know, he said -- yeah, what
4 she wrote down, not what she injected. Just cause she said
5 something and it's on the medical document doesn't mean it
6 happened or we wouldn't be here.

7 THE COURT: Well, that's just my ruling.

8 MS. GURRY: Okay. Well, I'd like to -- before we move
9 forward, I would like to go ahead -- if you can go ahead and
10 let me see where it says that the motion in limine can go
11 ahead and be ---

12 THE COURT: Well, I've gone ahead and I've -- we -- I've
13 ruled on that. If you think that's an error of law, there are
14 avenues to correct that. But I went ahead and I heard the
15 motion and I've ruled on it. All right?

16 MS. GURRY: Okay.

17 THE COURT: All right. Now, where do we stand? We got
18 any other motions besides this one.

19 MS. SCALISE: We have lots of other motions but, Your
20 Honor, in light of your -- this Court's ruling, she does not
21 have expert testimony again that would prove her case and so
22 we would move for summary judgment on the part of all
23 defendants.

24 THE COURT: Well, do you have anything -- I'm gonna give
25 her the opportunity to proceed whether or not she can get

1 around a directed verdict, I don't know, but I'll allow her --
2 I'm not gonna go ahead and cut her off at this point in time.

3 MS. GURRY: Well, yeah, well, I just -- I feel like --
4 yeah, what do I need to do then to bring it forward to appeals
5 or something, because that's how I feel right now. I'm just
6 -- I'm not gonna go ahead and waste my time of anyone else's
7 time and try to bring this forth and then not have my expert
8 witness, who I just spoke to as well, telling him what was
9 going on here. And he said I did an excellent job, I went
10 ahead and told the causations and I went ahead -- I stated it
11 several times. So, I'd like to move -- if that's gonna be
12 your -- I'm not gonna waste my time or anyone else's time, but
13 I want to move forward with an appeal, I'll probably file -- a
14 motion in limine, whatever, I mean, you know ---

15 THE COURT: All right. That'll be fine. Well, then go
16 ahead, Ms. Scalise, and prepare an order that grants this
17 motion in limine and the reasons that I've cited for granting
18 it. Also grants your motion to dismiss based upon the fact
19 that there's no expert testimony as to the damages, that'll
20 dismiss the case and that'll give you your final order that
21 you can appeal from that. Okay?

22 MS. SCALISE: Yes, sir. Thank you, Your Honor.

23 THE COURT: All right. Thank you very much.

24 **ADJOURNED - 3:17 P.M.**

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C E R T I F I C A T E

I, the undersigned, Kay H. Richardson, Official Court Reporter for the State of South Carolina, do hereby certify that the foregoing is a true, accurate and complete Transcript of Record of the hearing held in the case of Tara Gurry v. Myrtle Beach Dermatology, et al., held in the Court of Common Pleas for Horry County, Horry County Courthouse, Conway, South Carolina, on June 28, 2021.

I do hereby certify that I am neither of kin, counsel, nor interest to any party hereto.

Kay H. Richardson
Official Court Reporter

September 30, 2021.

STATE OF SOUTH CAROLINA	)	IN THE COURT OF COMMON PLEAS
	)	
COUNTY OF HORRY	)	C/A No.: 2018-CP-26-05438
	)	
Tara Gurry,	)	
	)	
Plaintiff,	)	NOTICE OF MOTION AND
	)	MOTION IN LIMINE TO CHALLENGE,
v.	)	LIMIT, AND/OR EXCLUDE DR.
	)	SCHILD WIKAS'S TESTIMONY
Myrtle Beach Dermatology, LLC,	)	
Shannon Hussey, and Richard Hussey,	)	
M.D.	)	
	)	
Defendants.	)	
_____	)	

The Defendants Myrtle Beach Dermatology, LLC, Shannon Hussey, and Richard Hussey, M.D. (hereinafter “Defendants”), by and through their undersigned counsel, hereby submit the following Motion to Challenge, Limit, and/or Exclude Dr. Shield Wikas’s testimony pursuant to Rule 702, South Carolina Rule of Evidence. The basis for this Motion is that Plaintiff’s sole expert Dr. Wikas testified in his *de benne esse* trial deposition that the concentration and volume of intralesional steroid injection documented by NP Hussey in the medical record met the standard of care and was appropriate, and any resulting depression/atrophy was not a foreseeable outcome of that injection. He relied on a *res ipsa loquitor* argument that “the thing speaks for itself” and opined that the resulting depression/atrophy that Plaintiff has must mean that NP Hussey used an excessive concentration, excessive volume, and/or improper location for the injection. Despite his claims, he admitted that he had no literature to support his theory of liability and had never seen or heard of and had not tested his hypothesis or speculative theories on causation. Accordingly, Dr. Wikas’s opinions should be excluded by this Court under the Court’s gatekeeping function and the laws of South Carolina.

I. Statement of Facts

On or about January 27, 2016, the Plaintiff had a malignant melanoma on her right thigh excised by dermatologist Dr. Joseph Masessa. This procedure left her with a significant scar on her right leg. The Plaintiff came to the Defendants' office on February 22, 2016, for a routine check-up following her surgery, though it is unclear why she did not return to Dr. Masessa's office for follow-up. Defendant NP Shannon Hussey documented that the excision scar had central erythema and mild oozing at this time. Later, on May 3, 2016, the Plaintiff returned to the Defendants' office for further routine follow-up where the Defendant NP Hussey examined the scar and described the hypertrophic area as 7 cm long. She also documented that the Plaintiff reported a pulling sensation in the scar and the feeling of stitches being in it. The Defendant injected it with Kenalog, an intralesional steroid used by dermatologists for this type of scar to reduce the appearance of the scar by thinning and flattening it and to alleviate the pulling sensation.

After this visit, and as an alleged result of the Kenalog injection, the Plaintiff alleges that she became very ill for 72 hours, but that the illness lasted for two weeks and has continued to the present day, five years later, and included nausea, chills, racing heartbeat, cramps, body aches, headaches, insomnia, and a three-week menstrual cycle. The Plaintiff also alleges that her thigh began to atrophy within 24 hours and got worse over several months. She alleges that this caused her to have to stop doing activities she loves like running due to leg pain. In addition, the Plaintiff alleges lasting systemic impacts including "nerve sensitivity and a thinning [she can feel to her] knee," IT band syndrome, hip pain, early menopause, bone loss, "wasting away of her muscles," hypothyroidism, Hashimotos, adrenal fatigue and hormone problems, increase in the prominence of her veins, depression and anxiety, PTSD, nightmares, and loss of collagen. The Plaintiff

continued to see multiple providers for various treatment only returning to each once or twice before moving on to a different provider.

On September 27, 2018, the Plaintiff filed a Summons and Complaint against Defendants alleging gross negligence and claiming that the actions of NP Hussey caused her chronic pain and discomfort, humiliation, disability, fear, anxiety, mental anguish and emotional distress, loss of enjoyment of life, and otherwise unnecessary medical and surgical costs.

To support her allegations, the Plaintiff identified dermatologist Dr. Schield M. Wikas as an expert witness. Dr. Wikas was deposed by defense counsel on June 28, 2019, and he then provided *de bene esse* videotaped trial testimony on June 21, 2021.

II. Analysis

Rule 702 of the South Carolina Rules of Evidence provides, “[I]f scientific, technical or other specialized knowledge will assist the trier of fact to understand the evidence or to determine a fact in issue, a witness qualified as an expert by knowledge, skill, experience, training, or education, may testify thereto in the form of an opinion or otherwise.” Rule 702, SCRE. In determining the admissibility of expert opinion under Rule 702, this Court is a gatekeeper and must be satisfied that the opinion testimony meets all three of the following requirements: First, the trial court must find that the subject matter is beyond the ordinary knowledge of the jury, thus requiring an expert to explain the matter to the jury. Next, while the expert need not be a specialist in the particular branch of the field, the trial court must find that the proffered expert has indeed acquired the **requisite knowledge and skill to qualify as an expert in the particular subject matter**. Finally, the trial court must evaluate the **substance of the testimony and determine whether it is reliable**. Watson v. Ford Motor Co., 389 S.C. 434, 446, 699 S.E.2d 169 (2010) (emphasis added) (internal citations omitted) (holding that “in executing its gatekeeping duties,

the trial court must make [these] three key preliminary findings which are fundamental to Rule 702 before the jury may consider expert testimony”); State v. Council, 335 S.C. 1, 20, 515 S.E.2d 508, 518 (1999). The trial court should analyze the State v. Jones, 273 S.C. 723, 259 S.E.2d 120 (1979) factors to determine reliability. Id. Then, if the evidence is admissible under Rule 702, SCRE, the trial judge should determine if its probative value is outweighed by its prejudicial effect. Rule 403, SCRE. Once the evidence is admitted under these standards, the jury may give it such weight as it deems appropriate.

In this case, it is crucial that the Court fulfill its Watson gatekeeping function in ensuring that the Plaintiff's expert satisfies the criteria of Rule 702. Specifically, the Court must ensure that Dr. Wikas has the requisite knowledge and skill to qualify as an expert in a particular subject matter and that his opinion is based upon reliable medicine or science. See State v. White, 382 S.C. 265, 270 (2009); see also Daubert v. Merrill Dow Pharmaceuticals, Inc., 509 U.S. 579, 125 L.Ed. 2d 469, 113 S. Ct. 2786 (1993) (holding trial judges must act as gatekeepers to “ensure that any and all scientific testimony...is not only relevant, but reliable”). The gatekeeper function is critical due to the weight given to experts by a jury and, therefore, “courts must recognize that due to the difficulty of evaluating their testimony, expert witnesses have the potential to be both powerful and quite misleading.” Cooper v. Smith & Nephew, Inc., et al, 259 F.3d 194, 199 (4th Cir. 2001) (internal citations omitted). As our state supreme court has reaffirmed time and again, “reliability is a central feature of Rule 702 admissibility, and our jurisprudence is in complete accord.” White, 382 S.C. at 270. “The familiar tenet of evidence law that a continuing challenge to evidence goes to “weight, not admissibility” has never been intended to supplant the gatekeeping role of the trial court in the first instance in assessing the admissibility of expert testimony, including the threshold determination of reliability.” Id. at 273.

Moreover, expert opinion is generally required in medical malpractice actions. See David v. McLeod Reg'l Med. Ctr., 367 S.C. 242, 247, 626 S.E.2d 1, 3 (2006). Specifically, a plaintiff must demonstrate and provide evidence of the following via an expert witness: (1) the generally recognized and accepted practices and procedures that would be followed by average, competent practitioners in the Defendant's field of medicine under the same or similar circumstances, and (2) the defendant departed from the recognized and generally accepted standards. Id. 367 S.C. at 247-248, 626 S.E.2d at 4 (citing Pederson v. Gould, 288 S.C. 141, 143-44, 341 S.E.2d 633, 634 (1986); Cox v. Lund, 286 S.C. 410, 414, 334 S.E.2d 116, 118 (1985)). The Plaintiff must also establish that the Defendants' departure from such generally recognized practices and procedures was the proximate cause of the Plaintiff's alleged injuries and damages. See id. 367 S.C. at 248, 626 S.E.2d at 4 (citing Green v. Lilliewood, 272 S.C. 186, 193, 249 S.E.2d 910, 913 (1978)). While the Plaintiff is *pro se*, she still bears the burden of proof and must establish the above via expert testimony to prevail in a medical malpractice action. In South Carolina, medical malpractice actions require a greater showing than generic allegations and conjecture. Id. The admissibility of expert opinion requires more scrutiny than the admissibility of other evidence. See Watson, 389 S.C. at 446 (holding "expert testimony receives additional scrutiny relative to other evidentiary decisions").

A. Dr. Wikas has no experience or training outside of the field of dermatology, thereby rendering him not qualified to render any opinions outside of the realm of dermatology.

A person may be qualified as an expert in a particular area based upon knowledge, skill, experience, training or education. Rule 702, SCRE. The test for qualification is a relative one that is dependent on the particular witness's reference to the subject. Watson, *supra* at 447. In Watson, the court found the trial court had erred in qualifying Plaintiff's expert witness as an expert in

automobile cruise control systems. Id. at 448. The court noted that while Plaintiff's expert may have been qualified as an expert in other automobile components, there was no evidence to suggest he had any knowledge, skill, experience, education or training specifically related to cruise controls. Id. Watson directly controls the facts of this case.

Dr. Wikas has only trained in the field of dermatology, and he does not perform the type of melanoma excision which the Plaintiff had in the months prior to the Kenalog injection at issue in this case. [Exhibit B: Dr. Wikas Trial Dep. 8:25 – 9:4]. Dr. Wikas conceded in his discovery deposition that he is solely going to offer opinions about the Plaintiff's alleged atrophy in this case, and he would not be providing opinions about any other alleged injury. [Exhibit A: Dr. Wikas Discovery Dep. 131:20 – 132:23; 138:20 – 139:12]. Despite testifying that he would not be offering any testimony related to any claims regarding systemic effects, him not being able to say whether any of the things the Plaintiff alleges she has experienced (other than atrophy) were caused by the Kenalog injection as compared to her other medical issues, and him not being qualified as an expert in the fields of rheumatology, endocrinology, obstetrics and gynecology, orthopedics, or radiology, the Plaintiff proceeded to question Dr. Wikas about the impacts of corticosteroids such as Kenalog when it is absorbed systemically and about what he was able to interpret from a PET/CT/MRI scan images. [Exhibit B: Dr. Wikas Trial Dep. 25:13 – 29:25; 52:7 – 58:11]. Defense counsel properly objected and moved to strike the testimony and now asserts to the Court that this testimony is purely speculative and not based on any scientific evidence or opinion, and it would be misleading to the jury and cause confusion of the issues when Dr. Wikas himself testified that the only alleged injury he could comment on was Plaintiff's alleged atrophy. Because Dr. Wikas himself admitted that he was unable to provide any opinions about the Plaintiff's alleged injuries other than atrophy, any testimony about systemic absorption would also have very little

probative value but would be extremely prejudicial to the Defendants. As such, this testimony should be excluded pursuant to Rules 702 and 403 of the South Carolina Rules of Evidence as discussed in detail above.

Moreover, Dr. Wikas testified that he would have referred the Plaintiff to a plastic surgeon for her melanoma excision procedure because of the depth of the malignant melanoma and required excision. [Exhibit A: Dr. Wikas Discovery Dep. 16:8-25]. This is particularly important in that Dr. Wikas is providing testimony that a Kenalog injection caused atrophy and loss of subcutaneous tissue as compared to the atrophy/subcutaneous tissue loss being caused by the natural progression of the Plaintiff's melanoma excision site remodeling leading to the scar healing and stretching. Defendants assert that because Dr. Wikas testified that he would refer the Plaintiff to a plastic surgeon to perform the specific melanoma excision she required, he is unqualified to testify that the atrophy or loss of subcutaneous tissue was not a naturally occurring event with scar stretch from the Plaintiff's extensive melanoma excision.

For the foregoing reasons, Dr. Wikas is unqualified to provide opinions as to any alleged injury outside of atrophy which could occur as the result of an intralesional steroid injection, and he is unqualified to opine whether or not the alleged atrophy was really the natural progression of a post-melanoma excision scar healing. Therefore, for Dr. Wikas to assert that the Kenalog injection, rather than the naturally-occurring melanoma excision site remodeling and resultant scar, was the cause of Plaintiff's alleged atrophy in this case, there is great potential to mislead a jury who would be inclined to give his testimony greater weight just because he has been deemed an expert, and it is for this reason that the Court, pursuant to its critical gatekeeping function, should exclude Dr. Wikas as an expert in this case.

B. Dr. Wikas offers no opinion on how Defendant NP Hussey most likely breached the standard of care or how such breach was the proximate cause of Plaintiff's alleged damages, thereby rendering his testimony unreliable.

“A reliable expert opinion must be based on scientific, technical, or other specialized knowledge and not on belief or speculation, and inferences must be derived using scientific or other valid methods.” Oglesby v. General Motors Corp., 190 F.3d 244, 250 (4th Cir. 1999) (“expert” mechanical engineer's speculation about whether plastic inlet connector contained defect lacked reliability, foundation, and relevance necessary for admissibility). “An expert's opinion should be excluded when it is based on assumptions which are speculative and are not supported by the record.” Collier v. Varco-Pruden Buildings, et al., 911 F.Supp. 189, 192 (D. S.C. 1995) (citing Tyger Constr. Co. v. Pensacola Constr. Co., 29 F.3d 137, 142 (4th Cir. 1994), cert. denied, 130 L. Ed. 2d 633, 115 S. Ct. 729 (1995)). In a medical malpractice action, it is impermissible to speculate that an injury is the result of negligence “in the absence of any evidence as to how [a medical provider] deviated from the standard of care.” Fletcher v. Medical Univ. of S.C., 390, S.C. 458, 464 702 S.E.2d 372, (S.C. Ct. App. 2010). The Supreme Court of South Carolina in King stated the following:

In this State it is well settled that the burden rests upon the party to prove negligence. This burden cannot be met by relying upon the theory that the thing speaks for itself or that the very fact of injury indicates negligence... In order, therefore, for a plaintiff to recover damages, she must prove by the greater weight or preponderance of the evidence not only the injury but also that it was caused by the actionable negligence of the defendant.

King v. J. C. Penney Co., 238 S.C. 336, 339–40, 120 S.E.2d 229, 230 (1961) (internal citation omitted). Watson v. Ford Motor Co., 389 S.C. 434, 452-3, 699 S.E.2d 169, 178-9 (2010), is particularly instructive because after it was decided that Plaintiff's expert would be excluded, the court noted that South Carolina does not follow the doctrine of *res ipsa loquitur*, and that Plaintiff's case could not rely solely on the fact an accident occurred to prove negligence.

In Cooper v. Smith & Nephew, Inc., et al, 259 F.3d 194, 196-7 (4th Cir. 2001), the Fourth Circuit affirmed a trial court's granting of summary judgment dismissing a plaintiff's claim for personal injuries based upon allegedly defective pedicle screw fixation devices to treat spinal injuries. Plaintiff's expert testified that his determination of whether a device was defective or not was based simply on whether the surgery was successful. Id. at 201. The court stated, "Daubert requires more than an assertion that if there is a lack of surgical success, there is *ipso facto* a product defect, and hence causation is established." Id. In affirming the trial court's ruling that Plaintiff's testimony was unreliable, the Fourth Circuit found that Plaintiff's expert failed to provide any medical evidence as to what caused Plaintiff's injuries, but rather inferred causation because the surgery in question ultimately was not successful. Id. Similarly, although South Carolina does not explicitly follow Daubert, it does require the expert's testimony to be reliable. Just as in Cooper, the inability to testify as to proximate cause renders the expert's opinion unreliable.

"It is well settled under our decisions that where medical testimony is relied on to show a causal connection between an accident and a certain result, it is not sufficient for the doctors to say simply that the ailment in question 'possibly' or 'might have' resulted from the accident, but the medical experts must go further and testify at least that in their professional opinion the result in question 'most probably' came from the alleged cause." Windham v. City of Florence, 221 S.C. 350, 358, 70 S.E.2d 553, 556 (1952). Dr. Wikas has testified as an expert on behalf of a *pro se* plaintiff on multiple occasions. [Exhibit B: Dr. Wikas Trial Dep. 93:9-14]. He admitted to owning expert witness books and attending various expert witness courses. [Exhibit B: Dr. Wikas Trial Dep. 95:20 – 99:14]. He has his own expert witness website, he advertises with expert witness locator services, and has been an expert witness for the last twenty years. [Exhibit B: Dr. Wikas Trial Dep. 94:2 – 96:20]. He has even been to around ten national expert witness conferences.

[Exhibit B: Dr. Wikas Trial Dep. 95:20 – 99:14]. As such, he would understand the exacting legal standard requiring a medical malpractice expert to testify to a reasonable degree of medical certainty that the injury complained of was “most probably” caused by the alleged conduct. Despite having this foundational knowledge, Dr. Wikas did not once testify to a reasonable degree of medical certainty that the Kenalog injected by Defendant Nurse Practitioner Hussey was most probably the cause of the Plaintiffs’ atrophy or other alleged side-effects. Furthermore, Dr. Wikas admitted in his discovery deposition, and again in his trial deposition, that he knew his testimony amounted to a *res ipsa loquitor* argument:

Q: So, in essence, you are saying the thing speaks for itself? The fact that she has this injury, it must mean Shannon Hussey did something wrong?

A: Is that called *res ipsa loquitor*?

Q: Yes. So is that your contention?

A: Yes.

[Exhibit A: Dr. Wikas Discovery Dep 113:8-14].

Q. All right. Because I think the way you explained in your deposition is the thing speaks for itself.

A. Correct.

Q. In fact, it's kind of a legal term, *res ipsa loquitor*, that the fact that there's been an injury, somebody must have done something wrong to have caused that, correct?

A. In this case, yes.

[Exhibit B: Dr. Wikas Trial Dep. 60:12-23].

Moreover, Dr. Wikas testified on multiple occasions that the injury itself is evidence of negligence and an injection in an improper location/of improper concentration and/or of improper volume by Defendant Shannon Hussey. Specifically, Dr. Wikas’s testimony was in relevant part:

A: I felt that [NP Hussey] fell below the standard of care because [Plaintiff] had catastrophic thinning of the skin, a depression, accentuation of blood vessels, there was sensitivity to touch, so I felt that her activities were well below the standard of care.

[Exhibit B: Dr. Wikas Trial Dep. 14:22 – 15:2].

A: It was my impression that she injected too much corticosteroid, probably too deeply, too high a concentration, too large a volume.

[Exhibit B: Dr. Wikas Trial Dep. 15:7-10].

A: I think the results speak for themselves. I've never seen – Ms. Hussey said she injected 3.3 milligrams of the corticosteroid into the incision site. I've injected that amount of concentration many, many times, literally at least hundreds of times, and I've never seen a wound implode.

[Exhibit B: Dr. Wikas Trial Dep. 21:10-16].

A: The amount Ms. Hussey said she injected really doesn't jive with the results....

[Exhibit B: Dr. Wikas Trial Dep. 31:17-18].

A: Well, an excessive concentration of the corticosteroid was injected and it led to this. If there wasn't, if the right amount of injection was used, then you wouldn't have this result.

[Exhibit A: Dr. Wikas Discovery Dep. 93:10-17].

A: Well, all I can tell you is it really doesn't matter in this case because the results speak for themselves.

[Exhibit A: Dr. Wikas Discovery Dep. 107:21-23].

Q: Your opinions as to the cause of Mr. Gurry's injuries are solely based on the fact that she's got this atrophy, and now you've backtracked and tried to come up with some explanation as to what could have caused that. In essence, the thing speaks for itself; something must have been done wrong, correct?

A: Correct.

[Exhibit B: Dr. Wikas Trial Dep. 87:16-23].

Q: Yes, because you have no evidence to truly say that there was a wrong concentration or the wrong dose or the wrong site, correct?

A: There's no concrete evidence.

[Exhibit B: Dr. Wikas Trial Dep. 88:4-7].

Q: And as we've discussed, you've not seen and you're not aware of any literature that supports your opinion, correct?

A: Correct.

Q: And you've not performed any testing or any kind of methodology to see if your hypothesis is correct, correct?

A: Correct.

[Exhibit B: Dr. Wikas Trial Dep. 88:13-20].

A I have never seen such a catastrophic result if the correct concentration and correct volume were administered. Never.

Q So the fact of how it looks like now, it has to mean that Shannon did something wrong?

A Correct.

Q But if, in fact, she did administer 3.3 milligrams per cc [as the record supports], would that be an appropriate amount for a hypertrophic scar?

A It would be an appropriate amount if it was injected properly. But I think a higher concentration was -- what I see there is when you see all of the systemic side effects [which Dr. Wikas testified that he could not provide an opinion about] and everything like that, I'm more inclined to think of 40 milligrams totally injected into the area.

Q What I want to know is at least based on how she has it documented, would that be an appropriate amount to inject into a hypertrophic scar?

A That would be an appropriate concentration into a hypertrophic scar, which this wasn't.

Q And with that appropriate amount to inject, would you agree that you would not expect to see any type of atrophy, certainly not to the extent of what Ms. Gurry has?

A Yeah. You wouldn't expect to see it if it was appropriately administered with the right concentration with the correct volume in the correct location.

Q All right. And as far as the location, do you have any evidence that it was not appropriately administered into the correct location?

A **The only evidence is the result.**

[Exhibit A: Dr. Wikas Discovery Dep. 113:2 – 115:1 (emphasis added)].

Q So looking at Exhibit 5, can you give an opinion as to where this injection was located?

A I can't give you an opinion, but I can tell you it was injected in the wrong place, too high of volume, too high of concentration, because **the result speaks for itself**.

Q So again, getting back to the fact she has got what she has now, there was something going on wrong by nurse Hussey?

A There was no problem prior to the injections. After the injection, everything went wrong. It became a catastrophic event.

[Exhibit A: Dr. Wikas Discovery Dep. 120:13 – 121:2].

Q **Do you agree that a bad outcome doesn't necessarily mean that the medical provider was negligent?**

A **Correct. Except in this case.**

Q **Do you agree that the occurrence of an injury is not proof of medical negligence?**

A **Correct. Except in this case.**

[Exhibit A: Dr. Wikas Discovery Dep. 149:10-17(emphasis added)].

Dr. Wikas's testimony is purely supposition. As detailed above, he testified that the alleged negligence in this case is evidenced by the injury to the Plaintiff (atrophy), and that it is a known side effect of the injection given, which he assumes was caused by too high of a concentration of Kenalog, too much volume injected, and/or improper injection location. Dr. Wikas has never experienced, heard, or even read about an injection given as documented in the medical record in this case (approximately 1cc of 3.3 mg intralesional steroid) causing the type of atrophy which the Plaintiff alleges. Similarly, he is not aware of any literature that supports his theory that too high or a concentration of Kenalog, too much volume of injection, and/or an improper location causes the depression which Plaintiff has. He also bases his opinion on alleged "systemic side effects" which, as discussed above, he is unable to provide any opinions about because it is outside of his realm of expertise. This just further demonstrates that his speculative opinion is completely unreliable. He has conceded that if Nurse Practitioner Hussey gave the injection as she documented in the medical record, she met the standard of care in doing so. [Exhibit B: Dr. Wikas Trial Dep.

60:24 – 61:15]. Dr. Wikas testifies that the alleged injury is a logical result of the Kenalog injection in this case; however, a finding of medical malpractices does not require that the alleged injury be a logical result of the alleged negligent act. Instead, a finding of medical malpractice requires expert testimony to a reasonable degree of medical certainty, that the result in question “most probably,” or more likely than not, came from the alleged cause. Being only a logical cause is simply not enough. Moreover, Dr. Wikas testified he has never seen and never heard it described anywhere in the literature that approximately 1cc of 3.3 milligrams of an intralesional steroid would cause a depression like what Plaintiff has. [Exhibit B: Dr. Wikas Trial Dep. 62:6 – 63:21].

Q: And you would agree that injecting 1 cc of 3.3 milligrams of Kenalog, it would not be foreseeable that that’s going to cause the depression that Tara Gurry has, correct?

A: Yes.

Q: That would not be a natural or probable consequence of injecting that amount of steroid into a scar, correct?

A: Correct.

Q: It would be highly unusual, would it not?

A: Yes.

Q: Very abnormal, correct?

A: Correct.

[Exhibit B: Dr. Wikas Trial Dep. 65:6-18].

“When the injury complained of is not reasonably foreseeable, in the exercise of due care, there is no liability.” Eadie v. Krause, 381 S.C. 55, 64, 671 S.E.2d 389, 393 (Ct. App. 2008); Stone v. Bethea, 251 S.C. 157, 161, 161 S.E.2d 171, 173 (1968). If the atrophy the Plaintiff alleges truly occurred as the result of Nurse Practitioner Hussey injecting the amount of Kenalog which is reflected in the medical records, it would truly be a catastrophic and unforeseeable event. Because such a result would be unforeseeable based on the evidence, there can be no liability.

Dr. Wikas has chosen not to believe the medical record indicating that the proper amount of Kenalog was injected; however, Dr. Wikas candidly admitted that, other than the alleged injury itself, he has no direct evidence that the injection occurred in an improper location or was of an improper concentration and/or improper volume. This is a theory of causation, which has been rejected by South Carolina Courts, and this type of speculative testimony is unreliable and, therefore, under this Court's gatekeeping function, it should be excluded at trial.

Dr. Wikas testified that atrophy is a known side effect of an intralesional steroid such as Kenalog and is the purpose of the drug. Specifically, he stated as follows:

Q Do you know off the top of your head what are the side effects for an intralesional steroid such as Kenalog?

A Pain, atrophy, discoloration. Those are the major ones that I see.

[Exhibit A: Dr. Wikas Discovery Dep. 78:23 – 79:2].

Q Can there still be some atrophy even when Kenalog is appropriately used and injected?

A That's the definition. You are going to cause atrophy of the scar. You are going to soften the scar.

[Exhibit A: Dr. Wikas Discovery Dep. 99:18-23].

Without limiting or abandoning Defendants' additional theories of causation, Defendants submit that Fletcher is on point and requires granting Defendant's motion to exclude Dr. Wikas's testimony as unreliable. In Fletcher, the plaintiff had subclavian bypass surgery. Fletcher, 390 S.C. at 461, 702 S.E.2d at 373. Fletcher brought a medical malpractice claim alleging that the doctors were negligent in performing the procedure and that she was not properly advised of the risks associated with the procedure. See id. at 390 S.C. at 461-62, 702 S.E.2d at 373. Similarly to the Plaintiff in this case, the plaintiff in Fletcher testified that she would not have undergone the procedure had she known of the potential risks and outcome. See id. at 390 S.C. at 462, 702 S.E.2d

at 373. During cross-examination, the Plaintiff's expert testified that "complications ... could have occurred during this procedure even in the absence of any surgical negligence." Id. at 390 S.C. at 463, 702 S.E.2d at 374. As discussed above, Dr. Wikas testified that atrophy and pain are known side effects of a Kenalog injection. The expert in Fletcher testified, "Q: Do you see anything in there [the operative note and records] that indicates that Dr. Brothers used any improper technique to do this operation? A: No." Id. (brackets in original). Similarly, Dr. Wikas testified that the amount Nurse Practitioner Hussey documented to have injected was an appropriate amount, and with that amount, you would not expect to see the significant atrophy and depression she experienced. See [Exhibit B: Dr. Wikas Trial Dep. 60:24 – 61:15; 62:6 – 63:21; 65:6-18]. Based on this testimony in Fletcher, the Court of Appeals held the following:

Essentially, [the Plaintiff] asks us to conclude that the occurrence of a complication is itself evidence of negligence. However, South Carolina does not recognize the doctrine of *res ipsa loquitur*. Simply no evidence establishes how [the Defendants] deviated from the standard of care. Unfortunately, two of the risks associated with this procedure did befall [the Plaintiff]. Nevertheless, we are not permitted to speculate that misfortune was the result of negligence in the absence of any evidence as to how the physicians deviated from the standard of care.

Bowie v. Hearn, 292 S.C. 223, 355 S.E.2d 550 (Ct. App. 1987) (*Bowie I*), addresses this very point. This case was reversed based on the particular facts presented, but the reasoning employed by the court of appeals is instructive. Bowie sued the physician who delivered him via cesarean section because he was cut on the cheek during the procedure, resulting in a scar. Bowie's expert testified the standard of care required the physician not to cut the baby. In analyzing the sufficiency of this testimony, the court alluded to another oft-cited medical malpractice case [Cox v. Lund, 286 S.C. 410, 334 S.E.2d 116 (1985)] and stated: Under the plaintiff's reasoning in this case [*Bowie I*] the doctors in Cox could simply have testified that normally colons are not perforated during colonoscopies, the standard of care, therefore, is a doctor should not perforate the colon, and to do so violates the standard of care. Such reasoning would, in effect, make a doctor an insurer of perfect result in every surgical procedure. A doctor is not an insurer of health and negligence may not be inferred.

The analysis in *Bowie I* is precisely on point with this case, and we discern no factual basis that would cause the reasoning in that case to be inapplicable to the facts presented here. Therefore, we affirm the circuit court's granting of a directed

verdict as Fletcher presented no evidence, only speculation, that MUSC's agents deviated from the standard of care.

Fletcher, 390 S.C. at 463-65, 702 S.E.2d at 374-75 (some internal citations and quotation marks omitted).

The reasoning in Fletcher is on point, and Dr. Wikas readily admitted that he was relying on the doctrine of *res ipsa loquitur* to opine that the injury itself demonstrates negligence. This reasoning, and Dr. Wikas's reliance on *res ipsa loquitur*, warrants excluding his testimony at trial.

Similarly, Dr. Wikas initially testified that adequate informed consent was not given. [Exhibit B: Dr. Wikas Trial Depo. 15:12-14]. However, he then testified that what ultimately occurred with Ms. Gurry would not be something a medical provider would expect to occur such that the atrophy and large depression would not be a risk that a medical provider would advise a patient of as part of informed consent because it would not be something which could be expected to happen. [Exhibit B: Dr. Wikas Trial Depo. 89:4 – 90:10]. Instead, he agreed that the medical record documented that there was a discussion about the procedure, that NP Hussey reviewed causes and options, the treatment which was recommended was an intralesional steroid to decrease hypertrophy, and that side effects were reviewed; Dr. Wikas admitted that this was appropriate. [Exhibit B: Dr Wikas Trial Depo. 90:1-10].

Moreover, Dr. Wikas conceded that there was no evidence that had the Plaintiff been told about the potential for atrophy that she would have chosen not to get the injection. [Exhibit A: Dr. Wikas Discovery Dep. 111:23 – 112:4]. Despite the Plaintiff saying she would not have chosen to receive the injection if she knew she was going to experience pain, she testified that she did in fact experience pain from the injection, and she did not instruct the Defendant to stop. [Exhibit A: Dr. Wikas Discovery Dep. 109:20 – 110:2]. This speculative testimony is similarly unreliable and,

therefore, under this Court's gatekeeping function, Dr. Wikas should be excluded as an expert at trial.

In totality, Dr. Wikas's opinions are pure speculation solely relying on the doctrine of *res ipsa loquitur* and are impermissible under South Carolina law. See Watson, 389 S.C. at 452-453 (S.C. 2010) (noting that "Respondents may not rely solely on the fact that an accident occurred to prove their products liability case under a negligence theory since South Carolina does not follow the doctrine of *res ipsa loquitur*.")) (citing Snow v. City of Columbia, 305 S.C. 544, n.7, 409 S.E.2d 797, n.7 (Ct. App. 1991) (noting that South Carolina does not recognize the rule of *res ipsa loquitur*)); see also Fletcher v. Med. Univ., 390 S.C. 458, 463-465, 702 S.E.2d 372 (S.C. Ct. App. 2010) (refusing to apply *res ipsa loquitur* in a medical malpractice action). Accordingly, Dr. Wikas's testimony is unreliable under Rule 702 of the South Carolina Rules of Evidence and must be excluded.

D. Dr. Wikas's opinions regarding the occurrence of Plaintiff's alleged injury from an intralesional Kenalog injection are not based upon reliable medicine or science making them unreliable.

To be reliable, Dr. Wikas's opinions must be based upon reliable medicine or science. See State v. White, 382 S.C. 265, 270 (2009); see also Daubert v. Merrill Dow Pharmaceuticals, Inc., 509 U.S. 579, 125 L.Ed. 2d 469, 113 S. Ct. 2786 (1993) (holding trial judges must act as gatekeepers to "ensure that any and all scientific testimony...is not only relevant, but reliable"). As our state supreme court has reaffirmed time and again, "reliability is a central feature of Rule 702 admissibility, and our jurisprudence is in complete accord." White, 382 S.C. at 270. "The Court suggested four factors to consider in deciding reliability in scientific evidence cases: (1) scientific methodology; (2) peer review; (3) consideration of general acceptance; and (4) the rate of error of a particular technique." State v. Council, 335 S.C. 1, 20, 515 S.E.2d 508, 518 (1999) (internal

citation omitted). Dr. Wikas has provided pure speculation as to what may have caused the Plaintiff's alleged injury. He has suggested that the intralesional steroid being injected in an improper location, in improper concentration, and/or in improper volume caused the Plaintiff's atrophy. However, he has failed to conduct any research to establish that such an improper location, concentration, or volume would create the alleged injury. He admitted he has not seen and is not aware of any literature which supports his opinion. [Exhibit B: Dr. Wikas Trial Dep. 88:13-16]. Similarly, he has not identified any peer review literature that indicates such is even a possibility. He similarly has not performed any testing or any kind of methodology to see if his hypothesis is correct. [Exhibit B: Dr. Wikas Trial Dep. 88:17-20]. In contrast, Dr. Wikas gives these same Kenalog injections and has never experienced this type of result. [Exhibit B: Dr. Wikas Trial Dep. 63:22 – 64:10]. He admitted he has never seen an intralesional steroid injection cause an injury like what Plaintiff has. [Ex. B: Dr. Wikas Trial Dep. 31: 8-12]. Because Dr. Wikas's opinions are based purely on speculation, and he has failed to provide any research or medical literature to suggest that what the Plaintiff complains of is even a possibility, his opinions are wholly unreliable and should be excluded under Rule 702 of the South Carolina Rules of Civil Procedure.

E. If the Court finds Dr. Wikas's testimony admissible under Rule 702 of the South Carolina Rules of Evidence, it should exclude such testimony on the basis that any probative value is outweighed by its prejudicial effect.

Under Rule 403 of the South Carolina Rules of Evidence, relevant evidence may be excluded if its probative value is substantially outweighed by the danger of unfair prejudice, confusion of the issues, or misleading the jury, or by considerations of undue delay, waste of time, or needless presentation of cumulative evidence. Rule 403, SCRE. As discussed in detail above, Dr. Wikas is only trained and qualified to provide opinions in the field of dermatology. Because he is unqualified to provide opinions about any of the Plaintiffs' medical issues, any testimony as

to the cause of the Plaintiff's alleged injuries is purely speculative and not based on any scientific opinion or evidence. Any probative value in allowing Dr. Wikas to testify that a Kenalog injection is the sole cause of Plaintiff's alleged injury, when he is unable to provide opinions about all of her medical issues, would be substantially outweighed by prejudice to the Defendants, would cause confusion of the issues, and would mislead the jury to believe that 1) Dr. Wikas is qualified to consider, evaluate, and provide opinions about all of the Plaintiff's illnesses, and he believes that the Kenalog injection is the sole cause of all of the Plaintiff's problems, and 2) Dr. Wikas is qualified to consider all potential causes of the depression to Plaintiff's leg, and he has evidence to believe that the sole cause was the Kenalog injection. Dr. Wikas's whole opinion is based on a *res ipsa loquitur* argument, and he has not provided any evidence to show that the Plaintiff was injected with too high or a concentration of Kenalog, too much volume of injection, and/or an improper location, and he has failed to meet the exacting standard of a medical expert in testifying to a reasonable degree of medical certainty, that the result in question "most probably," or more likely than not, came from the alleged cause, and he has not testified that it was foreseeable that this type of injury could result from a Kenalog injection. If the Court finds any of the above testimony relevant and admissible under Rule 702, Defendants assert that any probative value in allowing Dr. Wikas to provide speculative opinions both circumvents the requirement of reliability in Rule 702 and would be substantially outweighed by prejudice to the Defendants, would cause confusion of the issues, and would be misleading to the jury. To prevail in a medical malpractice case, a Plaintiff must establish the standard of care, breach of such standard, causation, and damages, which typically requires the testimony of a medical expert. Dr. Wikas's speculative and unreliable testimony falls short of this standard, and allowing the Plaintiff to present such testimony to the jury would be substantially outweighed by prejudice to the Defendants, would

cause confusion of the issues, and would be misleading to the jury. Pursuant to Rule 403 of the South Carolina Rules of Evidence, the Court should exclude Dr. Wikas and his speculative testimony from the trial of this case.

III. Conclusion

For the foregoing reasons, Defendants respectfully move this Court to exclude Plaintiff's expert Dr. Wikas under Rule 702 and Rule 403 of the South Carolina Rules of Evidence and to instruct the Plaintiff not to mention, refer to, insinuate, or bring before the jury, directly or indirectly, on voir dire examination, reading of pleadings, statement of the case, interrogation of witnesses, argument, objections before the jury, or in any other manner, make any reference or suggestion of any testimony given by Dr. Wikas as set forth above. Further, these Defendants move this Court to instruct the Plaintiff to inform all witnesses called by the Plaintiff not to mention in the presence or hearing of the jury any of the same, unless and until specifically permitted to do so by ruling of the Court.

Respectfully submitted,

s/C. Hunter Holland

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Attorneys for Defendants Myrtle Beach Dermatology, LLC,
Shannon Hussey, and Richard Hussey, M.D.

June 28, 2021

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

TARA GURRY,)
)
Plaintiff(s),)
)
vs.)
) Case No.
) 2018-CP-26-05438
MYRTLE BEACH)
DERMATOLOGY, LLC,)
SHANNON HUSSEY AND)
RICHARD HUSSEY, M.D.,)
)
Defendant(s).)

- - - - -
DEPOSITION OF SCHIELD MARTIN WIKAS, D.O.
Friday, June 28, 2019
- - - - -

Deposition of SCHIELD MARTIN WIKAS, D.O., called
by the Defendant for examination under the
South Carolina Rules of Civil Procedure, taken
before me, the undersigned, Lisa A. Stropko,
Notary Public in and for the State of Ohio, at
Sheraton Cleveland Airport Hotel, 5300
Riverside Drive, Aires Board Conference Room,
Cleveland, Ohio 44135 commencing 10:15 a.m.,
the day and date above set forth.

- - - - -

A W R

A. WILLIAM ROBERTS, JR., & ASSOCIATES (800) 743-DEPO
scheduledepo.com

DEFENDANTS'
EXHIBIT A

Page 14 1 throughout the United States. It's the 2 same curriculum at Cleveland Clinic, 3 Harvard, Yale, Johns Hopkins. This goes 4 throughout the United States. 5 Q Do you have copies of that curriculum? 6 A No. But if you want it, I could get it. 7 Q All right. With regard to the 8 curriculum, does it say or specify what 9 you are to teach on different topics? 10 A It has the material that the residents 11 are supposed to be exposed to. 12 Q And so would that include, for example, 13 with melanoma, how to diagnose and treat 14 melanoma? 15 A I shouldn't have said that. Excuse me. 16 I shouldn't have interrupted you. I 17 apologize. It will not say that. It 18 will just say that these are things they 19 are going to be exposed to. 20 Q Of the ones, is more kind of bullet 21 points, as compared to actual, I don't 22 want to see lectures, but actual 23 materials as to things that they are 24 supposed to learn in a residency program? 25 A It will be things that they are to be	Page 15 1 exposed to. 2 Q But as far as the specifics within that 3 exposure, is that left to the teachers, 4 so to speak, or is that part of the 5 curriculum? 6 A They are going to be exposed to these 7 subjects, and the details will be 8 discussed during the rotations, and they 9 are also going to see it during grand 10 rounds. They are going to see it in 11 their reading of the dermatologic 12 textbooks. They are going to see it 13 dermatopathology. They are going to see 14 it in dermatologic surgery and in my 15 practice because we see melanomas like 16 weekly nowadays it seems like. So there 17 is going to be overlapping layers of 18 exposure. 19 Q And with regard to melanoma, is part of 20 your practice, as far as to biopsy 21 suspicious-looking moles or areas, to see 22 whether it is melanoma? 23 A Weekly. 24 Q And then is it also part of your practice 25 to actually excise those melanomas?
Page 16 1 A Only those I feel comfortable excising. 2 Q What would be a parameter as to what you 3 would feel comfortable excising? 4 A The parameters would consist of 5 location, thickness, histologic 6 characteristics, medical status of the 7 individual, among other things. 8 Q I know that you have reviewed some of the 9 records with regards to Ms. Gurry. With 10 regards to her type of melanoma that she 11 had on her leg, would that be something 12 that you would have excised, or would you 13 refer that to somebody else? 14 A I would refer it. 15 Q And why was it that you would refer it? 16 A Because of the thickness. 17 Q We will get into some of that later, but 18 what type of provider would you refer 19 with someone like Ms. Gurry? 20 A Generally, a plastic surgeon. 21 Q Why a plastic surgeon? 22 A Because they can do an adequate incision, 23 and, if necessary, do a central lymph 24 node evaluation. And I would also refer 25 her to an oncologist.	Page 17 1 Q What is a central lymph node evaluation? 2 A When you have a melanoma, it depends on 3 the location, but when they do the 4 excision, at the same time they inject 5 some sort of tracer, whether it's dye or 6 a radioactive substance. The substance 7 will travel by the lymphatics to the 8 nearest set of draining lymph nodes. 9 And the first lymph node goes into 10 what is called the sentinel lymph node. 11 This one is usually sampled, sent for 12 histologic evaluation at the time of the 13 procedure. And it is, also, sent for 14 regular sections at a later date in 15 addition in the determination if should 16 more lymph nodes be removed. It, also, 17 determines the potential for metastatic 18 spread. 19 Q Is it true that melanoma can travel 20 through the lymphatic system and not be 21 picked up right away on a PET Scan? 22 A It's possible. 23 Q What I'm wondering is if a patient opts 24 not to have a sentinel lymph node 25 evaluation, can the patient still have

Page 78

1 with that website?
2 A Not really.
3 Q Okay. Do you know whether that's a
4 reliable website to look up what side
5 effects are from a medication?
6 A It's not what I use.
7 Q What would you use?
8 A I have a lot of different websites I use.
9 Q What websites? If you are looking at
10 side effects of a medication, what do you
11 look at?
12 A Epocrates. Lexicomp. The Clinics in
13 Dermatology. Give me a moment. PubMed
14 ClinicalKey. Goodman & Gilman
15 Pharmacology. I think those are the
16 major ones.
17 Q All right. So if you were looking up
18 what potential side effects from
19 medication, would those be some of the
20 places you would look?
21 A The primary ones would be Epocrates or
22 Lexicomp.
23 Q Do you know off the top of your head what
24 are the side effects for an intralesional
25 steroid such as Kenalog?

Page 80

1 Q Okay. One thing I want to show you,
2 though, in Exhibit 12 is what I printed
3 off yesterday from Kenalog side effects,
4 the same exact website. Just take a look
5 at that.
6 -----
7 (Defendant's Exhibit 12
8 marked for identification.)
9 -----
10 Q Would you agree with that, first of all,
11 Exhibit 11 and Exhibit 12 are different?
12 A Yes.
13 Q Okay. And under where she has heading
14 where it says, "More common," you agree
15 that there is on Exhibit 12 a list that
16 says "More common." Do you see that?
17 A I do.
18 Q But then I want you to look at on Exhibit
19 12, there is one that says, "Incidence
20 not known."
21 A Correct.
22 Q Would you agree that on Ms. Gurry's list,
23 she has removed that heading that says,
24 "Incidence not known"?
25 A Yes.

Page 79

1 A Pain, atrophy, discoloration. Those are
2 the major ones that I see.
3 Q As far as what is common versus uncommon
4 with Kenalog is pain common or uncommon?
5 A Not uncommon.
6 Q How about atrophy?
7 A Well, that's the primary reason you use
8 injectable Kenalog is to thin or decrease
9 scarring.
10 Q Okay. So is atrophy, then, a common
11 cause or side effect of a Kenalog
12 injection?
13 A Your purpose is to thin the skin. If you
14 do too much Kenalog, you will get
15 atrophy.
16 Q How about discoloration? Is that a
17 common side effect or is it uncommon?
18 A It's infrequent.
19 Q Going back to my question with Exhibit
20 11, it appears that Ms. Gurry has done
21 and put in red is what she contends are
22 side effects from a Kenalog injection
23 that she had. Do you see that where she
24 put those in red?
25 A Yes.

Page 81

1 MS. GURRY: Objection. You
2 don't know when I took this from the website.
3 And you said you took that yesterday, was it?
4 So websites can change. The source can
5 change. So that would need to be looked into.
6 MS. SCALISE: We can
7 definitely do that.
8 Q But again, you would agree that on
9 Exhibit 11, right here we have the list
10 that says, "Weight gain." The next one
11 says "Abdominal cramping and/or burning
12 severe."
13 So what's missing is the heading that
14 says, "Incidence not known," would you
15 agree with that?
16 A I see.
17 Q Do you agree that that's not on there?
18 A I see the difference.
19 Q Okay. No, on Exhibit 11, do you see that
20 there is a heading that Ms. Gurry wrote
21 that says, "Side effects." But do you
22 see in Exhibit 12, the heading is
23 actually "Incidence not known." Do you
24 see that?
25 A I see.



Page 90

1 say that?

2 A Yes.

3 Q Okay. Thank you.

4 So the only breaches of the standard

5 of care that you found were on the part

6 of Shannon Hussey, correct?

7 A Correct.

8 Q And are you able to list for me what the

9 breaches are, and then we can go through

10 that? Or how would you like to describe

11 what the breaches of the standard of care

12 are?

13 A I can start by listing and you will

14 probably have to cue me in about other

15 things that I may have missed.

16 Q Okay.

17 A I think the primary one is lack of

18 informed consent. She did not tell

19 Ms. Gurry that she would experience any

20 adverse effects, such as pain, such as

21 possibility of distortion of the wound

22 site, atrophy. Those are the primary

23 ones.

24 Q Okay. Is it your contention that pain,

25 as well as the possibility of distortion

Page 92

1 A Patients need to know in advance that the

2 primary goal of the procedure is to

3 soften the tissue, and there will be some

4 atrophy. But if the patient had an idea

5 that there would be excessive atrophy,

6 they wouldn't allow the procedure to go

7 forward.

8 Q What are you basing that on that the

9 patient, and I assume you are meaning

10 Ms. Gurry, would not allow the procedure

11 to have gone forward if she had been

12 aware of atrophy?

13 A She had stated that in multiple

14 documents.

15 Q And these are documents that she has sent

16 to you that are in Exhibit 1?

17 A Correct. But any time you are dealing

18 with a patient, it makes no difference

19 what procedure you do with them. You

20 need to discuss with them what's going to

21 happen, and there is the possibility that

22 X, Y and Z can occur.

23 If you notice that a patient has any

24 hesitation about any of those potential

25 things, in all likelihood, you shouldn't

Page 91

1 of the wound site or atrophy were

2 required to be told to the plaintiff?

3 A I think if the plaintiff had any

4 indication that any of those would have

5 occurred, she would have not allowed the

6 procedure to go forward.

7 Q You are great at evading answers. Let me

8 go back to my original question.

9 My question was, is it your

10 contention that the standard of care

11 requires a medical provider to tell a

12 patient that side effects or risk of a

13 procedure, such as an intralesional

14 injection, include pain, or the

15 possibility of distortion of a wound

16 site/atrophy?

17 A Correct.

18 Q And is there anything that you are

19 relying on to say that that is the

20 standard of care, as far as those two

21 different things, pain, as well as the

22 possibility of distortion of the wound

23 site, that those are required to be told

24 to a patient for an intralesional steroid

25 injection?

Page 93

1 do the procedure. Not that they would

2 allow you to, but you shouldn't do it.

3 Q Before I get more into that, are there

4 any other breaches of the standard of

5 care?

6 A Yes. I feel that excessive

7 concentration was injected into the wound

8 site, deep in the wound site.

9 Q Any other opinions?

10 A Well, an excessive concentration of the

11 corticosteroid was injected and it led to

12 this. If there wasn't, if the right

13 amount of injection was used, then you

14 wouldn't have this result.

15 Q Any other opinions?

16 A No. I feel those are all what resulted

17 in the adverse effect.

18 Q Okay. Let's talk, then, about

19 intralesional steroids. As part of that

20 curriculum that you are teaching

21 dermatology residents, is there a section

22 in there on intralesional steroids?

23 A No. Just to know that they will learn

24 how to do it.

25 Q So is that something that you during the



Page 98

1 of pain when it's being injected?
2 A It can.
3 Q And then as far as, I guess, on either
4 one of our exhibits, looking on Exhibit
5 5, can you show me where on Exhibit 5
6 where the needle is inserting the
7 Kenalog?
8 A Just under the epidermis.
9 Q Can you use this marker and kind of show
10 us the area where it's going to be
11 inserted. And this is on Exhibit 5.
12 A Into the dermis. You really don't want
13 to do it into the epidermis unless the
14 epidermis is really thick. You could
15 even do it here. It really depends.
16 It's a clinical decision based on the
17 thickness of the scar.
18 Q All right. And you have used this kind
19 of reddish pen on Exhibit 5 to draw kind
20 of two dots. And you were explaining the
21 lower dot is in the dermis area, and then
22 the upper dot is somewhere in the
23 epidermis. And it would all depend on
24 clinical decision and clinical judgment
25 at the time as to exactly where the

Page 100

1 right words, with atrophy is that always
2 going to mean softening or does that also
3 mean depression?
4 A You want to avoid a depression. That's a
5 catastrophe. That's a disaster.
6 Q So when you are explaining about the
7 informed consent and talking about the
8 possibility of atrophy, that's something
9 that you want, correct?
10 A There is gradations of it. You are
11 really not getting atrophy. You are
12 softening the scar.
13 If you've gotten to the point of
14 causing a gully, then you have had an
15 adverse reaction. You have caused a
16 problem that was not necessary.
17 Q How quickly would you expect to see
18 atrophy if an injection of Kenalog was
19 done improperly?
20 A It depends on the concentration. If
21 excessive concentration is used, then you
22 would see it occurring in about a week
23 starting and then it would progress.
24 Q For how long?
25 A How long would it progress?

Page 99

1 Kenalog is injected, correct?
2 A It depends on the thickness of the scar.
3 Q But again, that depends on clinical
4 judgment determining the thickness of the
5 scar?
6 A Correct.
7 Q So how is the thickness of the scar
8 determined?
9 A By experience.
10 Q Is there a size of needle that is
11 typically used in this injection?
12 A Most people use a 30-gauge needle.
13 Q And you also said that you teach the
14 residents about the objectives of the
15 intralesional steroids. What are the
16 objectives?
17 A To soften the scar but avoid atrophy.
18 Q Can there still be some atrophy even when
19 Kenalog is appropriately used and
20 injected?
21 A That's the definition. You are going to
22 cause atrophy of the scar. You are going
23 to soften the scar.
24 Q Okay. So by softening the scar, and
25 maybe as a lay person I'm not using the

Page 101

1 Q Yes, sir.
2 A Probably at least a month. You would see
3 continued atrophy of the subcutaneous
4 tissue.
5 Q Where do you get that information to base
6 it that it would start in about a week
7 and progress for about a month?
8 A Clinical experience. The key is to avoid
9 using excessive concentration and
10 excessive volume in a place you shouldn't
11 be doing the injection.
12 Q What would be the indications to use
13 an intralesional steroid?
14 A To soften the scar.
15 Q How about if a scar is pulling or there
16 is tension on the scar? Would that be a
17 reason to use intralesional steroids?
18 A I don't think it's necessary.
19 Q If there is tension on a scar, will that
20 cause a scar to worsen?
21 A It will soften over time with the
22 remodeling of the underlying tissue.
23 Q So is it your testimony, then, that
24 pulling or tension on the scar is not an
25 indication for intralesional steroid?



Page 106

1 healing scars. I think they were fine.
2 I think time would be the best treatment
3 for these kind of scars.
4 **Q And again, you are relying on Ms. Gurry**
5 **to have not altered the photos and to**
6 **have correctly put the dates beside them,**
7 **correct?**
8 A Correct.
9 **Q So if there was some alteration to the**
10 **photo or if the date is incorrect, that**
11 **would then change your opinion?**
12 A I cannot attest to alterations of photos.
13 **Q So you are not going to say because you**
14 **have not seen the original photos**
15 **themselves, correct?**
16 A All I see is all I see.
17 **Q Which is Exhibit 14?**
18 A Correct.
19 **Q Also, looking back at Exhibit 13, which**
20 **is the office visit of May 3rd, 2016, do**
21 **you see under the third line at the top,**
22 **it says, "Feels scar pulling. Feels**
23 **sutures are still in scar."**
24 **Do you see that?**
25 A Yeah.

Page 108

1 need to be able to read your patient.
2 And if you look at Ms. Gurry, you know
3 she has a very high aesthetic acuity.
4 She's very sensitive about all of these
5 issues. If you know her, you can read
6 her. It just takes a second to read her.
7 You would know you don't want to be doing
8 anything invasive in her unless it's a
9 hundred percent necessary. I mean, it's
10 loud and clear to me.
11 And I think Ms. Hussey made a
12 catastrophic error in not being able to
13 read her patient, knowing there are some
14 things you do not do procedures on.
15 **Q Okay. Going back to the informed**
16 **consent, do you agree that the informed**
17 **consent can be oral and it doesn't have**
18 **to be in writing?**
19 A Correct.
20 **Q And based on the information that**
21 **Ms. Gurry has provided you and in some of**
22 **her statements, do you agree that at**
23 **least in the information she's told to**
24 **you, that as the injection started, that**
25 **she felt some pain? Do you recall that?**

Page 107

1 **Q Is it your testimony that neither the**
2 **fact that the scar was pulling, or the**
3 **fact that there was a suture in the scar,**
4 **neither of those would be a reason for an**
5 **intralesional steroid?**
6 A No indication at all.
7 **Q Okay. You talked the informed consent,**
8 **and you said that there was no informed**
9 **consent. But do you see on Exhibit 13,**
10 **it says "Side effects reviewed"?**
11 A Yeah.
12 **Q So how do you, then, determine whether**
13 **side effects were reviewed or not**
14 **reviewed?**
15 A Just because it's written doesn't mean it
16 occurred, but you don't know because it's
17 a situation in which two people say two
18 different things.
19 **Q So how do you as an expert determine**
20 **which one to believe?**
21 A Well, all I can tell you is it really
22 doesn't matter in this case because the
23 results speak for themselves.
24 And other thing that is really an
25 important thing with this issue is you

Page 109

1 A I do.
2 **Q All right. And did Ms. Gurry say, "Stop,**
3 **don't do anything more"?**
4 A Not that I know of.
5 **Q So, in fact, even if allegedly Ms. Hussey**
6 **had not said anything or warned her that**
7 **this could be painful, do you agree that**
8 **Ms. Gurry still opted to continue with**
9 **the injection even if it was painful?**
10 A She didn't say anything. But you also
11 know in dealing with patients, that
12 sometimes things may be going wrong, the
13 patient knows something is going wrong
14 but they won't say anything because they
15 are in a state of shock.
16 **Q Do you have any evidence that Ms. Gurry**
17 **was in a state of shock on May the 3rd,**
18 **2016?**
19 A I do not.
20 **Q Okay. But again, if truly hearing that**
21 **this was going to be painful would have**
22 **stopped her from having this injection,**
23 **do you agree that based on the**
24 **information she has provided to you that**
25 **as it started, as it was painful she**



Page 110

1 didn't tell anybody to stop?

2 A Correct.

3 Q Okay. So, in fact, she would have still

4 proceeded with the injection even if she

5 had been told it was painful?

6 A Could you repeat that?

7 Q Sure. It's my understanding from your

8 testimony that you don't believe informed

9 consent was given, correct?

10 A I think that is totally correct based on

11 the nature of the patient.

12 Q But we do know based on Ms. Gurry's own

13 admission through the documents that she

14 has given to you, that as this injection

15 started, she thought it was painful, but

16 yet, she still allowed it to proceed,

17 correct?

18 A That happened.

19 Q All right. So wouldn't you agree that

20 even if she had been told by Shannon

21 Hussey that this could be painful, that

22 she would have still proceeded with the

23 injection?

24 A No. We are talking about two totally

25 separate things.

Page 112

1 have said, "No, I don't want to have it

2 because there might be a little bit of a

3 scar thing," correct?

4 A There is no evidence.

5 Q Let's talk with your opinion with regard

6 to the concentration. What is your

7 understanding as to the amount of Kenalog

8 that Ms. Hussey injected?

9 A The amount of Kenalog injected, according

10 to her documentation, was 3.3 milligrams

11 per cc. Approximately, it would have

12 been 3.3 milligrams per cc.

13 Q Okay. And you are basing that on Exhibit

14 13?

15 A I think it was the Interrogatory. I'm

16 just trying to see. There is not enough

17 information here. It would have to be

18 the Interrogatory.

19 Q So you don't see at the bottom where it

20 says, "TAC 0.3 percent"?

21 A At the bottom you say? Oh, yeah. I say

22 0.3. Yeah, I see that. I'm sorry. But

23 the clearer explanation was in the

24 Interrogatory.

25 Q Okay. But your testimony is 3.3 was too

Page 111

1 Q And how is that separate?

2 A On is if she was told -- she had said

3 many times -- if she was told she knew

4 there would be side effects such as pain,

5 she wouldn't have allowed that to occur.

6 Q But we know from her own documents that

7 she sent to you that she experienced pain

8 and she didn't make it stop, correct?

9 A That's correct. But this is not unusual.

10 Some people are just in a state of kind

11 of shock or not knowing how to respond.

12 This is not unusual at all. I have seen

13 it a lot of times where people won't say

14 no because their voice is gone for that

15 time.

16 Q All right. And as far as the atrophy, I

17 think you have explained that given the

18 correct amount of injection, typically

19 you are not going to see a deep

20 depression or anything as to what

21 Ms. Gurry currently experienced, correct?

22 A Correct.

23 Q So you would agree, then, that if she had

24 been told there could be some atrophy,

25 that you have no evidence that she would

Page 113

1 much. It should have been 2.5?

2 A I doubt if that was the truth. I really

3 do.

4 Q Why do you doubt that?

5 A I have never seen such a catastrophic

6 result if the correct concentration and

7 correct volume were administered. Never.

8 Q So, in essence, you are saying the thing

9 speaks for itself? The fact that she has

10 this injury, it must mean Shannon Hussey

11 something wrong?

12 A Is that called Res ipsa loquitur?

13 Q Yes. So is that your contention?

14 A Yes.

15 Q So the fact of how it looks like now, it

16 has to mean that Shannon did something

17 wrong?

18 A Correct.

19 Q But if, in fact, she did administer 3.3

20 milligrams per cc, would that be an

21 appropriate amount for a hypertrophic

22 scar?

23 A It would be an appropriate amount if it

24 was injected properly. But I think a

25 higher concentration was -- what I see

Page 114

1 there is when you see all of the systemic
2 side effects and everything like that,
3 I'm more inclined to think of 40
4 milligrams totally injected into the
5 area.
6 **Q What I want to know is at least based on**
7 **how she has it documented, would that be**
8 **an appropriate amount to inject into a**
9 **hypertrophic scar?**
10 A That would be an appropriate
11 concentration into a hypertrophic scar,
12 which this wasn't.
13 **Q And with that appropriate amount to**
14 **inject, would you agree that you would**
15 **not expect to see any type of atrophy,**
16 **certainly not to the extent of what**
17 **Ms. Gurry has?**
18 A Yeah. You wouldn't expect to see it if
19 it was appropriately administered with
20 the right concentration with the correct
21 volume in the correct location.
22 **Q All right. And as far as the location,**
23 **do you have any evidence that it was not**
24 **appropriately administered into the**
25 **correct location?**

Page 116

1 any depressions?
2 A I have never had any depressions. Thank
3 goodness.
4 **Q So you would agree with me, then, that a**
5 **depression would be very rare to have**
6 **with a Kenalog injection?**
7 A It's a major adverse effect.
8 **Q But is it rare?**
9 A It's infrequent. But you can't say it's
10 not going to happen when an improper
11 amount of concentration of medication is
12 injected also improperly with the
13 improper volume of medication.
14 **Q Okay. So again, let me go back to that.**
15 **If it was injected properly in the**
16 **properly location, the properly volume,**
17 **et cetera, all that you said, but if it**
18 **as proper, then you would not expect to**
19 **see atrophy, correct?**
20 A Correct. And she used one cc from what I
21 saw. One cc. Even with what I saw, if
22 it would have occurred the way she says
23 it happened, it was too much to inject.
24 Way too much. Excessive. Even with the
25 proper concentration.

Page 115

1 A The only evidence is the result.
2 **Q But as far as how Ms. Hussey has**
3 **described how she did that injection,**
4 **that would be an appropriate method and**
5 **location as to how she injected it?**
6 A Well, she really didn't say where she
7 injected it. That's one problem.
8 So when you see what's written down,
9 yeah, I could see that would be
10 acceptable, but I don't believe it.
11 **Q How many times have you injected Kenalog**
12 **into a scar?**
13 A How many times?
14 **Q Yes, sir.**
15 A Hundreds, if not thousands of times.
16 **Q And during all of those times that you**
17 **have injected Kenalog, have you ever**
18 **heard any atrophy or depression?**
19 A Thank God, no.
20 **Q So none at all? It's skin has always**
21 **remained the same surface level as the**
22 **surrounding skin?**
23 A I've always been conservative when it
24 comes to injecting.
25 **Q So is the answer no, you have never had**

Page 117

1 **Q And how is that too much to inject?**
2 A When you see the location and the areas
3 that were injected, if you were going to
4 inject the area, you would only inject a
5 small area of the scar. A procedure that
6 was totally unnecessary because that
7 would have resolved by itself over the
8 next year.
9 **Q How about the pulling of the skin?**
10 A It doesn't matter. It doesn't matter.
11 **Q Could the pulling of the skin have**
12 **actually, or at least the pulling**
13 **sensation, could that have been the**
14 **sutures from the epidermis and dermal**
15 **layers actually coming apart?**
16 A No. If it would come apart, you would
17 feel a relaxation. You would feel
18 relaxation, not pulling. No, that
19 definitely would never have happened.
20 Pulling means that you are going
21 through the process of wound healing, and
22 that would have resolved over time just
23 by itself by doing nothing.
24 **Q And if Ms. Hussey had determined, "Hey, I**
25 **put too much," is there a way to retract**

Page 118

1 it back?

2 A No.

3 Q So once it's there, the damage is done?

4 A You've got it. Anything else you inject

5 would only magnify the degree of damage.

6 If you injected anything else, you'd

7 probably end up with necrosis, which

8 would be another major disaster.

9 Q So why would it not cause necrosis here?

10 A Because if you inject too much into the

11 epidermis, you are increasing the risk of

12 necrosis. If you injected into the

13 dermis the proper amount, the proper

14 concentration, you are not going to get

15 necrosis.

16 Q But if you inject too much and/or an

17 improper concentration, wouldn't you have

18 necrosis?

19 A If it's too superficial into the

20 epidermis and you are getting it leaching

21 through the surrounding tissue.

22 Q Okay. If it's not an epidermal layer but

23 it's in the dermal, aren't you going to

24 have necrosis there?

25 A If you inject too much, too high a

Page 120

1 Q No, there is?

2 A No, there is not any evidence of

3 necrosis.

4 Q And there is no evidence of the injection

5 being down into the lymphatics?

6 A Well, something is going to go into the

7 lymphatics if you inject it deeply.

8 Q But is there any evidence this injection

9 was a deep injection?

10 A There was evidence that it was injected

11 improperly, which is deeper than it

12 probably should have been.

13 Q So looking at Exhibit 5, can you give

14 an opinion as to where this injection was

15 located?

16 A I can't give you an opinion, but I can

17 tell you it was injected in the wrong

18 place, too high of volume, too high of

19 concentration, because the result speaks

20 for itself.

21 Q So again, getting back to the fact she

22 has got what she has now, there was

23 something going on wrong by nurse Hussey?

24 A There was no problem prior to the

25 injections. After the injection,

Page 119

1 concentration, you could. But it's based

2 on a person who knows what they are doing

3 who does it correctly.

4 Q It's my understanding your testimony is

5 Ms. Hussey injected too much, too high of

6 a concentration, wrong location, all of

7 that. So that's what I'm trying to find

8 out is where is the necrosis?

9 A There wasn't any.

10 Q So why would there not be necrosis if

11 truly this is too much and/or the wrong

12 concentration?

13 A If you are injecting deep into the skin,

14 into the deep dermis, subcutaneous fat,

15 then you are having the medication being

16 directed throughout, which could go into

17 blood vessels, lymphatic vessels,

18 anything else imaginable.

19 Basically necrosis usually results

20 from a circulation being disturbed. If

21 you cut off the circulation one way or

22 another, the tissue dies.

23 Q So you would agree there is no evidence

24 of any necrosis here?

25 A No.

Page 121

1 everything went wrong. It became a

2 catastrophic event.

3 Q What are you basing that on, that after

4 this injection, quote, "Everything went

5 wrong"?

6 A There was no problem. The wound was

7 healing perfectly naturally prior to the

8 injection. After the injection, atrophy

9 started to occur. She had systemic side

10 effects. A lot of the systemic side

11 effects are comparable to the results of

12 corticosteroid.

13 Q That's why I asked if you had read the

14 endocrinologist, Ms. LaRochelle's

15 deposition, and you said you had not?

16 A Correct.

17 Q Her testimony is none of the side effects

18 that Ms. Gurry has were caused by this

19 intralesional steroid. So I'm wondering

20 --

21 MS. GURRY: Objection.

22 That's not properly stated. Objection.

23 Q So would you agree you would have to

24 defer to an endocrinologist as to whether

25 the side effects were related to an



Page 130

1 evaluation records. I'm just going to
2 show you this. One for the record, it's
3 Bates stamp Community Behavioral Health,
4 page 4. And do you see where under
5 "Content of thought," he's got marked
6 "obsession"?
7 A I do.
8 Q Are you aware that Ms. Gurry has
9 metastatic melanoma?
10 A No.
11 Q Are you aware that she had later a lymph
12 node removed that was positive for
13 cancer?
14 A I have no documentation of that at all.
15 Q If she has got cancer in her lymph nodes,
16 how does that affect her life expectancy?
17 A It decreases her life expectancy.
18 Q Are you going to be offering any opinions
19 at trial as to what stage of cancer she
20 has, what life expectancy, anything like
21 that?
22 A No.
23 Q I assume you have treated patients with
24 metastatic melanoma?
25 A Yes.

Page 132

1 any other medical issues she may have?
2 A May I?
3 Q Sure.
4 A No. All I can really comment on
5 specifically is the adverse effect of the
6 injection locally.
7 Q And so that adverse effect was the
8 atrophy that you are referencing?
9 A Yes. And all of the results thereof.
10 Q So what other results thereof are you
11 referencing?
12 A Well, with atrophy, you have loss of
13 subcutaneous tissue and anatomic
14 components in that area.
15 Q What anatomic components in that area are
16 you going to contend were lost or damaged
17 or injured as a result of the Kenalog
18 injection?
19 A A loss of adipose tissue.
20 Q And that's it?
21 A Thinning of the skin.
22 Q Anything else?
23 A No, not right now.
24 Q Okay. As far as that loss of adipose
25 tissue, if she had some of the adipose

Page 131

1 Q Have you found in your experience with
2 those patients that some patients focus
3 on their disease and some don't?
4 A Correct.
5 Q And could it be here in this case that
6 Ms. Gurry is focused on this scar and the
7 atrophy that she has rather than dealing
8 with her metastatic melanoma?
9 A I can't comment on it.
10 Q If Ms. Gurry has, as we saw from the
11 record from her psychiatrist, that she
12 had been prescribed Zoloft, if she is not
13 taking the anti-depressant or
14 anti-anxiety, would that increase someone
15 else's depression and/or anxiety?
16 A I can't comment on that.
17 Q Just because that's outside of your area
18 of expertise?
19 A It is.
20 Q In Exhibit 11, that was the list of
21 various side effects that Ms. Gurry has
22 kind of highlighted in red as things she
23 has experienced. Are you able to say
24 whether any of these are specifically due
25 to the Kenalog injection as compared to

Page 133

1 tissue already lost from the melanoma
2 excision, then you would agree there
3 would be no additional adipose tissue
4 that was lost because of the Kenalog,
5 correct?
6 A There was no indication that she had
7 substantial loss of subcutaneous fat as a
8 result of the procedure. The changes
9 occurred after the injection.
10 Q Are you able to piece together or tell
11 when those changes occurred after the
12 injection?
13 A They began to occur within a week or two.
14 Q What are you basing that on?
15 A I would have to see the photo.
16 Q Let me mark it as Exhibit 15.
17 -----
18 (Defendant's Exhibit 15
19 marked for identification.)
20 -----
21 Q I will show you what we marked as Exhibit
22 15. Is that what you are referencing?
23 A Yes. I really can't say too much with
24 May 14th, but certainly, in July and
25 August it's really obvious.

Page 138

1 Q That's six weeks later. If, truly, she
2 is having all of these issues from the
3 beginning, wouldn't you have expected her
4 to have gone to some medical provider to
5 see what was causing all of this?
6 A I would have expected it, yes.
7 Q Kind of with the advent of the Internet,
8 have you had patients who read things on
9 the Internet and basically self-diagnose
10 themselves?
11 A Always.
12 Q Do you believe in any way of this, that
13 Ms. Gurry has gone on the Internet and
14 basically convinced herself that what
15 issues she has were all related to that
16 Kenalog injection?
17 A I can't make that opinion.
18 Q Just one way or the other you cannot say?
19 A I cannot say.
20 Q And other than the localized issues that
21 you discussed, which was the atrophy and
22 the loss of subcutaneous tissue, is it
23 fair to say you are not going to come to
24 trial and say that the injection caused
25 any other issues or problems for

Page 140

1 it done?
2 A I'm not aware of that.
3 Q Okay. Has she said why she hasn't had
4 this done?
5 A I'm not aware of any of that.
6 Q I think it's fair to say you haven't been
7 provided with any of her pretreatment
8 records to show what kind of medical
9 issues she had prior to the injection,
10 correct?
11 A All I have is what's in here.
12 Q Okay. But nothing prior to that? I've
13 got three volumes of records, which you
14 agree is significantly more than what you
15 have been provided, correct?
16 A Correct.
17 Q If, in fact, hypothetically, the
18 epidermal and dermal layers separated
19 underneath this suture line, would you
20 agree that that could explain why she has
21 this depression in her leg?
22 A I don't think so.
23 Q So with those circumstances that wouldn't
24 explain this?
25 A It would have happened before the

Page 139

1 Ms. Gurry?
2 A Systemically?
3 Q Other than this atrophy and this loss of
4 subcutaneous tissue?
5 A I think that would be what I would
6 probably be the most comfortable to
7 discuss.
8 Q At trial you are not going to give
9 an opinion that the injection caused
10 anything else other than atrophy and loss
11 of subcutaneous tissue?
12 A That's what I'm going to say.
13 Q Thank you.
14 As far as now that she has this issue
15 that you have evaluated and looked at
16 this morning, is there anything that can
17 be done for that area on her thigh?
18 A Sure.
19 Q What can be done?
20 A Scar revision, excise the surrounding
21 tissues, injecting fatty tissue, fat
22 transplantation. I think that's all.
23 Q And are you aware that she went to a
24 plastic surgeon who made that
25 recommendation, but yet, she hasn't had

Page 141

1 injection.
2 Q Have you had any instances where a
3 patient has had some type of excision in
4 their leg where a section of the leg has
5 been removed, including the epidermis
6 around dermal layers, that, then, have
7 gone onto cause a depression in the leg?
8 A No. The only time I have ever seen
9 depressions in the leg is when somebody
10 had a graft.
11 Q How much have you been paid thus far from
12 this case?
13 A \$2,500 from Ms. Gurry and \$2,500 from
14 you.
15 Q My \$2,500 was the charge that you had for
16 your deposition?
17 A Correct.
18 Q And as far as the \$2,500 that you charged
19 Ms. Gurry, what all did that encompass?
20 A Evaluation of records and communication.
21 Q Has there been any additional work done
22 since you have, I guess used up that
23 \$2,500 retainer? Has there been any time
24 you haven't billed her for?
25 A I have not billed additional time.



Page 146

1 consent needed to be given for this
2 injection?
3 A I read that.
4 Q But you disagree?
5 A I feel there should be at least a verbal
6 informing of informed consent.
7 Q Just so I'm clear, I'm like the patient,
8 and you are going to give me an
9 intralesional steroid injection. To give
10 me informed consent, what would you say
11 to be in compliance with the standard of
12 care?
13 A I would say if we are talking about
14 injecting into a scar, I would say
15 normally you are going to feel some
16 discomfort. The objective of this is to
17 soften and flatten the scar. There is a
18 slight possibility that there may be
19 excessive thinning of the skin and
20 flattening of the skin. But I think
21 that's pretty much all I would say.
22 Q So the thinning and flattening of the
23 skin, does that imply a depression?
24 A No, absolutely not. We want to avoid
25 that at all costs. Because patients will

Page 148

1 an appropriate amount in the correct
2 location using the correct technique, and
3 for whatever reason, Ms. Gurry just had a
4 very bad outcome from it?
5 A I can't see it.
6 Q So you think it had to have been she did
7 something improper?
8 A The result was so egregious, just so
9 excessive, that if it was injected
10 properly, you wouldn't get that result.
11 The result was horrible, especially in an
12 individual with a high aesthetic acuity.
13 Q Doctor, do you have any relatives that
14 live in South Carolina?
15 A No, Ma'am.
16 Q Have you ever been arrested or had any
17 kind of criminal history?
18 A In South Carolina?
19 Q Anywhere?
20 A No, not that I know of. No.
21 Q No DUI, no bad checks?
22 A No, I don't do that.
23 Q How about have you had to seek treatment
24 for any drug or alcohol counseling?
25 A No, Ma'am.

Page 147

1 tell me if that occurs, "This isn't what
2 I wanted."
3 Q And so you would agree that even doing
4 things correctly and appropriately,
5 sometimes bad things happen to patients,
6 correct?
7 A Yes. And I think really the most
8 important thing in patient care that
9 every physician will learn is to read
10 your patient. Certain people should not
11 have procedures done.
12 Q So what about Ms. Gurry would cause
13 someone not to do a procedure?
14 A Just by talking to her you see she has
15 what we call a high aesthetic acuity.
16 She's very sensitive to her total body
17 and its appearance. And as a result, you
18 shouldn't do a procedure on somebody like
19 that unless you feel highly comfortable
20 that you can give the results you are
21 suggesting you can give. In those kinds
22 of cases, if you have the slightest
23 hesitation, it's better to refer to
24 another person.
25 Q Is it possible that Shannon Hussey gave

Page 149

1 Q Any psychological or psychiatric
2 counseling?
3 A Yeah. I see a therapist on a regular
4 basis. But, you know, nothing in terms
5 of mental illness or anything like that.
6 Q Do you agree, doctor, that good experts
7 can disagree on the appropriate course of
8 treatment for a patient?
9 A Yes.
10 Q Do you agree that a bad outcome doesn't
11 necessarily mean that the medical
12 provider was negligent?
13 A Correct. Except in this case.
14 Q Do you agree that the occurrence of an
15 injury is not proof of medical
16 negligence?
17 A Correct. Except in this case.
18 Q Do you agree that you can't judge a
19 medical provider in light of what
20 hindsight might reveal?
21 A When you say "Judge a provider," what do
22 you mean?
23 Q Do you agree that as an expert, you have
24 an inherent hindsight bias?
25 A Of course. We all do.



1 IN THE COURT OF COMMON PLEAS
2 OF HORRY COUNTY, SOUTH CAROLINA

3 ~~~~~

4 TARA GURRY,

5
6 Plaintiff,

7
8 vs. Case No. 2018-CP-26-05438

9
10 MYRTLE BEACH DERMATOLOGY, LLC, et al.,

11
12 Defendants.

13 ~~~~~

14 Deposition of
15 SCHIELD M. WIKAS, D.O.

16
17 Monday, June 21, 2021
18 1:07 p.m.

19 Taken at:
20 Cleveland Reporting Partners
21 2012 West 25th Street, Suite 516
22 Cleveland, OH 44113

23
24 Michelle L. Harper, RPR
25

Page 6		Page 8	
1	object..... 50	1	THE VIDEOGRAPHER: We are on the record.
2	object..... 51	2	It's 1:07. You may swear in the witness.
3	objection..... 52	3	SCHIELD M. WIKAS, D.O., of lawful age,
4	objection..... 54	4	called for examination, as provided by the Ohio
5	objection..... 54	5	Rules of Civil Procedure, being by me first duly
6	objection..... 55	6	sworn, as hereinafter certified, deposed and said
7	objection..... 55	7	as follows:
8	objection..... 56	8	EXAMINATION OF SCHIELD M. WIKAS, D.O.
9	objection..... 56	9	BY MS. GURRY:
10	objection..... 56	10	Q. Doctor, what is your full name for the
11	objection..... 57	11	record?
12	objection..... 57	12	A. Schield Martin Wikas.
13	objection..... 58	13	Q. What is your profession?
14	objection..... 58	14	A. I'm a dermatologist.
15	object..... 58	15	Q. How many years have you been a
16	objection..... 60	16	dermatologist?
17	objection..... 61	17	A. Since 1984.
18	objection..... 61	18	Q. Okay. So that would be 6 -- okay.
19	objection..... 62	19	And what is your educational background?
20	objection..... 62	20	A. I went to pharmacy school, graduated
21	objection..... 68	21	19 -- I'm just trying to think. 1970 -- no,
22	objection..... 69	22	excuse me. I went to pharmacy school. Then I
23	objection..... 69	23	went to graduate school in pharmacology for four
24	objection..... 70	24	years. Then I took two years to work as a
25	objection..... 80	25	pharmacist. Then I went to medical school in 1975
Page 7		Page 9	
1	objection..... 82	1	to 1979. Then I had a rotating internship in
2	objection..... 85	2	Cuyahoga Falls, Ohio. Then I went to the
3	objection..... 91	3	Cleveland Clinic where I spent one year in
4	object..... 103	4	internal medicine and three years in dermatology.
5		5	Q. Excellent. And what degrees,
6		6	certificates, and/or licenses do you have?
7		7	A. I had a BS in pharmacy, a master's degree
8		8	in pharmacology, a DO degree through medical
9		9	school, and I was certified one year of internal
10		10	medicine and three years of dermatology.
11		11	Q. Okay. And where are you board-certified?
12		12	A. I'm board-certified by the American
13		13	Osteopathic College of Dermatology.
14		14	Q. And please state any professional
15		15	organizations and/or societies you're a member of.
16		16	A. The American Medical Association, the
17		17	American Osteopathic Association, the Ohio State
18		18	Medical Association, the Ohio Osteopathic
19		19	Association, the American Osteopathic College of
20		20	Dermatology. Those are the major ones.
21		21	Q. And what is your experience in authoring
22		22	publications in dermatology?
23		23	A. I have approximately 19 publications and
24		24	a total of 40 presentations. The publications
25		25	were dealing with malignancies, skin cancers,

Page 14 1 A. It will lead to thinning of the skin, 2 what we call -- atrophy is the medical term. Is 3 can cause -- allow for the generation of new small 4 blood vessels, capillaries, that are more obvious 5 as the skin gets thinner. 6 Q. And moving on, tell us about when you 7 examined me and what was your assessment? 8 A. Your skin was thin, atrophic. It 9 actually had a chicken skin appearance. There was 10 an accentuation of blood vessels, some of them 11 red, some of them bluish, but the most obvious 12 appearance was a thinning of the skin and a bit of 13 a depression. 14 Q. What documents have you reviewed in this 15 case? 16 A. I've reviewed clinical documents, I've 17 reviewed affidavits, I've reviewed depositions, 18 and other materials, a whole host of materials. 19 Q. What is your opinion of Shannon Hussey's 20 treatment and the standard of care of May 3rd, 21 2016? 22 A. I felt that she fell below the standard 23 of care because you had catastrophic thinning of 24 the skin, a depression, accentuation of blood 25 vessels, there was sensitivity to touch, so I felt	Page 16 1 have you explain, and I'm just going to read to 2 you two sentences here and then have you expand 3 upon it. 4 MS. SCALISE: And at this point, I would 5 raise an objection to any questions asked about 6 the affidavit. That is not a proper way to ask 7 him questions. That would be a needless 8 presentation of cumulative evidence. 9 MS. GURRY: Let me restate that then, 10 Ms. Scalise. Let me restate that, the question. 11 MS. SCALISE: Okay. Go ahead. 12 Q. Yeah. So if you would look at the last 13 page of your affidavit, Dr. Wikas, and then if you 14 would look at the last two sentences in the 15 second-to-last paragraph, starting off with 16 "Shannon Hussey's narration," and then if you 17 would go ahead and expand upon what you wrote in 18 your affidavit and how you feel about that today 19 after everything that you've looked at. 20 A. I believe -- 21 MS. SCALISE: And again, I would like to 22 raise that as an objection. That is not a proper 23 way to ask him questions with regard to what his 24 opinions are. Throughout his deposition, as far 25 as the discovery deposition, he was asked various
Page 15 1 that her activities were well below the standard 2 of care. 3 Q. Regarding Shannon Hussey's deviation from 4 the standard of care, please list the breaches. 5 A. The first breach was misdiagnosis. She 6 diagnosed a hypertrophic scar when there was no 7 hypertrophic scar. It was my impression that she 8 injected too much corticosteroid, probably too 9 deeply, too high a concentration, too large a 10 volume. 11 Q. And regarding informed consent? 12 A. I don't feel that there was adequate 13 informed consent given at the time, so I don't 14 feel there was adequate informed consent given. 15 Q. Okay. So let's move on to your 16 affidavit. If you'll go ahead and pull that up, 17 please. 18 A. Okay. 19 - - - - - 20 (Thereupon, Plaintiff's Exhibit 14, 21 Dr. Wikas Affidavit, was marked for 22 purposes of identification.) 23 - - - - - 24 Q. Okay. So I'm just going to read to you 25 your testimony on your affidavit and then just	Page 17 1 questions related to his opinions and with regard 2 to causation, which he has explained in his 3 discovery deposition he is not qualified by 4 education, experience, or training to render 5 opinions with regard to the multitude of causation 6 that Plaintiff has claimed. So I do object to 7 this line of questioning. 8 MS. GURRY: Okay. Well, the judge will 9 go ahead and decide upon that. This is a 10 deposition, so we're going to go ahead and move 11 forward with the questions that I have. The judge 12 will decide upon. 13 Q. Okay. So Dr. Wikas, if you would just 14 expand upon the second-to-last paragraph, if you 15 would just expand upon some of those things. 16 A. So according to the imaging -- 17 MS. SCALISE: Okay. Before he says 18 anything, again, I raise an objection to that 19 under Rules 702 and 403 of the South Carolina 20 Rules of Evidence. 21 He testified in his deposition he was not 22 an expert in imaging, he has no education, 23 experience, or training to say what the imaging 24 reveals, that was pages 67 through 68, lines 23 25 through 8 of his discovery deposition. He

Page 18 1 testified he has never reviewed the actual PET 2 scan or MRI images themselves, that was on page 3 68, line 13 through 17, and he admitted in his 4 deposition that he never saw any words from any 5 physicians in the medical records he reviewed that 6 would support Plaintiff's words that have been 7 added to her proposed exhibits related to the 8 radiologic imaging, that was on page 68, lines 21 9 through 25 of his deposition, so the defense 10 contend it would be improper for Dr. Wikas to 11 offer any comments or opinions related to the 12 imaging in this case. 13 Additionally, during his discovery 14 deposition, I asked him to let me know prior to 15 trial if he changed, altered, amended, or added to 16 any of his opinions, and he said he would and 17 agreed that that would only be fair for the 18 defense to know all of his opinions and that we 19 had already discussed at the time of his 20 deposition all of his opinions in this case. 21 To date, I have received no notice of any 22 changes, alterations, amendments or additions to 23 his opinions expressed in his deposition, so I 24 oppose any changes from that discovery deposition 25 and I would point to his prior deposition	Page 20 1 about the imaging. And as far as me adding words 2 to it, it's all -- it's tangible. It's, you know, 3 skin is missing and I added some of the elements, 4 the thin skin. But we're going to be getting to 5 all that, so that's fine. Thank you. 6 BY MS. GURRY: 7 Q. So Dr. Wikas, we'll continue here, and 8 you can just -- you can just modify as you'd like. 9 You can -- 10 A. Basically, what I saw, and this is really 11 based on my examination, which pretty much says 12 the same thing, is that there was significant 13 atrophy. There appear to be destruction of 14 underlying tissue. With destruction of underlying 15 tissue, there was a significant depression in the 16 skin, there was an accentuation of blood vessels; 17 some of them were blue, some of them were pinkish. 18 With the atrophy, there was a chicken skin 19 appearance, and it was that way to touch. And I 20 basically think that's covers it. 21 Q. Thank you. If you would go ahead and 22 talk about dehiscence. What is the definition of 23 dehiscence? 24 A. Dehiscence is when a wound comes apart. 25 The other term is ruptures. It totally comes
Page 19 1 testimony pages 142 to 43, lines 18 through 18, as 2 well as page 151, line 10 through 18. 3 Moreover, he has not been qualified by 4 any court as an expert witness to render opinions 5 regarding radiologic imaging. As such, any 6 testimony would be purely speculative and not 7 based on any scientific evidence or opinion and it 8 would lead to the confusion of the issues and 9 misleading of the jury and it is not reliable. By 10 his own admission, he has no scientific, 11 technical, or other specialized knowledge that 12 would assist the trier of fact to understand the 13 evidence or to determine a fact in issue related 14 to the radiologic imaging. Any minimal probative 15 value of Dr. Wikas's testimony must be balanced 16 against the danger of unfair prejudice, confusion 17 of the issues, and misleading the jury. 18 So accordingly, under Rules 702 and 403 19 in the South Carolina Rules of Evidence, we object 20 to that line of questioning and move to strike any 21 response he may give related to the imaging. 22 MS. GURRY: Okay. Thank you. So we're 23 going to move forward though with the questions, 24 and as I said, the judge will go ahead and decide. 25 You don't know what questions I'm going to ask	Page 21 1 apart, and if we're talking about stitches, the 2 stitches either break open or they eat through the 3 skin. But it's literally when a wound opens up. 4 Q. Did you see any indication of this when 5 you examined me? 6 A. No, I didn't. 7 Q. So Ms. Hussey's narration of the 8 preparation and injection of the corticosteroid, 9 what is your opinion on that? 10 A. I think the results speak for themselves. 11 I've never seen -- Ms. Hussey said she injected 12 3.3 milligrams of the corticosteroid into the 13 incision site. I've injected that amount of 14 concentration many, many times, literally at least 15 hundreds of times, and I've never seen a wound 16 implode. So my impression is, in all likelihood, 17 she injected too high a concentration, too high a 18 volume probably, too deep into the underlying 19 tissue. 20 Q. And did you -- the injection that 21 Ms. Hussey did, did you think that that was 22 necessary in any -- for any reason? 23 A. In the photographs that I saw, the wound 24 looked just fine. I saw no indication of a 25 hypertrophic scar, it was healing absolutely

Page 22 1 beautifully, and I think if no medication was used 2 at all, the scar would have healed fantastically, 3 beautifully, and maybe even not even visible. 4 Q. Okay. If we can move onto Exhibit 1, and 5 that is the Kenalog package insert. 6 - - - - - 7 (Thereupon, Plaintiff's Exhibit 1, 8 Kenalog Package Insert, was marked 9 for purposes of identification.) 10 - - - - - 11 A. Okay. 12 Q. Okay. So what medical literature is the 13 authority on the drug Kenalog 10? 14 A. I think the primary one would be the FDA 15 package insert. There are other -- 16 Q. Okay. When you -- 17 A. There are others that are available, but 18 this would have to be the most important one. 19 Q. Okay. If you would please go to page 15 20 to the dosage and administration. 21 MS. SCALISE: And I guess I do want to 22 make sure it's clear, Tara. I know that you are 23 referencing various exhibits. I object to this 24 being an exhibit at trial in that under South 25 Carolina Rule of Evidence 803, any type of learned	Page 24 1 volume would be the most appropriate. A lot of 2 times, one drop of the medication is sufficient in 3 each injection site, and a lot of times that 4 injection site is one. 5 Q. Okay. Great. Dr. Wikas, if you would do 6 this, please, and put down the package insert. I 7 want to go ahead and -- you can put that down. 8 I'm going to go ahead, because you have 9 enough knowledge and even with your background in 10 pharmaceutical education and what not, so I'd like 11 to just move forward. You know enough about 12 Kenalog 10 drug; is that correct? 13 A. I have sufficient background, yes. 14 Q. Excellent. So if you can let me know, as 15 far as the intralesional administration, you've 16 already explained how that is done with a Kenalog 17 scar. If you can let me know about what happens 18 if it's injected to a great volume as well as 19 concentration, what happens to the drug regarding 20 the bodies of fat? 21 MS. SCALISE: Objection. Calls for 22 speculation. 23 A. The medication, if injected too deep, 24 that means -- when I'm saying too deep, we're 25 talking about a millimeter to 2 millimeters, so if
Page 23 1 treatise may not be received as an exhibit. 2 MS. GURRY: Okay. 3 Q. So if you look at the dosage and 4 administration, if you would go ahead and give 5 your opinion on the enlarged in all caps last 6 paragraph, if you'll expand upon that, page 15, so 7 it's right below dosage and administration. 8 A. Yes. What is your question? 9 Q. Yes, so if you will explain, it says 10 right here that, "It should be emphasized that the 11 dosage requirements are variable and must be 12 individualized on the basis of the disease under 13 treatment and the response of the patient." 14 How do you do that in your practice when 15 deciding to inject a keloid scar? 16 A. First of all, in the dosage and 17 medication given by Ms. Hussey, it was 18 unnecessary. It should not have been given. 19 Totally unnecessary. 20 Second of all, you customize the 21 medication, the dosage, the volume, to each 22 individual. It has to be customized. The 23 smallest amount would be the -- and that means 24 smallest amount in terms of concentration, that is 25 the number of milligrams, smallest amount in	Page 25 1 the amount is injected too deep, it will lead to a 2 destruction of the underlying tissue, it will 3 allow for absorption of the medication into blood 4 vessels, into lymphatic vessels. 5 With the destruction, there's a 6 cataclysmic change in the underlying tissues such 7 that they're all destroyed with the atrophic 8 implosion. And there's absorption systemically. 9 So you do have a local effect, that's correct, but 10 you also have systemic absorption of the 11 medication, which can go to other parts of the 12 body. 13 Q. And regarding that systemic absorption 14 that goes to the other parts of the bodies, 15 what -- give me some of the adverse effects that 16 you know about on that? 17 MS. SCALISE: And for this, I will raise 18 an objection. Again, under Rule 702 and 403, I 19 object to Dr. Wikas offering any testimony related 20 to any claims regarding systemic effects. He has 21 previously testified that he will not be offering 22 any opinions in the field of rheumatology, 23 endocrinology, or obstetrics or gynecology. He's 24 not educated, trained or experienced in those 25 fields.

Page 26 1 Further, in his discovery deposition, he 2 was shown an Exhibit Number 11, which was a 3 document where Ms. Gurry highlighted in red as to 4 things she claims she has experienced as a result 5 of intralesional steroid injection. When I asked 6 Dr. Wikas in his deposition if he was able to say 7 whether any of those side effects were 8 specifically due to the Kenalog injection as 9 compared to any of her other medical issues she 10 had, his answer was no. The only thing he 11 testified he could comment on was the atrophy. He 12 could not comment on any systemic effects. That's 13 pages 131 to 132, lines 21 through 23, of his 14 deposition. 15 Again, during his discovery deposition, I 16 asked him if he was going to come to trial and say 17 that the injection caused any issues or problems 18 for Ms. Gurry other than atrophy and loss of 19 subcutaneous tissue, and his response was, "I 20 think that would be where I would probably be the 21 most comfortable to discuss. That's what I'm 22 going to say." That was pages 138 to 139, lines 20 23 through 12. 24 And again, I asked him to let me know if 25 he changed, altered, added to any of his opinions.	Page 28 1 this. Dr. Wikas has testified in his deposition 2 that he cannot comment about whether or not you 3 had any systemic effects. That was outside the 4 scope of his expertise. 5 MS. GURRY: I have not -- my question I 6 rephased, I did not mention my health at all. I 7 am asking him about the drug Kenalog and what 8 adverse reactions it can cause if it goes 9 systemically. 10 MS. SCALISE: Right. And I appreciate 11 that. 12 MS. GURRY: Thank you. 13 MS. SCALISE: I appreciate that. But I 14 think the concern for him to discuss any type of 15 systemic effects would simply confuse the jury and 16 mislead them, because there is no evidence of any 17 systemic effects from this Kenalog injection, and 18 Dr. Wikas has previously testified that he cannot 19 give any of that information or opinion. So I 20 think for him to -- for you to ask questions about 21 what are the systemic effects when there is no 22 evidence of Plaintiff having systemic effects 23 simply leads to the confusion of the issues and 24 misleading the jury, so I do object. 25 MS. GURRY: Well, I object to your
Page 27 1 He said he would, and again, I've not been 2 notified of any new opinions. 3 Additionally, he's not been qualified by 4 the court as an expert in the field of 5 rheumatology, endocrinology, or obstetrics and 6 gynecology, so any testimony would be purely 7 speculative and not based on any scientific 8 evidence or opinion and would lead to confusion of 9 the issues and misleading of the jury and is not 10 reliable. 11 Any minimal probative value of his 12 testimony must be balanced against the danger of 13 unfair prejudice, confusion of the issues, and 14 misleading the jury, so accordingly, under Rule 15 403 and 702, we object to the line of questioning 16 and move to strike his response. 17 Q. Dr. Wikas, I'd like to go ahead and 18 rephrase my question for you, okay? 19 Regarding the Kenalog packet insert, when 20 the drug goes systemically, what are the adverse 21 reactions to it, if you can let me know some of 22 the adverse reactions? 23 MS. SCALISE: And again, I raise the 24 exact same objection that I've just raised. There 25 is no evidence that you had a systemic effect from	Page 29 1 objection, because it's not correct because I do 2 have evidence of systemic effect in medical 3 records, and we will let the judge decide upon 4 that, and I'm going to move forward with my 5 questions and Dr. Wikas will be able to answer. 6 And I've heard your objections very well. You've 7 stated it several times. Thank you. 8 BY MS. GURRY: 9 Q. So Dr. Wikas, regarding, again, the same 10 question, if you remember. Or if you need to me 11 to repeat that, just let me know. 12 A. Sure. Some of the -- 13 MS. SCALISE: Same objection. 14 A. Some of the occurrences with injection of 15 corticosteroids such as Kenalog when it becomes 16 systemic can be elevation of blood sugar, it can 17 lead to a decrease in the absorption of calcium, 18 increase in the excretion of calcium, the matrix 19 of bones, which is basically the framework of 20 bones, the proteins are no longer laid down, so it 21 can lead to deterioration of bones and lead to 22 what's called bone loss. The early one is called 23 osteopenia. It can lead to some effects, 24 emotional effects. It can lead to anxiety, upset. 25 Those are some of the common ones I see.

Page 30 1 Q. Okay. Okay, Dr. Wikas, if we can move on 2 to the deposition, so if you can look at your 3 deposition here, and -- 4 - - - - - 5 (Thereupon, Plaintiff's Exhibit 13, 6 Dr. Wikas 6/28/19 Deposition 7 Excerpts, was marked for purposes of 8 identification.) 9 - - - - - 10 MS. SCALISE: And again, this is an 11 improper question I think you're about to ask. 12 MS. GURRY: Okay, okay. Thank you. I'll 13 go ahead and move on. 14 Q. So Dr. Wikas, you can put that down, your 15 deposition down, and I'm just going to ask you a 16 few questions here. 17 So regarding the injection itself and 18 what it caused, if you can expand upon that and 19 how you feel the drug, with what it did, I know 20 you already have said some of this, but if you can 21 expand upon that and, yes, you can -- 22 MS. SCALISE: Objection. Asked and 23 answered. 24 A. I'm not sure what you're asking right 25 now.	Page 32 1 dose of corticosteroid would -- someone would 2 experience side effects? 3 A. Could be anywhere from one to three 4 months. 5 Q. And in the situation of my injury and 6 what you've examined and the pictures you've seen, 7 would you think that that would be -- what would 8 you think the side effect duration would be? 9 A. Well, from the point of view of the 10 depression, that's permanent. So the side 11 effects, we're talking about making a permanent 12 structural change in the skin, probably with an 13 effect on muscles, deterior -- loss of muscle and 14 a change in function. 15 MS. SCALISE: Doctor, I'm going to 16 interrupt you and I've got to raise an objection 17 and move to strike. 18 Dr. Wikas has previously testified that 19 he is not an orthopedist, he cannot offer any kind 20 of orthopaedic opinions, so again, under 702 and 21 403, I think it's highly improper for him to offer 22 any testimony about muscle or effects on muscle or 23 damage to muscle. He has previously testified 24 that he has no opinions on that, he cannot offer 25 any opinions, this goes to pages 73, lines 3
Page 31 1 Q. Okay. Let's see. Yeah, just give me one 2 moment here. 3 So if you will, I find it very 4 interesting, you've been a dermatologist nearly 40 5 years; is that correct? 6 A. Correct. 7 Q. From '84? That would be -- and you have 8 never -- have you ever seen anything like the 9 atrophy that I -- and the injury that I got from 10 the injection? 11 A. No, thank goodness, because that would be 12 considered catastrophic. 13 Q. So what is your expert opinion on how 14 much she did inject and what dosage? 15 MS. SCALISE: Object to the form. Calls 16 for speculation. 17 A. The amount Ms. Hussey said she injected 18 really doesn't jive with the results, because in 19 order to get that kind of result, the 20 concentration would have to be much higher, and in 21 all likelihood, there was a much greater volume 22 that was injected. So that literally was 23 dissolving the underlying tissues. 24 Q. And so how long do you think 25 corticosteroids, in most situations, an excessive	Page 33 1 through 13, as well as page 128, line 12 through 2 22. 3 Again, I've asked him to let me know if 4 there were any additions, changes, alterations to 5 his opinions prior to having this trial 6 deposition. He never notified me of that. Again, 7 he has not been qualified by a court to render any 8 opinions in the field of orthopaedics, so his 9 testimony is purely speculative and not based on 10 any scientific evidence or opinion and it simply 11 would lead to confusion of the issues and 12 misleading of the jury and is not reliable. 13 Again, any minimal probative value of his 14 testimony has to be balanced against the danger of 15 unfair prejudice, confusion of the issues, and 16 misleading the jury. 17 And so under Rules 403 and 702, the 18 Defendants object to the line of questioning and 19 move to strike his response related to the effects 20 of this structural change underneath the skin. 21 BY MS. GURRY: 22 Q. Dr. Wikas, let's move on. Let's move on 23 to Exhibit 10, skin anatomy. You should have a 24 copy of that there. 25 And again, that's Exhibit 10.

Page 34 1 - - - - - 2 (Thereupon, Plaintiff's Exhibit 10, 3 Anatomy of the Skin Diagram, was 4 marked for purposes of 5 identification.) 6 - - - - - 7 A. I do. 8 Q. Okay. Great. So this is what you 9 specialize in, correct? You're a doctor of 10 dermatology; this is your forte? 11 A. Yes. 12 Q. Is that correct? Okay. 13 And so let's go ahead, so if you'll tell 14 me, what is in skin and subcutaneous tissue? 15 A. Well, the first thin layer is the 16 epidermis; the second layer is the dermis. 17 Thickness varies with different parts of the body. 18 And under this is subcutaneous fat, and within 19 these areas, you see hair follicles, nerves, 20 lymphatic vessels, oil glands, other vessels. So 21 that's basically what you see in that area. 22 Q. Okay. So with my situation and the 23 atrophy and the depression that I received, what 24 was destroyed by that? 25 A. Everything --	Page 36 1 just -- what was destroyed, what did I have 2 destroyed that's within skin anatomy? 3 A. A large amount of the subcutaneous fat, 4 anything within the fat, and probably some of the 5 dermis, which would include hair follicles, 6 lymphatic vessels, nerves, oil glands, sweat 7 glands, everything, and a host of blood vessels 8 therein. 9 Q. Thank you. And what are your thoughts on 10 present and future pain with that major loss to 11 the subcutaneous tissue? 12 MS. SCALISE: I'm sorry. Say that again? 13 Q. And what are your thoughts on present and 14 future pain with that major loss to subcutaneous 15 tissue and skin? 16 MS. SCALISE: Objection. Calls for 17 speculation. 18 A. With loss of cushioning, it could lead to 19 greater sensitivity and discomfort. 20 Q. Okay. Let's move on, Dr. Wikas. So 21 we're going to move onto the late pictures, so 22 you'll be using that iPad there that Grace gave 23 you. 24 A. Yes. 25 Q. So we're going to start off with, yes,
Page 35 1 MS. SCALISE: Object to the form. Calls 2 for speculation. 3 A. -- below the dermis. 4 Q. So your testimony is you examined me and 5 you've seen the depression and the loss, the 6 atrophy, the major atrophy, and so the anatomy of 7 skin, that's what I lost, where there's a 8 depression and everything -- 9 MS. SCALISE: And again, I just raise the 10 objection as I previously raised as to any 11 opinions that deal with orthopedics, rheumatology, 12 endocrinology, obstetrics and gynecology, et 13 cetera, as to, yeah, the prior objections that 14 I've raised. 15 MS. GURRY: I object to your objection. 16 We're talking about skin anatomy right here. He's 17 a doctor of skin, of dermatology. This is his 18 specialty. I object to you objecting frivolous 19 objections. 20 MS. SCALISE: I appreciate your 21 objection, but I have to place things on the 22 record that I think are improper questions and 23 that's simply all that I'm doing. 24 Q. So explain, Dr. Wikas, again, and I 25 apologize, you may have explained it before, I'm	Page 37 1 we'll start off with Number 3, Exhibit Number 3. 2 - - - - - 3 (Thereupon, Plaintiff's Exhibit 3, 4 5/4/16 Photograph taken at 8:48 5 a.m., was marked for purposes of 6 identification.) 7 - - - - - 8 A. Yes. 9 Q. Okay. So this image was taken the day 10 after, it was actually, the metadata on the image 11 states that it was taken at 8:48 on May 4th. This 12 was less than 20 hours after I was injected with 13 Kenalog. 14 Would you please tell me what you see 15 there and what your impression is? 16 A. I see superiorly the normal scar. As we 17 go inferiorly, I can see the significant thinning 18 of the skin, bubbling of the skin, maybe due to 19 some accumulation of cortisone medication, but the 20 skin is getting really thin, and possibly 21 accentuation of underlying stitches, that they 22 have not yet dissolved. 23 Q. Okay. So if you were to, again, keeping 24 in mind that this was less than 24 hours from when 25 I was with Ms. Hussey's care and she injected me,

Page 38 1 how would you classify that healing from a 5-inch 2 incision site where melanoma was removed just 13 3 weeks prior? How was I healing? 4 MS. SCALISE: Object to the form. Calls 5 for speculation. 6 Q. Can you, with your professional opinion 7 assessing scars, which you do every day in your 8 practice, if you can go ahead and assess that 9 scar, please. 10 MS. SCALISE: Again, just for the record, 11 I'm just raising an objection as to speculation in 12 the sense that he is looking at one photo which is 13 a one-dimensional image. He was not looking at 14 your leg on May the 4th of 2016, and this photo 15 is, you know, I'm not sure as far as the lighting, 16 the accuracy, the detail that is evident from 17 that. So I just would raise those objections to 18 him offering any opinions as to a medical 19 diagnosis based on this photo. 20 Q. And Dr. Wikas, I don't know if you're 21 able to zoom in on that, if you can zoom in -- 22 A. Um-hum. 23 Q. -- on the photo? 24 A. Yes. The -- 25 Q. Yes. So, and do you see on the photo,	Page 40 1 hypertrophic scar there? 2 A. No, I see a lot of damage. 3 Q. Damage from the injection? 4 A. Yes. 5 Q. If we can move on then to Exhibit 4. 6 That's the next picture. 7 - - - - - 8 (Thereupon, Plaintiff's Exhibit 4, 9 5/4/16 Photograph, was marked for 10 purposes of identification.) 11 - - - - - 12 Q. So if you would just explain what you see 13 here, and again, knowing that the Kenalog was 14 injected, you see the date there, so the injection 15 was May 3rd, you'd be able to tell the time, you 16 know, and what you're seeing and if that's a 17 normal reaction to Kenalog. 18 MS. SCALISE: And again, just for 19 purposes of the record, I would again raise an 20 objection with regard to the quality of the photos 21 with the lighting and, you know, there are 1,500 22 photos that Plaintiff has taken and she has only I 23 think submitted maybe seven or so, so these are 24 not the full presentation of all the photos of her 25 leg, which show different aspects.
Page 39 1 too, there's a piece of hair, I believe it's below 2 the scar? 3 A. Oh, yeah. 4 Q. So the detail on that -- so the detail on 5 that photograph is excellent. And again, there's 6 the metadata information on it, exactly when it 7 was taken. 8 If you would go ahead and from that 9 there, you know, give your professional opinion as 10 to how it was healing and what you think the 11 prognosis would have been if it was never injected 12 with Kenalog. 13 A. I think the most superior part of the 14 scar is looking fine. There's a little bit of 15 redness. But as we go down, the skin is getting 16 thinner and then it's starting to bubble up as we 17 go down more, and my impression would be these are 18 areas where stitches that have not dissolved would 19 be located and maybe even accumulation of some of 20 the cortisone medication, and I'd be concerned 21 about this would predict potential skin 22 destruction underneath. 23 Q. Because of the injection? 24 A. Yes. 25 Q. Yes. Okay. If we can -- do you see a	Page 41 1 A. Superiorly, I see a widening of the scar 2 with redness. That's going to predict a lot of 3 blood vessels growing in. Then you go inferiorly, 4 there's a bubble. This would most likely indicate 5 thinning of the skin, a possible accumulation of 6 cortisone medication. And then inferiorly, you 7 see a number of red areas, a little bit elevated, 8 and the influx or ingrowth of new blood vessels, 9 which is kind of unusual. Usually you don't see 10 it that quick after an injection. 11 So, and then, and the surrounding areas 12 between the bubble and the lowest red area, you 13 see the beginning of thinning of the skin, 14 bruising, the chicken skin appearance. That's 15 all. 16 Q. And what does a bruise indicate in an 17 area where someone's been injected? 18 A. It's an injury. Opening and destruction 19 of blood vessels, destruction of underlying 20 tissue. 21 Q. Okay. If you'll move onto the next 22 picture, Exhibit 5. 23 - - - - - 24 (Thereupon, Plaintiff's Exhibit 5, 25 5/30/16 Photograph, was marked for

Page 42 1 purposes of identification.) 2 - - - - - 3 Q. And what do you see here? 4 A. Superiorly, in the very superior, going 5 to the edge of the photograph, you see the 6 uppermost portion of the scar, and then lower, you 7 see where atrophy is occurring, destruction of 8 underlying tissue. You go down farther, you see 9 more redness, more atrophy. In the surrounding 10 areas, left and right, you see bruising, the 11 appearance of destruction of underlying tissue. 12 And under that, you've got two areas that are red 13 and possibly a little bit raised. That's 14 indicating destruction of underlying tissue. 15 But I think these are in areas where the 16 stitches that were placed is where you see these 17 accentuations, because the stitches that were used 18 by the physician were extremely slow dissolving 19 stitches. They were extremely large stitches and 20 exquisitely slow dissolving. That's all. 21 Q. So the damage that you see that you've 22 stated, what is that from? 23 A. That's from the injection of the Kenalog 24 by Ms. Hussey. 25 Q. Thank you. Okay. And then if you would	Page 44 1 appearance with some bruising. You see as you go 2 lower on the lateral portions of it the mottling 3 of the skin, discoloration, beginning to form that 4 chicken skin appearance and feel. 5 And then you see destruction of the 6 underlying skin because it's, the atrophy is 7 becoming more accentuated, and then the inferior 8 of this, you see the results of thinning of the 9 skin, atrophy, and I think the areas where you're 10 having the greatest redness is where the 11 underlying -- the absorbable stitches were placed. 12 And then in the superior, mid-superior portion of 13 this, you see a little bit of what I call 14 denudation or loss of epidermis. 15 Q. Okay. And if you move onto the next 16 exhibit, the next picture. 17 A. That's Exhibit 9? 18 Q. Okay. How about Exhibit 8, let's move 19 onto Exhibit 8. 20 A. Exhibit 8? Just a second. Oh, here it 21 is. 22 - - - - - 23 (Thereupon, Plaintiff's Exhibit 8, 24 7/9/16 Photograph, was marked for 25 purposes of identification.)
Page 43 1 go ahead, you can move onto the other pictures. 2 You can just -- and if you notice anything 3 different in the pictures, you can go ahead and 4 talk about those. 5 So basically, here, will you explain the 6 progression of the effects of the drug? 7 A. Do you want me -- 8 MS. SCALISE: Objection. Leading. 9 A. Do you want me to go to Exhibit 6? 10 Q. Yes. You can go to Exhibit 6 and 7. 11 - - - - - 12 (Thereupon, Plaintiff's Exhibit 6, 13 6/31/16 Photograph; and Plaintiff's 14 Exhibit 7, 7/2/16 Photograph, were 15 marked for purposes of 16 identification.) 17 - - - - - 18 A. Okay. 19 Q. Okay. You can go to -- what exhibit are 20 you on right now? 21 A. I'm on 6 right now. 22 Q. Okay. 23 A. You see in the superior portion of it, 24 you see the influx of new blood vessels, which 25 spreads out laterally. These have a bluish	Page 45 1 - - - - - 2 A. Okay. In this -- 3 Q. And Dr. Wikas, if you would just kind of 4 expand upon the progression of like what you've 5 seen before and what you're seeing here. 6 MS. SCALISE: And again, Plaintiff, I 7 would just object to the leading. 8 Q. If you would just explain what you see in 9 the picture, Dr. Wikas. Thank you. 10 A. I see progression of atrophy superiorly 11 and underneath the tissue. The redness is getting 12 a little less. You see the results of spreading 13 of the incision site and the widening of the thin 14 skin, and you can see there's a hint right here of 15 a depression where the underlying skin is -- has 16 been lost and you don't see any more of that 17 little scab that was there before. 18 So basically, it's a progression of loss 19 of underlying tissue, widening of the scar. 20 Q. Thank you. And if you'll go to the last 21 exhibit, go to Exhibit 9. 22 - - - - - 23 (Thereupon, Plaintiff's Exhibit 9, 24 Photograph, was marked for purposes 25 of identification.)

Page 46 1 - - - - - 2 A. Okay. 3 Q. And again, please explain what you see 4 there. 5 MS. SCALISE: And again, for purposes of 6 the record, again objecting to the use of the 7 photos and not looking at all 1,500 to show that 8 certain ones have been picked out due to lighting, 9 distortion, exposure, et cetera. 10 A. Basically, you see widening of the scar. 11 In the middle of the scar, you see the addition of 12 blood vessels. Some of them are bluish. Some of 13 them are reddish. And then in the surrounding 14 areas, you see extreme whiteness, which would 15 indicate lack of vascular supply. And as you go 16 downward, the scar is widening a bit with increase 17 in number of blood vessels. 18 So you see some scarring, a loss of -- 19 where you see the white areas, most likely, 20 there's a loss of blood supply, and just a 21 widening of the scar, besides the red areas, it 22 just shows that the loss of tissue is profound. 23 Q. Okay. Thank you. If you would go back 24 to exhibit -- so keep it fresh in your mind what 25 you've just seen here in the pictures towards the	Page 47 1 end, and then if you would go back please to 2 Exhibit 3, that's the first photograph you looked 3 at. 4 A. Yes. 5 Q. Okay. So you remember this was taken 6 less than 20 hours after the injection. If you 7 will tell me the difference between this photo and 8 the latter photos, 6, 7, 8, and 9, as far as skin 9 appearance, the texture, the veins? 10 A. The surrounding tissue looks somewhat 11 normal, but you can see, in the middle of the 12 scar, you can see the destruction occurring with 13 discoloration, with new blood vessels starting to 14 grow in. When you look from the first to the last 15 one you showed me, it's like there's a slow 16 motion, almost like a nuclear explosion going on 17 underneath the skin with destruction. So you see 18 here the skin beginning to thin out, and that's 19 actually kind of rapid, which would indicate a 20 higher dose or concentration of cortisone 21 medication injected here because the period of 22 time is so short. So we're just seeing a 23 progression of destruction and deterioration. 24 Q. Okay. And the -- other than the scar 25 itself and what you've already described there,
Page 48 1 the leg skin, what do you notice in that 2 appearance, just that -- the leg skin beyond the 3 scar, that compared to the latter images? 4 A. Well, you see, at least laterally, you 5 see discoloration, which was the beginning of 6 atrophy, and then if you go out farther laterally 7 to either end, the skin looks fairly normal. But 8 when you go to the other slides or photos, you see 9 a slow, destructive deterioration of the 10 underlying skin. 11 Q. And I'm trying to get at the skin 12 appearance beyond the scar itself as well, what 13 you see compared to this first one to the latter 14 images. 15 A. Well, you're beginning to see some 16 changes with discoloration in this first one, but 17 it's just the beginning of a process. It's not as 18 profound. 19 Q. Okay. And -- 20 A. But you know something bad is going on 21 here. 22 Q. And how does Kenalog break down collagen? 23 A. I'm not sure how it actually breaks down 24 collagen, but I know it happens. It may cause -- 25 some of it may be getting rid of the fibroblasts	Page 49 1 that make the collagen, but we know that collagen 2 is destroyed with the injection of a 3 corticosteroid medication. 4 Q. And what's the significance and 5 importance of collagen in the skin? 6 A. Collagen provides body to the skin. If 7 you didn't have collagen, for example, on the 8 upper arms, you would see the skin sagging. Same 9 thing on the face. When you have sunlight exposed 10 to the skin, there's a breakdown in collagen and 11 then you get wrinkles. When you have on the face 12 the breakdown of collagen, muscles working against 13 each other, there you have an accentuation of 14 wrinkling. 15 Q. So with what I endured, would you 16 anticipate that I'd have sagging skin and -- 17 because I've had the Kenalog break down my 18 collagen? 19 MS. SCALISE: Objection. Calls for 20 speculation. 21 A. I don't know if it would be sagging skin, 22 but I know that you have that chicken skin 23 appearance, you have a depression there. So I 24 don't think it would be so much sagging skin in 25 that area, but certainly, the skin would appear

Page 50 1 thinner, you would have influx of new blood 2 vessels which would be pink and blue, and it 3 extends pretty significantly into the surrounding 4 skin. 5 Q. Thank you. We're going to move on to 6 Exhibit 11, and this is a picture as well, 7 Dr. Wikas. This is my healed scar from my lymph 8 node removal surgery, which was February 28th, so 9 that's Exhibit 11. 10 - - - - - 11 (Thereupon, Plaintiff's Exhibit 11, 12 Photograph of Scar from Lymph Node 13 Removal, was marked for purposes of 14 identification.) 15 - - - - - 16 MS. SCALISE: And again, for that 17 particular exhibit, it has writing on it, so I 18 object to any writing describing what that photo 19 is. 20 Q. So if you'll just ignore the writing, 21 Dr. Wikas, and go ahead and look at the picture. 22 So just looking at the picture, 23 Dr. Wikas, how would you classify this healed 24 scar? 25 A. I'd say it's perfectly healed and I don't	Page 52 1 A. No, I don't think so. The sutures that 2 were placed there were extremely, extremely strong 3 and they were -- they're very slow to be absorbed 4 to dissolve, so, you know, you would have had 5 adequate time for the top layer of the skin to 6 heal nicely. 7 Q. Okay. So we'll move on to Exhibit 8 Number 2, so this is the PET/CT scan. So this 9 is -- that's not on the laptop. That's going to 10 be -- or maybe it is. I'm not positive. I 11 think -- 12 A. It's there. 13 Q. It's there? Yep. 14 A. Yeah. 15 - - - - - 16 (Thereupon, Plaintiff's Exhibit 2, 17 PET/CT Scans, was marked for 18 purposes of identification.) 19 - - - - - 20 MS. GURRY: Okay. Great. So, and I 21 already have your objection on this, Marian. 22 MS. SCALISE: Well, I was going to say, 23 just for purposes of the record, I will raise an 24 objection to him being asked any questions about 25 the imaging, again, under Rules 702 and 403.
Page 51 1 see any scarring. 2 Q. How do you believe I would have healed 3 from the melanoma removal surgery? 4 MS. SCALISE: Object to the form. Calls 5 for speculation. 6 A. When you look at the incision site on 7 your leg and you see the upper portion of it, it 8 was healing absolutely beautifully, and I believe 9 without the injection of the Kenalog into the 10 scar, you would more likely than not heal in such 11 a way where the scar may not even be visible. 12 Q. Excellent. Would there be a dent in my 13 leg? 14 A. You didn't -- any of the changes that you 15 had were not there before the injection. It 16 looked like a normal healing area. Afterwards, 17 everything went downhill. The skin was thinning 18 rapidly, being depressed, loss of body, loss of 19 smoothness. So I think it certainly would not 20 have healed anything to the way you've got it 21 healed now. 22 Q. And you had mentioned the sutures before. 23 You don't believe the sutures had anything to do 24 with my adverse -- the atrophy and the damage in 25 my leg?	Page 53 1 He has testified in his discovery 2 deposition that he is not an expert in imaging, 3 has no education, experience, or training to say 4 what the imaging reveals, that was page 67 through 5 68, lines 23 through 8 of his deposition. He 6 testified he never reviewed the actual PET scan or 7 MRI images themselves, that was page 68, line 13 8 through 17, and he admitted in his deposition that 9 he never saw any words from any physicians in the 10 medical records he reviewed that would support the 11 Plaintiff's wording that she has typed or written 12 into Exhibit Number 2. So that would be page 68, 13 lines 21 through 25. So we believe it is improper 14 for Dr. Wikas to offer any comments or opinions 15 related to the imaging in this case. 16 Again, I've talked about it before that I 17 asked him to let me know if he had any changes to 18 his opinions. He has not. Additionally, he has 19 not been qualified by the court as an expert 20 witness to render opinions regarding radiologic 21 imaging, so any testimony he could give is purely 22 speculative and not based on any scientific 23 evidence or opinion, and would simply lead to the 24 confusion of the issues, misleading the jury, and 25 is not reliable.

Page 54 1 Under Rule 403 and 702, we contend that 2 the Court must balance the danger of unfair 3 prejudice, confusion of the issues, and misleading 4 the jury with any potential probative value of 5 this testimony, and we object to the line of 6 questioning and move to strike any response 7 related to Exhibit 2 related to these PET scan/CAT 8 scan images. 9 Q. Dr. Wikas, do you have any experience 10 with identifying basic anatomy on scans, 11 specifically subcutaneous tissue? 12 MS. SCALISE: And again, I raise the same 13 objection and point to his prior deposition 14 testimony when he said he has no -- he is not an 15 expert in imaging and has no education, 16 experience, or training to say what imaging 17 reveals. So I object to any answer related to 18 that. 19 Q. Dr. Wikas, I'll repeat the question. Do 20 you have any experience with identifying basic 21 anatomy on scans, specifically subcutaneous 22 tissue? 23 MS. SCALISE: Same objection. 24 A. Yes, I do, on skin. 25 Q. Great. Yes, very good. If you would	Page 56 1 it, the shark bite appearance with the tissue 2 missing, can you -- which scan is that? What 3 date? 4 A. September -- 5 MS. SCALISE: And again, I raise the same 6 objections and the fact that he is being shown 7 images that Plaintiff has somehow gotten. There's 8 no evidence that this is truly images from the 9 Plaintiff. This witness has not looked at all of 10 the PET scan images to determine the accuracy or 11 to verify whether these are accurate 12 interpretations or images from those scans, and 13 based on my prior objections that I've raised 14 regarding his qualifications to comment on that. 15 A. September 21st -- 16 Q. Dr. Wikas, did you -- thank you. I'm 17 sorry. 18 A. September 21, 2016. 19 Q. And say again what you see? 20 MS. SCALISE: Same objection. 21 A. The thinning of the superficial tissue. 22 Q. And you had said also it looks like -- 23 you had just said it. 24 MS. SCALISE: Same objection. 25 A. A shark bite.
Page 55 1 please identify where the subcutaneous tissue is 2 on the upper legs. 3 MS. SCALISE: Well, and for -- 4 Q. Verbally. 5 MS. SCALISE: Sorry, and I do raise an 6 objection. There's been no evidence and no 7 foundation laid that he is able to evaluate and 8 interpret PET scans or CAT scans, and by his prior 9 deposition testimony, that was his testimony is 10 that he does not review those types of imaging and 11 has no experience, education, or training in that. 12 So I do not believe that his -- any testimony or 13 answer to that question would be reliable, and it 14 would not be scientifically based. 15 Q. Dr. Wikas, if you will identify where the 16 subcutaneous tissue is on the upper leg, can 17 verbally state this? 18 A. What I -- 19 MS. SCALISE: Same objection. 20 A. -- see is a loss of the top layer of the 21 skin. It looks like a bit of a shark bite. 22 Q. And you are referring to -- which scan 23 are you referring to? There's one scan that was 24 after the surgery and then there was one that was 25 after the injection. The one that has, as you put	Page 57 1 Q. So looking at, after the surgery and 2 after the injection, just looking at the 3 subcutaneous tissue there, what conclusion do you 4 draw from this, or what do you -- what do you 5 see -- 6 MS. SCALISE: And again, same -- sorry, 7 go ahead. 8 Q. Dr. Wikas, does this show you the atrophy 9 that you have testified to to the Kenalog 10 injection? Does this show you what that did to 11 the subcutaneous tissue? 12 MS. SCALISE: Objection. Leading. But 13 also, based on the same objections I've been 14 raising about Dr. Wikas and his lack of 15 qualifications as an expert in imaging and his own 16 testimony that he's not an expert in imaging, has 17 no education, experience, or training, and the 18 various other objections I've made under 702 and 19 403 to this line of questioning. 20 Q. So let me rephrase that, Dr. Wikas. 21 If you could just expand upon what you 22 see as far as the difference between the two scans 23 in your words, sir. 24 MS. SCALISE: And again, the same 25 objections that I've raised under 702 and 403 and

Page 58 1 with Dr. Wikas's prior deposition testimony. 2 A. A significant thinning in the top layer 3 of tissue. 4 Q. In what scan? 5 MS. SCALISE: Same objection. 6 A. The September 21, 2016. 7 Q. Okay. Do you see that as a significant 8 loss of -- how much of a loss of subcutaneous 9 tissue do you see? 10 MS. SCALISE: Same objection. 11 A. Enough to be appearing as an indentation. 12 Q. Very good. Okay. So, Dr. Wikas, getting 13 back to what occurred May 3rd, 2016, could you -- 14 could you expand upon that a little bit more? I 15 know you've already given testimony. If you can 16 just go ahead, we're going to be wrapping things 17 up here, if you could maybe encapsulate and expand 18 upon, again, Shannon Hussey's treatment of me on 19 May 3rd, 2016. 20 MS. SCALISE: And again, I would just 21 object. Asked and answered. 22 A. Basically, I think Ms. Hussey gave too 23 high a concentration of corticosteroid, too large 24 a volume of corticosteroid, which led to thinning 25 of the skin, loss of the underlying subcutaneous	Page 60 1 correct? 2 A. Correct. 3 Q. And your opinion is that something must 4 have been done wrong to have caused that atrophy, 5 correct? 6 A. Correct. 7 Q. You don't know exactly what, but 8 something had to have been done wrong, correct? 9 A. I thought it was due to the injection of 10 excessive concentration, excessive volume of 11 Kenalog. 12 Q. All right. Because I think the way you 13 explained in your deposition is the thing speaks 14 for itself. 15 A. Correct. 16 Q. Okay. Basically, a res ipsa loquitur -- 17 MS. GURRY: Objection. He -- yeah, okay. 18 Go ahead. 19 Q. In fact, it's kind of a legal term, res 20 ipsa loquitur, that the fact that there's been an 21 injury, somebody must have done something wrong to 22 have caused that, correct? 23 A. In this case, yes. 24 Q. All right. And you would agree though 25 that if Nurse Practitioner Hussey had administered
Page 59 1 tissue, which would mean a lot of fat, and leading 2 to a depression in the subcutaneous tissue. Like 3 I said, it appears to be a implosion of the tissue 4 leading to the visual appearance and the touch of 5 an indentation. 6 Q. So regarding what occurred on that day, 7 how would you classify Shannon Hussey's behavior? 8 A. It was below the standard of care. 9 MS. GURRY: No further questions at this 10 time. 11 MS. SCALISE: Doctor, as I understand -- 12 THE WITNESS: Excuse me. 13 MS. SCALISE: Oh, sure. Yes, sir. 14 THE WITNESS: Can I take a one-minute 15 break? 16 MS. SCALISE: Absolutely. Yes, sir. 17 THE VIDEOGRAPHER: Off the record, 2:28. 18 (Recess taken.) 19 THE VIDEOGRAPHER: We are back on record. 20 It's 2:29. 21 EXAMINATION OF SCHIELD M. WIKAS, D.O. 22 BY MS. SCALISE: 23 Q. Dr. Wikas, as I understand your opinion 24 in this case, your opinion is that you see a 25 depression or atrophy on Tara Gurry's leg,	Page 61 1 3.3 milligrams per CC of an intralesional steroid 2 for a hypertrophic scar, that would be an 3 appropriate amount and concentration, correct? 4 A. Correct. 5 Q. So based on the medical record of May the 6 3rd, 2016, that was the amount and the 7 concentration of intralesional steroid that was 8 documented in the record, correct? 9 A. Correct. 10 Q. So what Nurse Practitioner Hussey 11 documented as far as what she injected, that would 12 be acceptable and that meets the standard of care, 13 but you just don't believe that she did that, 14 correct? 15 A. Correct. 16 MS. GURRY: Objection. Her documents 17 have already been violated by the Board of Nurses, 18 violation that she -- inaccurate records for that 19 date. 20 MS. SCALISE: And I raise an objection to 21 that objection in the sense that the only issue 22 that the Board of Nursing found was that she had 23 not documented a metformin dose. The Board of 24 Nursing did not find any issues with the Kenalog 25 injection or find any causation with regard to

Page 62 1 this intralesional steroid injection causing any 2 of the claims that Plaintiff has. 3 MS. GURRY: That doesn't mean there 4 wasn't a problem with it. Objection to that. 5 BY MS. SCALISE: 6 Q. So, Doctor, you would agree that the 7 amount of approximately 1 CC of a 3.3 milligram of 8 intralesional steroid, that should not cause the 9 depression like what you see in Ms. Gurry's leg, 10 correct? 11 A. Yes, you're correct. 12 Q. Okay. So the amount, you would not 13 expect that to cause the depression or atrophy if 14 you're giving 1 CC of about 3.3 milligrams of 15 Kenalog? 16 A. That's correct. 17 Q. And, in fact, you've never seen, you've 18 never heard, you've never even seen it anywhere in 19 the literature that approximately 1 CC of 3.3 20 milligrams of an intralesional steroid would cause 21 a depression like what Ms. Gurry had, correct? 22 A. Correct. 23 Q. And I think as you've -- 24 MS. GURRY: Objection. Objection. 25 Assuming facts not in evidence.	Page 64 1 Q. And you've done that hundreds of times, 2 correct? 3 A. Yes. 4 Q. And you've given that medication in doses 5 that could even be higher than 3.3 milligrams, 6 correct? 7 A. Yes. 8 Q. And you have never had any depression 9 ever, correct? 10 A. Correct. 11 Q. Now, with the Kenalog injection, this 12 intralesional steroid, the purpose is to soften 13 and flatten any kind of raised area on a scar, 14 correct? 15 A. Yes. 16 Q. And so is that caused -- is that called 17 atrophy? 18 A. Can you go over that question one more 19 time? 20 Q. Sure. With an intralesional steroid, is 21 the goal of utilizing an intralesional steroid to 22 flatten or soften the appearance of the scar? 23 A. Yes. 24 Q. And by flattening or softening that scar, 25 is that in itself atrophy?
Page 63 1 MS. SCALISE: And what is -- I don't 2 understand your objection. 3 MS. GURRY: Okay. My objection is, it's 4 not fact, evidence, that that's what was injected. 5 But that's okay. I mean her medical records -- 6 maybe it's the wrong objection, but your -- that's 7 okay. 8 MS. SCALISE: All right. 9 Q. Well, let's make sure we're clear on 10 this, Doctor. You've never seen ever that 1 CC of 11 3.3 milligrams of Kenalog is going to cause what 12 you see in Tara Gurry's leg, correct? 13 A. Correct. 14 Q. You've never heard of something like that 15 happening, correct? 16 A. Correct. 17 Q. You've never seen anything in any 18 literature that would describe that type of result 19 with about 1 CC of 3.3 milligrams of Kenalog, 20 correct? 21 A. Correct. 22 Q. And you yourself, as you've testified, 23 you give intralesional steroid Kenalog in your 24 patients, correct? 25 A. Yes.	Page 65 1 A. Technically, yes. 2 Q. Okay. But what we're talking about here 3 is a greater amount of atrophy; is that fair to 4 say? 5 A. Yes. 6 Q. And you would agree that injecting 1 CC 7 of 3.3 milligrams of Kenalog, it would not be 8 foreseeable that that's going to cause the 9 depression that Tara Gurry has, correct? 10 A. Yes. 11 Q. That would not be a natural or probable 12 consequence of injecting that amount of steroid 13 into a scar, correct? 14 A. Correct. 15 Q. It would be highly unusual, would it not? 16 A. Yes. 17 Q. Very abnormal, correct? 18 A. Correct. 19 Q. Because if that amount of injection is 20 used, you would not have the result that she has, 21 correct? 22 A. Yes. 23 Q. And your opinion is that you find no 24 other possibility, no other reason for this 25 depression other than Nurse Practitioner Hussey

Page 66 1 must have done something wrong, correct? 2 A. Correct. 3 Q. Now, the area where this scar is located, 4 on her thigh, you agree that's the area where 5 Ms. Gurry had a mass removed from her original 6 melanoma cancer surgery, correct? 7 A. Correct. 8 Q. And that particular type of surgery is 9 not a surgery that you perform, correct? 10 A. Not anymore. I used to. 11 Q. Okay. But didn't you also tell me in 12 your deposition that the extensive melanoma that 13 she had would not be a surgery that you would 14 perform? 15 A. Currently, that's totally correct. 16 Q. Okay. But I think in your deposition you 17 testified you would always have referred that type 18 of surgery to someone else, correct? 19 A. I don't know if I'd use the term 20 "always," but currently, I do not do those 21 procedures. 22 Q. Okay. And is the reason why you would 23 refer that type of surgery is because of how thick 24 the cancer is? 25 A. Yes. The thickness, I would refer to an	Page 68 1 Q. And do you remember when we talked about 2 this issue in your deposition, we talked about the 3 fact that the standard of care would require 4 removal of the fat in order to remove this type of 5 surgery. Do you recall seeing that? 6 A. I think we had a contention there at that 7 point. What I'm getting at is you had mentioned 8 that according to the American Academy of 9 Dermatology, that usually, go down to fascia. 10 Q. Correct. 11 A. However, there was no indication that the 12 surgeon went down to fascia. 13 Q. So if in fact the surgeon, and that was 14 Dr. Masessa, correct? 15 A. Correct. 16 Q. And he's not been deposed, and he 17 unfortunately has passed away. 18 A. Really? 19 Q. He has. 20 A. Wow. 21 Q. But you would agree that if Dr. Masessa 22 did not comply with the American Academy of 23 Dermatology guidelines of going down to that 24 fascial layer -- 25 MS. GURRY: Objection. Objection.
Page 67 1 oncologic surgeon. 2 Q. Okay. And, in fact, it's a major surgery 3 to remove the cancer that Tara Gurry had removed 4 in January of 2016, correct? 5 A. It's significant. 6 Q. And by significant, you would agree that 7 part of removing that cancer is getting margins 8 all the way around the cancer, correct? 9 A. Correct. 10 Q. And that includes on the sides as well as 11 underneath the cancer, correct? 12 A. Correct. 13 Q. And part of what you're removing includes 14 all the things that you've identified in this 15 diagram, Plaintiff's Exhibit -- I think it was 8, 16 yeah, which is the diagram of the skin, correct? 17 A. That's -- you know, that's kind of an 18 interesting point, because when we see what's 19 under here, we see fat. However, the surgeon that 20 did the procedure said in his operative report 21 that he went down to the fat, and when you look at 22 the pathology reports, nothing is said about fat 23 being removed. There was no indication -- they 24 did not make a mention that there was any fat in 25 the surgical specimen.	Page 69 1 Q. -- that would have been a breach of the 2 standard of care on his part, correct? 3 A. No. The guidelines by the American 4 Academy of Dermatology are merely guidelines. 5 They're not laws. They are not things that must 6 be done. Because when a physician is giving 7 therapy, doing procedures, they do what's right 8 because everybody's different. 9 Q. Okay. But, Doctor, you would agree 10 though that if the academy as well as other 11 literature recommends going to that fascial layer, 12 that that would include the removal of some fat, 13 correct? 14 MS. GURRY: Objection. Lack of personal 15 knowledge. 16 A. You know, a lot of people do go down to 17 the fat when they do that kind of procedure, but 18 there was no evidence that Dr. Masessa did that. 19 Q. Okay. And you're basing that on what? 20 A. His notes and the pathology notes. 21 Q. Okay. But in his note, he says he went 22 to the layer of the fat. You don't know whether 23 that means -- 24 MS. GURRY: Objection. Asked and 25 answered.

Page 70 1 Q. Doctor, you would agree that in looking 2 at that operative note, you don't know whether or 3 not Dr. Masessa actually took some of that fat, do 4 you? 5 A. No, he said "went to the fat," and then I 6 went to the pathology report, and I said this is 7 really interesting, and in the pathology report, 8 there was nothing that said anything about fatty 9 tissue, so I was confused. 10 Q. Okay. And you were confused because he 11 should have taken some of that fat, correct? 12 A. No, you can't use the word "should," 13 because obviously, he felt comfortable in maybe 14 not wanting to have a depression if he took out 15 fatty tissue, and he thought that he -- you know, 16 I can't say what he thought. But he may have 17 thought that maybe if I don't take out fatty 18 tissue, I'll have a nice, thin, flat area after 19 the procedure. 20 Q. All right. And, Doctor, as part of that 21 cancer being removed, you would agree though that 22 it was a substantial depth that was removed, was 23 it not? 24 MS. GURRY: Objection. Lack of personal 25 knowledge.	Page 72 1 Q. And your opinion is that mass that had 2 been removed, that would not account for this 3 depression that she now has, correct? 4 A. Correct. 5 Q. So it's not even possible that that is 6 the explanation or cause of the depression that 7 she has? 8 A. I think that you would have noticed a 9 depression directly after the procedure if that 10 would have occurred. 11 Q. Okay. And it wouldn't be once those 12 sutures have dissolved? 13 A. No. 14 Q. Are you familiar with the idea of 15 remodeling and scar stretch? 16 A. It's the modulus of elasticity, which I 17 said during my last deposition. 18 Q. Okay. So what is that? 19 A. It's that with -- if you put tension on 20 skin, the skin will stretch. The longer you put 21 tension on it, what I mean, you could do it with 22 stitches or you could do it with a, like, what we 23 call a bulldog clamp, the skin will stretch. So 24 for example, if you find that you cannot close a 25 wound at the time of surgery, what you do is you
Page 71 1 Q. Doctor, you've read the medical record, 2 have you not? 3 A. Yes. 4 Q. Okay. And in that medical record, you 5 would agree that he had a margin of 2 centimeters, 6 did he not? 7 A. Yeah. That's lateral. 8 Q. All right. And how -- what was the 9 depth, do you recall? 10 A. No. Do you have something with the 11 depth? 12 Q. Yes, sir. It looks like it went down 13 1 centimeter. I'll show you. It's marked as 14 Masessa page 9. It's the second part of his -- 15 the pathology report. 16 A. Correct. 17 Q. Okay. So it went down 1 centimeter of 18 depth, correct? 19 A. Um-hum. 20 Q. Thank you, sir. So in removing a mass 21 that was -- had 2 centimeters on all margins on 22 the sides as well as 1 centimeter of depth, you 23 would agree that that's a large mass that's been 24 removed from Tara Gurry's thigh, correct? 25 A. Correct.	Page 73 1 take stitches or clamps, you put it on it, wait 20 2 minutes or 30 minutes, and the skin will stretch 3 probably 50 percent. 4 Q. But, Doctor, to answer my question, you 5 agree that once sutures dissolve, there can be a 6 remodeling of the tissues underneath? 7 A. Of course. 8 Q. All right. And in fact, there can also 9 be scar stretch, correct? 10 A. Yeah, there can be, but I don't think you 11 saw it in this situation, because with remodeling, 12 you wouldn't see a depression, a gully. 13 Q. Okay. And that's your opinion? 14 A. Yes. 15 Q. All right. And you talked about that you 16 evaluated Ms. Gurry. Was that right before your 17 deposition on June the 28th of 2019? 18 A. Yes. 19 Q. And is it fair to say you have not seen 20 her since then, correct? 21 A. Correct. 22 Q. And in fact, here for this videotaped 23 deposition, she is appearing by Zoom, correct? 24 A. Correct. 25 Q. I'm going to show you what I've marked as

Page 74 1 Defendant's Exhibit Number 1 and 2. 2 MS. SCALISE: And Tara, just so you're 3 aware, these are the photos I sent to you. 4 MS. GURRY: Yes. Thank you. I saw 5 those. 6 - - - - - 7 (Thereupon, Defendant's Exhibit 1, 8 Photograph Taken 6/28/19; and 9 Defendant's Exhibit 2, Photograph 10 Taken 6/28/19, were marked for 11 purposes of identification.) 12 - - - - - 13 Q. And, Doctor, these are photos I will 14 represent to you that I took of Ms. Gurry at the 15 time of your deposition on June the 28th, 2019. 16 A. Um-hum. 17 Q. Do these appear to be accurate 18 representations of how her leg appeared when you 19 saw her that day? 20 A. Yeah, they appeared to be to me a little 21 wider, but -- and there was more of a chicken skin 22 when I touched it, appearance. 23 MS. SCALISE: Okay. And so at this time, 24 I will move into evidence Defendant's Exhibit 25 Number 1 and Defendant's Exhibit Number 2.	Page 76 1 lighting? How does the lighting affect the photos 2 that you're reviewing? 3 A. With the initial photos I was shown, 4 there was just a difference in the appearance 5 compared to these ones, because when I saw the 6 other ones, there was a greater proliferation of 7 blood vessels into the scar. 8 Q. All right. And, Doctor, if you will hold 9 these up for the camera, Defendant's Exhibit 10 Number 1 and Defendant's Exhibit Number 2, you 11 would agree that these do not show that 12 proliferation of blood vessels, correct? 13 A. But over time -- you're correct. But 14 over time, these blood vessels normally will 15 disappear. 16 Q. All right. And in fact, would you expect 17 even more improvement here in June of 2021? 18 A. Yes. You would see, you know, you 19 wouldn't see a change in the depression, but you 20 would see fewer blood vessels. That's the natural 21 sequence. 22 Q. All right. So, and you can put those 23 down. Thank you, sir. 24 So other than the depression, though, 25 currently, you would expect at least the
Page 75 1 Q. With regard to Exhibit Number 1 and 2, 2 you've mentioned something about a chicken skin 3 appearance. What do you mean by that? 4 A. When you put your fingers over the skin, 5 it's like after you've plucked a chicken -- you 6 haven't done that. After you've -- 7 Q. I grew up in the country. 8 A. Okay. After you pluck the chicken, it 9 has that kind of pebbly appearance. 10 Q. All right. But do you know whether or 11 not -- I guess how long did you spend examining 12 Ms. Gurry? 13 A. Five minutes. 14 Q. All right. And do you know whether or 15 not that was just she was chilly that day? 16 A. Don't know. 17 Q. All right. And as far as what you're 18 seeing in Defendant's Exhibit Number 1 and 19 Defendant's Exhibit Number 2, you would agree that 20 these photos look very different than the photos 21 that you were shown by Ms. Gurry? 22 A. Not really. The difference is the 23 lighting. The big difference is the lighting and 24 time -- significant -- much more time has passed. 25 Q. Okay. And what do you mean by the	Page 77 1 appearance of her leg to have improved over the 2 course of time, correct? 3 A. The appearance of the blood vessels, 4 certainly, but the depression and the widening 5 would not change very much. 6 Q. Okay. So just the depression and the 7 widening, that should not change, but the other 8 appearance as far as coloration, texture, that 9 should improve with time, correct? 10 A. Yes. 11 Q. And you talked about, though, that the 12 photos that you were shown, that some of those 13 revealed some blood vessels, et cetera. Do you 14 agree, though, that a lot of that has to do with 15 the lighting from any given photo as to whether or 16 not you see blood vessels or not? 17 A. No. It makes no difference what it is. 18 You're going to see blood vessels. 19 Q. Well, but again, if you're seeing blood 20 vessels, are you not seeing blood vessels along 21 the entire leg, not just at the scar? 22 A. No, you would see it in the surrounding 23 area, because right afterwards, directly 24 afterwards, you saw a peripheral change, lateral, 25 right and left sides of it. You saw

Page 78 1 discoloration, which show -- it was a prediction 2 of what was going to happen over the next few 3 months. 4 Q. Okay. And, Doctor, I want you to hold up 5 for the jury Plaintiff's Exhibit Number 3. This 6 is the one from May the 4th of 2016, and as I 7 understand, your testimony is that this does not 8 show a hypertrophic scar; is that correct? 9 A. Correct. 10 Q. Okay. Thank you, sir. 11 Now, let's talk about your opinions in 12 this case as it relates to Nurse Practitioner 13 Hussey. You again have kind of backtracked and 14 said, okay, because she's got this depression, she 15 must have done something wrong and you attribute 16 that to too much concentration of Kenalog, too 17 much injection of Kenalog, and/or the wrong 18 location; is that fair to say? 19 A. I also included too much volume. 20 Q. Well, that's what I meant for excessive 21 concentration. 22 Let's talk first about this claim of 23 excessive concentration. With that, are you just 24 basically guessing that Nurse Practitioner Hussey 25 grabbed the wrong bottle of Kenalog and got	Page 80 1 that. 2 Q. Okay. But, Doctor, you've testified 3 previously, have you not, that you've never seen 4 anything like this before? 5 A. At a wound, at a wound. But when -- for 6 example, if I may. 7 Q. Sure. 8 A. It is -- I've seen this over the years 9 many times when -- whether it's a child or an 10 adult is given an injection in a muscle, and if 11 it's incorrectly injected, all of a sudden, they 12 come to me because they say I've got this big 13 indentation. And what happened was there was an 14 incorrect injection, and if you open that up, you 15 see a big hole going down to the bone. So in that 16 sense, I've seen it. 17 Q. All right. But, Doctor, you would agree 18 that for Kenalog, it can be administered 19 intramuscularly, like what you're talking about, 20 or it can be intralesionally, it can be given 21 orally, it can be given IV. There are all 22 different methods that Kenalog or an intralesional 23 steroid can be given, correct? 24 A. Kenalog is never given -- 25 MS. GURRY: Objection. Out of scope.
Page 79 1 Kenalog 40 instead of Kenalog 10? 2 A. I'm not guessing. I'm just saying that 3 something happened, and with 3 milligrams 4 injected, you're not going to see that change. So 5 I'm thinking, what are the potential things that 6 cause this kind of catastrophic event, and the 7 only things that I can think of was too large a 8 concentration, too large of volume, those are the 9 kinds of things I'm thinking about. 10 But you don't see this with 3 milligrams, 11 and frankly, it shouldn't -- the procedure should 12 never have been done because the scar was healing 13 beautifully. 14 Q. But let's talk about this about too large 15 of a concentration or too large of a volume. You 16 would agree, you cannot say what specifically it 17 was; these are just kind of your hypotheses as to 18 what potentially could have caused this, correct? 19 A. Yes. 20 Q. And you have not performed any testing to 21 see whether this would be accurate, whether if you 22 put in too much concentration, that it would cause 23 this depression? 24 A. You don't need to do testing because I've 25 seen what happens when other physicians have done	Page 81 1 Q. Sorry. Go ahead. 2 A. Kenalog is never given IV. 3 Q. Okay. But as far as intramuscular or 4 intra-articularly, that can be given, correct? 5 A. Correct. 6 Q. And that's usually a lot of times the 7 orthopedist, if they're giving a steroid 8 injection, that would be something that they can 9 give, correct? 10 A. Correct. 11 Q. But here, again, as far as it being given 12 intralesionally, you've never seen a depression 13 like what Ms. Gurry has sustained, correct? 14 A. Correct. 15 Q. And so you've not read any literature, 16 you've not performed any testing to see whether 17 that truly would take place, if you gave too much 18 of a concentration intralesionally, that it would 19 cause the depression such that she has? 20 A. If you gave it intralesionally or even 21 too deep. 22 Q. All right. But, Doctor, answer my 23 question. Is it fair to say that you have not 24 reviewed any peer-review literature that supports 25 your theory, correct?

Page 82 1 A. Correct. 2 Q. And you've not performed any testing to 3 confirm your theory, correct? 4 A. I would never do that. 5 Q. Okay. Yeah, but even on some of the -- 6 MS. GURRY: Objection. 7 Q. But even on some, you know, model, 8 whether it be, you know, an animal model or 9 something like that, you have not done, performed 10 any testing to test the accuracy of your 11 hypothesis, correct? 12 A. Correct. 13 Q. And is it, I'm stating the obvious, but 14 you were not present on May the 3rd, 2016, were 15 you? 16 A. No, I was not. 17 Q. All right. As far as the volume of an 18 intralesional steroid that's being injected, you 19 would agree that there's no set amount as to how 20 much Kenalog or intralesional steroid should be 21 injected into a hypertrophic scar at any given 22 point in time, correct? 23 A. Can you repeat that? 24 Q. Sure. Would you agree that there's no 25 set amount as to how much intralesional steroid	Page 84 1 Kenalog to inject for a particular scar? 2 A. Correct. 3 Q. Now, when you looked at the May the 4th, 4 2016 photo, you would agree that you cannot give 5 any opinion based on that one photo alone that 6 there was an excessive amount of Kenalog injected 7 the day before, correct? 8 A. No, you -- if you weren't told, you would 9 not know. 10 Q. Well, but you weren't told. That's just 11 your hypothesis. But you would agree that there's 12 nothing about this photo that when you look at it, 13 you say, huh, there was an excessive amount of 14 Kenalog that's been injected? 15 A. I can't, the way you're saying it, I 16 can't say that. 17 Q. Well, do you recall when I took your 18 deposition, I asked you whether you could give any 19 opinion based on that photo as to whether there 20 was an excessive amount of Kenalog injected, and 21 you said you can't say one way or the other? Do 22 you remember saying that? 23 A. Correct, unless you've been told. 24 Q. And you haven't been told that there was 25 an excessive amount, correct?
Page 83 1 should be injected into a hypertrophic scar? 2 A. Correct. 3 Q. That's all patient-dependent, correct? 4 A. Correct. 5 Q. And it's also provider-dependent, is it 6 not? 7 A. Yes. 8 Q. And in fact, some providers would 9 administer a certain amount of intralesional 10 steroid whereas others might have a different 11 amount, correct? 12 A. Correct. 13 Q. And same as far as concentration. Some 14 would give 2.5 milligrams, some would give 3.3 15 milligrams, some would give 5, some would give 10. 16 It's all provider-dependent, correct? 17 A. Depending on the area you're going to 18 treat, yes. 19 Q. Okay. But even within an area you're 20 going to treat, you would agree that different 21 providers would potentially utilize different 22 concentrations, correct? 23 A. Correct. 24 Q. And the clinical judgment of the medical 25 provider at the time is what dictates how much	Page 85 1 A. Correct. 2 Q. I mean, there's been nobody, there's no 3 evidence, there's no witness, nobody has come to 4 you and said, or you've seen in any record, that 5 Nurse Practitioner Hussey actually gave -- 6 MS. GURRY: Objection. Mis-evidence. 7 Q. That Nurse Practitioner Hussey actually 8 gave more than 1 CC of 3.3 milligrams of Kenalog, 9 correct? 10 A. Correct. 11 Q. All right. And the same with this May 12 the 14th photo. I think I asked you based on that 13 photo, isn't it true that you cannot say looking 14 at that photo that an inappropriate amount of 15 intralesional steroid was given? 16 A. Unless you were told something happened 17 beforehand. 18 Q. Right. And you haven't been told that, 19 correct? 20 A. Correct. 21 Q. All right. 22 A. Well, I have been told that there was an 23 injection of corticosteroid into the area. 24 Q. Correct. You know that, and I think in 25 your deposition, you would agree you know that

Page 86 1 there was intralesional steroid injected, but 2 there's nothing about that photo dated May the 3 14th, in just looking at that photo, that tells 4 you some excessive amount or a improper 5 concentration was utilized looking at the photo 6 alone, correct? 7 A. Correct. 8 Q. And as far as the location of the 9 injection, you would agree that the photos don't 10 tell you exactly where she injected the 11 intralesional steroid, correct? 12 A. Correct. 13 Q. And in fact, if in Plaintiff's Exhibit 14 Number 3, which is the May 4th, 2016 photo, if in 15 fact the opinion was that was a hypertrophic scar, 16 those raised areas were a hypertrophic scar -- 17 A. They weren't there before the injection. 18 Q. Now, do you see a picture from May the 19 3rd of 2016? 20 A. No. 21 Q. All right. So isn't it true you have not 22 seen any documentation or any photo to say what 23 the appearance of the skin looked like on the day 24 that Shannon Hussey injected the Kenalog, correct? 25 A. Correct.	Page 88 1 all speculative on your part, correct? 2 A. That was logical to me, and so you would 3 call it speculative. 4 Q. Yeah, because you have no evidence to 5 truly say that there was a wrong concentration or 6 the wrong dose or the wrong site, correct? 7 A. There's no concrete evidence. 8 Q. All right. Because based on the actual 9 medical record itself, it would appear that an 10 appropriate amount would have been given for a 11 hypertrophic scar? 12 A. Based on the record. 13 Q. And as we've discussed, you've not seen 14 and you're not aware of any literature that 15 supports your opinion, correct? 16 A. Correct. 17 Q. And you've not performed any testing or 18 any kind of methodology to see if your hypothesis 19 is correct, correct? 20 A. Correct. 21 Q. Now, we talked about informed consent, 22 and you contend that Nurse Practitioner Hussey did 23 not give informed consent; is that accurate? 24 A. Correct. 25 Q. And you would agree that informed consent
Page 87 1 Q. And you would agree that you have no 2 evidence that Shannon Hussey actually injected 3 something other than what she believed and what 4 her opinion and clinical judgment was of a 5 hypertrophic scar, correct? 6 A. There's no concrete evidence. 7 Q. Right. There's no evidence at all, is 8 there? 9 A. There's no concrete evidence. 10 Q. Well, Doctor, you'd agree there's nothing 11 even on Plaintiff's Exhibit Number 3, dated May 12 the 4th, 2016, that you see any evidence of an 13 injection anywhere on that photo, correct? 14 A. Correct. 15 Q. All right. So, Doctor, I just want to 16 make sure I understand. Your opinions as to the 17 cause of Ms. Gurry's injuries are solely based on 18 the fact that she's got this atrophy, and now 19 you've backtracked and tried to come up with some 20 explanation as to what could have caused that. In 21 essence, the thing speaks for itself; something 22 must have been done wrong, correct? 23 A. Correct. 24 Q. And whether it's the wrong site, the 25 wrong concentration, or the wrong dosage, that's	Page 89 1 can be oral; it doesn't have to be in writing; is 2 that correct? 3 A. Correct. 4 Q. And you agree that informed consent is 5 educating the patient about the procedure that's 6 about to occur and telling them that you can have 7 some pain, and potentially what some of the most 8 common adverse reactions or side effects are; is 9 that correct? 10 A. Correct. 11 Q. As part of informed consent, you're not 12 required as a medical provider to tell a patient 13 of every possible thing that could potentially 14 happen to them; is that accurate? 15 A. Yes. 16 Q. And in fact, as you've explained, what 17 ultimately occurred with Ms. Gurry would not be 18 something that you would expect. You would not 19 expect to have this large depression; is that 20 correct? 21 A. Correct. 22 Q. So that would not be something that you 23 would advise a patient of because it wouldn't be 24 something that would be expected? 25 A. Correct, if the proper therapy was given.

Page 90 1 Q. All right. And do you agree that in the 2 medical record, it is documented that there was a 3 discussion about the procedure, that they reviewed 4 causes, options, and the treatment that was 5 recommended was an intralesional steroid to 6 decrease hypertrophy, side effects were reviewed. 7 A. Correct. 8 Q. And that would be appropriate; is that 9 correct? 10 A. Yes. 11 Q. Now, there are other defendants who have 12 been sued in this case, which include Dr. Richard 13 Hussey as well as Myrtle Beach Dermatology. 14 As I understand your testimony, you are 15 not offering any criticisms as to Dr. Richard 16 Hussey or the practice itself, Myrtle Beach 17 Dermatology; is that correct? 18 A. Correct. 19 Q. So your only criticisms are against 20 Shannon Hussey? 21 A. Correct. 22 Q. And do you agree that in the record, it 23 indicates that Ms. Gurry called back to the office 24 on May the 12th of 2016 and that Dr. Hussey asked 25 that she come back to the office for an	Page 92 1 Q. And that's because you're grandfathered 2 in? 3 A. Correct. 4 Q. But you've never voluntarily gone back 5 and retaken your boards? 6 A. No, but I get a lot of continuing medical 7 education. 8 Q. All right. And you're certified by the 9 Osteopathic Board of Dermatology; is that correct? 10 A. Correct. 11 Q. But you're not board-certified by the 12 American Academy of Dermatology? 13 A. Correct. 14 Q. Are you a member of the American Academy 15 of Dermatology? 16 A. Yes. 17 Q. But you're not a fellow; is that 18 accurate? 19 A. You know, I think, I'm not sure, that DOs 20 may have been given fellowship status, but I'm not 21 sure. 22 Q. Well, sitting here today, you don't -- 23 you do not hold yourself out as a fellow of the 24 American Academy of Dermatology; is that correct? 25 A. Correct. I don't need to be.
Page 91 1 evaluation? 2 A. Um-hum. 3 Q. Is that yes? 4 A. Yes. 5 Q. Okay. And do you agree that the patient 6 never did return to Dr. Hussey? 7 MS. GURRY: Option -- objection. Out of 8 his scope or his knowledge. 9 Q. Dr. Wikas, do you see anything in the 10 record from Myrtle Beach Dermatology that 11 Ms. Gurry returned to see Dr. Hussey after he 12 recommended that she come by the office for an 13 evaluation? 14 A. No. 15 Q. Doctor, I want to talk a little bit kind 16 of about your work as an expert. It's my 17 understanding you received a doctorate of 18 osteopathic medicine degree; is that correct? 19 A. Correct. 20 Q. And that's instead of a medical degree? 21 A. Correct. 22 Q. And while you were board-certified in 23 dermatology, you've never taken the boards to be 24 recertified? 25 A. Don't need do.	Page 93 1 Q. Because, in fact, to be a fellow of the 2 American Academy of Dermatology, you have to take 3 and pass their board-certification exams; is that 4 correct? 5 A. Correct. 6 Q. Now, Doctor, as an expert, you agree you 7 advertise your services? 8 A. Correct. 9 Q. And, in fact, is this the third or the 10 fourth time that you've served as an expert for a 11 pro se plaintiff, somebody who is representing 12 themselves? 13 A. Yes. We discussed that during my 14 deposition. 15 Q. All right. And, in fact, almost all the 16 cases that you reviewed, 95 percent plus, are for 17 the patient plaintiff, correct? 18 A. Correct. 19 Q. And this expert witness work that you do, 20 this is an additional source of income for you, is 21 it not? 22 A. Correct. 23 Q. And you have your own personal expert 24 witness website? 25 A. On that website, I only have my CV. I

Page 94 1 don't make any promises. I just say here's my CV. 2 Q. Okay. But you have a website that 3 advertises that you're an expert for hire, 4 correct? 5 A. Correct. 6 Q. And also, you are listed with a number of 7 expert witness locator services, are you not? 8 A. Really only one right now. 9 Q. And what's the one right now? 10 A. SEAK. 11 Q. And SEAK, does that stand for the expert 12 witness training company? 13 A. I don't know. SEAK -- no, SEAK is 14 actually, the letters stand for the names of the 15 children of the owner. 16 Q. All right. But did you also used to 17 advertise with ALM Experts? 18 A. Oh, yeah. 19 Q. With expertwitness.com? 20 A. Yes. 21 Q. With Forensic Expert Litigation Support? 22 A. Yes. 23 Q. With dermexpertwitness.com? 24 A. I'm not familiar -- the name is familiar, 25 but I'm not -- it doesn't ring a bell right now.	Page 96 1 Q. Okay. And I have a sticky tab. It's 2 your name. Can you pull that, open that up for 3 me? 4 A. Sure. 5 Q. And so in this, I guess for SEAK, you 6 paid to advertise your name, correct? 7 A. Yes. 8 Q. All right. And at the top of that, it 9 says how many times you've been deposed in the 10 last four years, and it says 25 times; is that 11 right? 12 A. I'm just looking. On the top? 13 Q. Yes, sir. That's your information. 14 A. Oh, yes. Yes, yes, yes. 15 Q. Okay. So it also says that you've been 16 an expert for, what, the past 20 years? 17 A. Since 2001. 18 Q. Now, and that would be 20 years, right, 19 if we're 2021? 20 A. Um-hum. 21 Q. All right. Now, for SEAK, did you ever 22 go to any of their courses on how to be an expert 23 witness? 24 A. Yes. 25 Q. And some of the courses they offer is How
Page 95 1 It may have happened. 2 Q. Okay. With JurisPro? 3 A. Yes. 4 Q. With Consolidated Consultants? 5 A. Oh, yes. 6 Q. With HG.org? 7 A. Yes. 8 Q. With, I think I already said that, 9 Forensic Expert Litigation Support; is that right? 10 A. Correct. 11 MS. SCALISE: All right. We're going to 12 take a break for a second to change the tape and 13 we'll finish up. 14 THE VIDEOGRAPHER: Okay. We are off the 15 record. The time is 3:09. 16 (Discussion off record.) 17 THE VIDEOGRAPHER: We are back on the 18 record. It's 3:11. 19 BY MS. SCALISE: 20 Q. All right, Doctor. When we broke for a 21 minute to change the tape, I grabbed -- it's a 22 book. Can you hold that up for the jury. And it 23 says SEAK, the Expert Witness Training Company, 24 does it not, like on the front of that? 25 A. It does.	Page 97 1 to be a More Persuasive Expert Witness at Trial. 2 Do you go to that one? 3 A. Yes. 4 Q. How to Make More Money as an Expert 5 Witness. Did you go to that? 6 A. I missed that one. 7 Q. How to Start, Build, and Run a Successful 8 Expert Witness Practice. Did you go to that? 9 A. I may have. 10 Q. How to Write a Bulletproof Expert Witness 11 Report? 12 A. I don't -- I may have. I bought their 13 book about it. 14 Q. Okay. How to Excel at Your Expert 15 Witness Deposition? 16 A. I know I attended a course on 17 depositions. 18 Q. Law for Experts: What You Need to Know 19 to Succeed. Did you go to that one? 20 A. Yes. 21 Q. Did you go to the conferences that they 22 put out for national expert witnesses? 23 A. Yes. 24 Q. How many times have you gone to that? 25 A. Now, this is a guesstimate. Maybe around

Page 98 1 ten times. 2 Q. All right. And as far as the books, you 3 know, SEAK, they do put out different expert 4 witness books. 5 A. Correct. 6 Q. And one of it, one of the books is called 7 How to Be an Effective Expert Witness at 8 Deposition and Trial. Do you own that book? 9 A. Yes. 10 Q. Another one is How to Be a Successful 11 Expert Witness: SEAK's A to Z Guide to Expert 12 Witnessing. Do you own that book? 13 A. Yes. 14 Q. How to Write an Expert Witness Report. 15 Do you own that book? 16 A. Yes. 17 Q. The Expert Witness Retention Contract. 18 Do you own that book? 19 A. I don't think there's a book about it. 20 Is it a book? 21 Q. Or is it a download? Have you downloaded 22 that? 23 A. It was a CD a bunch of years ago. 24 Q. Okay. But you've got that CD on how to 25 write your contract for expert retention?	Page 99 1 A. Don't have the CD anymore. 2 Q. But you had it at some point? 3 A. I did. 4 Q. And how about the book, How to Market 5 Your Practice -- I'm sorry, How to Market Your 6 Expert Witness Practice? 7 A. No, never got that one. 8 Q. Did you get the book, The Biggest 9 Mistakes Expert Witnesses Make and How to Avoid 10 Them? 11 A. Yes. 12 Q. How many other books have you gotten 13 regarding how to be an expert witness? 14 A. I think those are enough. 15 Q. Yeah. Have you gone to any other courses 16 or seminars on how to be an expert? 17 A. No. 18 Q. Now, are you aware that the American 19 Academy of Dermatology has published a position 20 statement on expert witnesses? 21 A. Oh, yes. 22 Q. And is that something that you comply 23 with? 24 A. I'd have to read it, because I haven't 25 read it in years.	Page 100 1 Q. All right. I'll show you a copy. Do you 2 agree that this position statement on expert 3 witnesses says, "The integrity of the judicial 4 process depends in part on the honest, unbiased 5 testimony of expert witnesses on both sides of 6 courtroom controversies"? 7 A. That's right. 8 Q. It says, "Justice, humaneness, and 9 professionalism demand that dermatologists bring 10 to the courtroom the same confidence, expertise, 11 objectivity, and compassion that they bring to the 12 care of the patients." Do you agree? 13 A. That's true. 14 Q. Does it also talk about, "The expert 15 witness is expected to be impartial and should not 16 assume the role of an advocate, except as a 17 spokesperson for the field of special knowledge 18 that he or she represents."? 19 A. Correct. 20 Q. And it says, "A physician should never 21 testify concerning matters about which he or she 22 is not knowledgeable"? 23 A. Correct. 24 Q. And it also says, "The expert witness 25 should testify honestly, fully, and impartially"?	Page 101 1 A. Correct. 2 Q. And that, "The expert witness should 3 offer expert testimony that is objective, 4 truthful, and accurate based solely on medical 5 knowledge of the matter at issue and never on the 6 litigation posture of the Plaintiffs or 7 Defendants"? 8 A. Correct. 9 Q. And in fact, in this case, before you 10 looked at any medical records, Ms. Gurry contacted 11 you and she told you her side of the story and her 12 theories as to what occurred, did she not? 13 A. Correct. 14 Q. And you agreed without reviewing any 15 deposition testimony that you would be her 16 advocate, did you not? 17 A. I don't think I was her advocate. I 18 would just deal with the facts of the case. 19 Q. All right. And those facts are the 20 medical records themselves, correct? 21 A. Correct. 22 Q. And those medical records are the records 23 that show that Shannon Hussey administered an 24 appropriate amount of Kenalog into a hypertrophic 25 scar, correct?

STATE OF SOUTH CAROLINA	)	IN THE COURT OF COMMON PLEAS
	)	
COUNTY OF HORRY	)	C/A No.: 2018-CP-26-05438
	)	
Tara Gurry,	)	
	)	
Plaintiff,	)	ORDER GRANTING DEFENDANTS'
	)	MOTION IN LIMINE TO
v.	)	EXCLUDE DR. SCHIELD WIKAS'S
	)	TESTIMONY
Myrtle Beach Dermatology, LLC,	)	
Shannon Hussey, and Richard Hussey,	)	
M.D.	)	
	)	
Defendants.	)	
_____	)	

This matter came before the Court upon a Motion in Limine by the Defendants to Challenge, Limit, and/or Exclude the testimony from trial of Plaintiff's expert Dr. Schield Wikas. Present at the hearing were counsel for Defendants Marian Scalise, Esquire and Lydia Magee, Esquire, and Plaintiff Tara Gurry represented herself *pro se*¹.

This case involves allegations of medical malpractice against the Defendants, specifically that Defendant Nurse Practitioner Shannon Hussey improperly injected Kenalog into a hypertrophic scar on Plaintiff's thigh (which was a sequela of a melanoma excision), resulting in atrophy and systemic effects.

Prior to the start of trial and selection of a jury, counsel for Defendants sought an Order to Challenge, Limit, and/or Exclude Plaintiff's dermatology expert Dr. Shield Wikas's testimony. The basis for this Motion was that: 1) Plaintiff's expert Dr. Wikas should be excluded as he was not qualified to offer an opinion on any alleged injury outside of the field of dermatology; 2) Dr.

¹ This hearing was held just prior to the selection of a jury in this case, and Plaintiff intended to represent herself *pro se* throughout the course of the trial.

Wikas offered no opinion on how the Defendants breached the standard of care or how such breach caused Plaintiffs' alleged injuries, and therefore, his testimony should be excluded as unreliable; and 3) Dr. Wikas's opinions regarding the occurrence of atrophy were not supported by any research or medical literature and should be excluded by this Court under the Court's gatekeeping function and laws of South Carolina.

After reviewing the pleadings, the Motion in Limine filed by the Defendants with supporting exhibits, listening to the arguments of defense counsel and Plaintiff, and reviewing the entire *de bene esse* deposition of Plaintiff's expert Dr. Wikas, the Court finds the following facts pertinent to Court's decision: On or about January 27, 2016, the Plaintiff had a malignant melanoma on her right thigh excised by dermatologist Dr. Joseph Masessa. This surgical procedure in which a 7.5 cm width and 1 cm depth mass was excised left her with a significant 16 cm scar on her right leg. The Plaintiff came to the Defendants' office on May 3, 2016, for further routine follow-up where the Defendant NP Hussey examined the scar and described the hypertrophic area of the scar as being 7 cm long. NP Hussey also documented that the Plaintiff reported a pulling sensation in the scar and the feeling of stitches being in it. The Defendant injected it with 1 cc of 3.3. mg of Kenalog, an intralesional steroid used by dermatologists for this type of scar, to reduce the appearance of the scar by thinning and flattening it and to alleviate the pulling sensation.

After this visit and as an alleged result of the Kenalog injection, the Plaintiff alleges that she became very ill for 72 hours, but that the illness lasted for two weeks and has continued to the present day, five years later, and included nausea, chills, racing heartbeat, cramps, body aches, headaches, insomnia, and a three-week menstrual cycle. The Plaintiff also alleges that her leg began to atrophy within 24 hours and got worse over several months. She alleges that this caused her to have to stop doing activities she loves like running due to leg pain.

On September 27, 2018, the Plaintiff filed a Summons and Complaint against Defendants alleging gross negligence which allegedly caused her chronic pain and discomfort, humiliation, disability, fear, anxiety, mental anguish and emotional distress, loss of enjoyment of life, otherwise unnecessary medical, and surgical costs which is the subject of the case currently before the Court.

To support her allegations, the Plaintiff identified her sole expert witness, dermatologist Dr. Schield M. Wikas, as an expert witness. Dr. Wikas was deposed by Marian W. Scalise, Esquire for a discovery deposition on June 28, 2019, and Dr. Wikas provided *de bene esse* trial testimony on June 21, 2021, 6 days prior to the first day of trial.

In South Carolina, with few exceptions, expert opinion is required in medical malpractice actions. See David v. McLeod Reg'l Med. Ctr., 367 S.C. 242, 247, 626 S.E.2d 1, 3 (2006). Specifically, a Plaintiff must demonstrate and provide evidence of the following via an expert witness: (1) the generally recognized and accepted practices and procedures that would be followed by average, competent practitioners in the Defendant's field of medicine under the same or similar circumstances, and (2) the defendant departed from the recognized and generally accepted standards. Id. 367 S.C. at 247-248, 626 S.E.2d at 4 (citing Pederson v. Gould, 288 S.C. 141, 143-44, 341 S.E.2d 633, 634 (1986); Cox v. Lund, 286 S.C. 410, 414, 334 S.E.2d 116, 118 (1985)). The Plaintiff must also establish that the Defendants' departure from such generally recognized practices and procedures was the proximate cause of the Plaintiff's alleged injuries and damages. See id. 367 S.C. at 248, 626 S.E.2d at 4 (citing Green v. Lilliewood, 272 S.C. 186, 193, 249 S.E.2d 910, 913 (1978)). While the Plaintiff is *pro se*, she still bears the burden of proof and must establish a duty, breach, and causation via expert testimony to prevail in her medical malpractice action. In South Carolina, medical malpractice actions require a greater showing than generic allegations and conjecture. Id. Importantly, the admissibility of expert opinion requires

more scrutiny than the admissibility of other evidence. See Watson v. Ford Motor Co., 389 S.C. 434, 446, 699 S.E.2d 169 (2010) (holding “expert testimony receives additional scrutiny relative to other evidentiary decisions”).

Rule 702 of the South Carolina Rules of Evidence provides, “[I]f scientific, technical or other specialized knowledge will assist the trier of fact to understand the evidence or to determine a fact in issue, a witness qualified as an expert by knowledge, skill, experience, training, or education may testify thereto in the form of an opinion or otherwise.” Rule 702, SCRE. However, in determining the admissibility of expert opinion under Rule 702, this Court is a gatekeeper and must be satisfied that the opinion testimony meets all three of the following requirements:

- (1) the trial court must find that the subject matter is beyond the ordinary knowledge of the jury, thus requiring an expert to explain the matter to the jury;
- (2) while the expert need not be a specialist in the particular branch of the field, the trial court must find that the proffered expert has indeed acquired the requisite knowledge and skill to qualify as an expert in the particular subject matter; and
- (3) the trial court must evaluate the substance of the testimony and determine whether it is reliable.

Watson v. Ford Motor Co., 389 S.C. 434, 446, 699 S.E.2d 169 (2010) (emphasis added) (internal citations omitted) (holding that “in executing its gatekeeping duties, the trial court must make [these] three key preliminary findings which are fundamental to Rule 702 before the jury may consider expert testimony”).

This Court recognizes that expert witnesses have the potential to be “both powerful and quite misleading,” and that the gatekeeper function is critical due to the weight given to experts. Cooper v. Smith & Nephew, Inc., et al, 259 F.3d 194, 199 (4th Cir. 2001) (internal citations

omitted). In fulfilling this Court's Watson gatekeeping function as it applies to the Plaintiff's expert's testimony, and applying the criteria of Rule 702, SCRE, the entire *de bene esse* transcript of Plaintiff's expert Dr. Schield Wikas was reviewed *in camera* to ensure that Dr. Wikas had the requisite knowledge and skill to qualify as an expert and that his opinion was based upon reliable medicine or science. See State v. White, 382 S.C. 265, 270 (2009); see also Daubert v. Merrill Dow Pharmaceuticals, Inc., 509 U.S. 579, 125 L.Ed. 2d 469, 113 S. Ct. 2786 (1993) (holding trial judges must act as gatekeepers to "ensure that any and all scientific testimony...is not only relevant, but reliable"). As the South Carolina Supreme Court has reaffirmed time and again, "reliability is a central feature of Rule 702 admissibility, and our jurisprudence is in complete accord." White, 382 S.C. at 270. "The familiar tenet of evidence law that a continuing challenge to evidence goes to 'weight, not admissibility' has never been intended to supplant the gatekeeping role of the trial court in the first instance in assessing the admissibility of expert testimony, including the threshold determination of reliability." Id. at 273.

After reviewing the pleadings, the Motion in Limine filed by the Defendants with supporting exhibits, listening to the arguments of defense counsel and Plaintiff, and reviewing the entire *de bene esse* deposition of Plaintiff's expert Dr. Wikas, this Court finds that Dr. Wikas offered no opinion on how the Defendants' alleged breach in the standard of care was the proximate cause of Plaintiff's alleged damages, thereby rendering his testimony unreliable and inadmissible.

"A reliable expert opinion must be based on scientific, technical, or other specialized knowledge and not on belief or speculation, and inferences must be derived using scientific or other valid methods." Oglesby v. General Motors Corp., 190 F.3d 244, 250 (4th Cir. 1999) ("expert" mechanical engineer's speculation about whether plastic inlet connector contained defect

lacked reliability, foundation, and relevance necessary for admissibility). “An expert's opinion should be excluded when it is based on assumptions which are speculative and are not supported by the record.” Collier v. Varco-Pruden Buildings, et al., 911 F.Supp. 189, 192 (D. S.C. 1995) (citing Tyger Constr. Co. v. Pensacola Constr. Co., 29 F.3d 137, 142 (4th Cir. 1994), cert. denied, 130 L. Ed. 2d 633, 115 S. Ct. 729 (1995)). In a medical malpractice action, it is impermissible to speculate that an injury is the result of negligence “in the absence of any evidence as to how [a medical provider] deviated from the standard of care.” Fletcher v. Medical Univ. of S.C., 390, S.C. 458, 464 702 S.E.2d 372, (S.C. Ct. App. 2010). The Supreme Court of South Carolina in King stated the following:

In this State it is well settled that the burden rests upon the party to prove negligence. This burden cannot be met by relying upon the theory that the thing speaks for itself or that the very fact of injury indicates negligence... In order, therefore, for a plaintiff to recover damages, she must prove by the greater weight or preponderance of the evidence not only the injury but also that it was caused by the actionable negligence of the defendant.

King v. J. C. Penney Co., 238 S.C. 336, 339–40, 120 S.E.2d 229, 230 (1961) (internal citation omitted). Watson v. Ford Motor Co., 389 S.C. 434, 452-3, 699 S.E.2d 169, 178-9 (2010), is particularly instructive because, after it was decided that Plaintiff's expert would be excluded, the court noted that South Carolina does not follow the doctrine of *res ipsa loquitur*, and that Plaintiff's case could not rely solely on the fact an accident occurred to prove negligence.

In Cooper v. Smith & Nephew, Inc., et al, 259 F.3d 194, 196-7 (4th Cir. 2001), the Fourth Circuit Court of Appeals affirmed a trial court's granting of summary judgment dismissing a Plaintiff's claim for personal injuries based upon allegedly defective pedicle screw fixation devices to treat spinal injuries. Plaintiff's expert testified that his determination of whether a device was defective or not was based simply on whether the surgery was successful. Id. at 201. The court stated, “Daubert requires more than an assertion that if there is a lack of surgical success, there is

ipso facto a product defect, and hence causation is established.” Id. In affirming the trial court that Plaintiff’s testimony was unreliable, the court found that Plaintiff’s expert failed to provide any medical evidence as to what caused Plaintiff’s injuries, but rather inferred causation because the surgery in question ultimately was not successful. Id. Similarly, although South Carolina does not explicitly follow Daubert, the courts of this state do require the expert’s testimony to be reliable. Just as in Cooper, the inability to testify as to proximate cause renders Dr. Wikas’s opinion to be unreliable.

“It is well settled under our decisions that where medical testimony is relied on to show a causal connection between an accident and a certain result, it is not sufficient for the doctors to say simply that the ailment in question ‘possibly’ or ‘might have’ resulted from the accident, but the medical experts must go further and testify at least that in their professional opinion the result in question ‘most probably’ came from the alleged cause.” Windham v. City of Florence, 221 S.C. 350, 358, 70 S.E.2d 553, 556 (1952). Dr. Wikas’s testimony indicates that he has testified as an expert on behalf of Plaintiffs in medical malpractice actions on numerous occasions. He admitted to owning expert witness books and attending various expert witness courses. As such, he would understand the exacting standard that South Carolina law requires for a medical malpractice expert to testify to a reasonable degree of medical certainty that the injury complained of was “most probably” caused by the alleged conduct. Despite having this foundational knowledge, this Court finds that Dr. Wikas did not once testify to a reasonable degree of medical certainty that the Kenalog injected by Defendant Nurse Practitioner Hussey was most probably the cause of the Plaintiff’s atrophy or other alleged side-effects.

In contrast, Dr. Wikas testified on multiple occasions that the injury itself is evidence of negligence and an injection in an improper location/of improper concentration and/or of improper

volume by Defendant Nurse Practitioner Shannon Hussey. Specifically, Dr. Wikas's testimony was in relevant part:

Q: Dr. Wikas, as I understand your opinion in this case, your opinion is that you see a depression or atrophy on Tara Gurry's leg, correct?

A: Correct.

Q: And your opinion is that something must have been done wrong to have caused that atrophy, correct?

A: Correct.

Q: You don't know exactly what, but something had to have been done wrong, correct?

A: I thought it was due to the injection of excessive concentration, excessive volume of Kenalog.

Q: All right. Because I think the way you explained in your deposition is the thing speaks for itself.

A: Correct.

Q: Okay. Basically, a *res ipsa loquitur*....In fact, it's kind of a legal term, *res ipsa loquitur*, that the fact that there's been an injury, somebody must have done something wrong to have caused that, correct?

A: In this case, yes.

[Dr. Wikas *de bene esse* Dep. 59: 23-25; 60: 1-23]

Portions of Dr. Wikas discovery deposition were attached to the Motion in Limine, and it in relevant part reads as follows:

A: Well, all I can tell you is it really doesn't matter in this case because the results speak for themselves.

[Dr. Wikas Discovery Dep. 107:21-23].

Moreover, in Dr. Wikas's *de bene esse deposition*, he testified as follows:

Q: All right. And you would agree though that if Nurse Practitioner Hussey had administered 3.3 milligrams per CC of an intralesional steroid for a hypertrophic scar, that would be an appropriate amount and concentration, correct?

A: Correct.

Q: So, based on the medical record of May the 3rd, 2016, that was the amount and the concentration of intralesional steroid that was documented in the record, correct?

A: Correct.

Q: So, what Nurse Practitioner Hussey documented as far as what she injected, that would be acceptable and that meets the standard of care, but you just don't believe that she did that, correct?

A: Correct.

[Dr. Wikas *de bene esse* Dep. 60:24-25; 61: 1-15]

Q: So, Doctor, you would agree that the amount of approximately 1 cc of a 3.3 milligram of intralesional steroid, that should not cause the depression like what you see in Ms. Gurry's leg, correct?

A: Yes, you're correct.

Q: Okay. So the amount, you would not expect that to cause the depression or atrophy if you're giving 1 CC of about 3.3 milligrams of Kenalog?

A: That's correct.

Q: And, in fact, you've never seen, you've never heard, you've never even seen it anywhere in the literature that approximately 1 cc of 3.3 milligrams of an intralesional steroid would cause a depression like what Ms. Gurry had, correct?

A: Correct.

[Dr. Wikas *de bene esse* Dep. 62:6-22; 63: 1-15]

Q: You've never seen ever that 1 cc of 3.3 milligrams of Kenalog is going to cause what you see in Tara Gurry's leg, correct?

A: Correct.

Q: You've never heard of something like that happening, correct?

A: Correct.

Q: You've never seen anything in any literature that would describe that type of result with about 1 cc of 3.3 milligrams of Kenalog, correct?

- A: Correct.
- Q: And you yourself, as you've testified, you give intralesional steroid Kenalog in your patients, correct?
- A: Yes.
- Q: And you've done that hundreds of times, correct?
- A: Yes.
- Q: And you've given that medication in doses that could even be higher than 3.3 milligrams, correct?
- A: Yes.
- Q: And you have never had any depression ever, correct?
- A: Correct.
- Q: Now, with the Kenalog injection, this intralesional steroid, the purpose is to soften and flatten any kind of raised area on a scar, correct?
- A: Yes.
- Q: And so is that caused -- is that called atrophy.... With an intralesional steroid, is the goal of utilizing an intralesional steroid to flatten or soften the appearance of the scar?
- A: Yes.
- Q: And by flattening or softening that scar, is that in itself atrophy?
- A: Technically, yes.
- Q: Okay. But what we're talking about here is a greater amount of atrophy; is that fair to say?
- A: Yes.
- Q: And you would agree that injecting 1 cc of 3.3 milligrams of Kenalog, it would not be foreseeable that that's going to cause the depression that Tara Gurry has, correct?
- A: Yes.

Q: That would not be a natural or probable consequence of injecting that amount of steroid into a scar, correct?

A: Correct.

Q: It would be highly unusual, would it not?

A: Yes.

Q: Very abnormal, correct?

A: Correct.

Q: Because if that amount of injection is used, you would not have the result that she has, correct?

A: Yes.

Q: And your opinion is that you find no other possibility, no other reason for this depression other than Nurse Practitioner Hussey must have done something wrong, correct?

A: Correct.

[Dr. Wikas *de bene esse* Dep. 63:10-25; 64: 1-25; 65: 1-25; 66: 1-2]

A: I felt that [NP Hussey] fell below the standard of care because [Plaintiff] had catastrophic thinning of the skin, a depression, accentuation of blood vessels, there was sensitivity to touch, so I felt that her activities were well below the standard of care.

[Dr. Wikas *de bene esse* Dep. 14:22 – 15:2]

A: It was my impression that she injected too much corticosteroid, probably too deeply, too high a concentration, too large a volume.

[Dr. Wikas *de bene esse* Dep. 15:7-10]

A: I think the results speak for themselves. I've never seen – Ms. Hussey said she injected 3.3 milligrams of the corticosteroid into the incision site. I've injected that amount of concentration many, many times, literally at least hundreds of times, and I've never seen a wound implode.

[Dr. Wikas *de bene esse* Dep. 21:10-16]

A: The amount Ms. Hussey said she injected really doesn't jive with the results....

[Dr. Wikas *de bene esse* Dep. 31:17-18]

Q: Your opinions as to the cause of Mr. Gurry's injuries are solely based on the fact that she's got this atrophy, and now you've backtracked and tried to come up with some explanation as to what could have caused that. In essence, the thing speaks for itself; something must have been done wrong, correct?

A: Correct.

[Dr. Wikas *de bene esse* Dep. 87:16-23].

Q: Yes, because you have no evidence to truly say that there was a wrong concentration or the wrong dose or the wrong site, correct?

A: There's no concrete evidence.

[Dr. Wikas *de bene esse* Dep. 88:4-7].

Q: And as we've discussed, you've not seen and you're not aware of any literature that supports your opinion, correct?

A: Correct.

Q: And you've not performed any testing or any kind of methodology to see if your hypothesis is correct, correct?

A: Correct.

[Dr. Wikas *de bene esse* Dep. 88:13-20].

This Court finds that Dr. Wikas's testimony is purely supposition and does not pass the requirements imposed upon the Court and its gatekeeping function. Clearly, this case involves medical issues which are outside the ordinary knowledge of the jury, thus, requiring an expert to explain the matter to the jury. Watson, 389 S.C. at 446, 699 S.E.2d at 175. While the Court acknowledges that Dr. Wikas may be qualified by his education and training to testify as an expert in the field of dermatology and may testify as to matters specifically related to dermatology, the Court does not make a determination on the qualification of Dr. Wikas to testify as to his expertise in matters outside the field of dermatology. However, this Court finds that the substance of his

testimony is not reliable, in part because he does not perform the type of melanoma excision which Plaintiff had in the months prior to the Kenalog injection at issue, but primarily because he cannot causally relate the Plaintiff's alleged injuries to any breach in the standard of care.

As detailed above, Dr. Wikas testified that the alleged negligence in this case is evidenced by the injury to the Plaintiff (atrophy), and that it is a known side effect of the injection given, which he assumes was caused by too high of a concentration of Kenalog, too much volume injected, and/or improper injection location. Dr. Wikas admitted that he has never experienced, heard, or even read about an injection given as documented in the medical record in this case (1cc 3.3 mg intralesional steroid) causing the type of atrophy which the Plaintiff alleges. This demonstrates that his speculative opinion is completely unreliable as he has failed to locate any literature to support his supposition. Furthermore, Dr. Wikas conceded that if Nurse Practitioner Hussey gave the injection as she documented, she met the standard of care in doing so. "When the injury complained of is not reasonably foreseeable, in the exercise of due care, there is no liability." Eadie v. Krause, 381 S.C. 55, 64, 671 S.E.2d 389, 393 (Ct. App. 2008). If the atrophy the Plaintiff alleges truly occurred as the result of Nurse Practitioner Hussey injecting the amount of Kenalog that is reflected in the medical records, it would truly be a catastrophic, unforeseeable event. Because such a result would be unforeseeable based on the evidence, there could be no liability. See Kennedy v. Carter, 249 S.C. 168, 153 S.E.2d 312; Stone v. Bethea, 251 S.C. 157, 161, 161 S.E.2d 171 (1968) ("Foreseeability of some injury from an act or omission is a prerequisite to its being a proximate cause of the injury for which recovery is sought"); McQuillen v. Dobbs, 262 S.C. 386, 204 S.E.2d 732 (1974) (stating that the standard by which foreseeability is determined is that of looking to the "natural and probable consequences" of the complained of

act, and that while it is not necessary that the actor must have contemplated or could have anticipated the particular event which occurred, liability cannot rest on mere possibilities).

Moreover, Dr. Wikas testified and admitted that there is no evidence that there was an injection in an improper location, of improper concentration, and/or of improper volume other than the injury itself, which is a theory of causation that has been rejected by South Carolina Courts. This type of speculative testimony is unreliable and, therefore, under this Court's gatekeeping function, this testimony is inadmissible trial.

Dr. Wikas further testified that atrophy is a known side effect of an intralesional steroid such as Kenalog and is the purpose of the drug. Specifically, he stated as follows:

Q: Now, with the Kenalog injection, this intralesional steroid, the purpose is to soften and flatten any kind of raised area on a scar, correct?

A: Yes.

Q: And so is that caused -- is that called atrophy.... With an intralesional steroid, is the goal of utilizing an intralesional steroid to flatten or soften the appearance of the scar?

A: Yes.

Q: And by flattening or softening that scar, is that in itself atrophy?

A: Technically, yes.

[Dr. Schield Wikas *de bene esse* Dep. 64: 11-25; 65: 1]

This Court finds the Fletcher case on point and, thus, requires granting Defendants' motion to exclude Dr. Wikas's testimony as unreliable. In Fletcher, the Plaintiff had subclavian bypass surgery. Fletcher, 390 S.C. at 461, 702 S.E.2d at 373. Fletcher brought a medical malpractice claim alleging that the doctors were negligent in performing the procedure and that she was not properly advised of the risks associated with the procedure. See id. at 390 S.C. at 461-62, 702

S.E.2d at 373. Similar to the Plaintiff in this case, the Plaintiff in Fletcher testified that she would not have undergone the procedure had she known of the potential risks and outcome. See id. at 390 S.C. at 462, 702 S.E.2d at 373. During cross-examination, the Plaintiff's expert testified that "complications ... could have occurred during this procedure even in the absence of any surgical negligence." Id. at 390 S.C. at 463, 702 S.E.2d at 374.

Analogously to the expert in Fletcher, Dr. Wikas testified that atrophy and pain are known side effects of a Kenalog injection. The expert in Fletcher testified "Q: Do you see anything in there [the operative note and records] that indicates that Dr. Brothers used any improper technique to do this operation? A: No." Id. (brackets in original). Similarly, Dr. Wikas testified that the amount of Kenalog Nurse Practitioner Hussey documented to have injected was an appropriate amount, and with that amount, you would not expect to see any atrophy.

Based on the testimony in Fletcher, the Court of Appeals held the following:

Essentially, [the Plaintiff] asks us to conclude that the occurrence of a complication is itself evidence of negligence. However, South Carolina does not recognize the doctrine of *res ipsa loquitur*. Simply no evidence establishes how [the Defendants] deviated from the standard of care. Unfortunately, two of the risks associated with this procedure did befall [the Plaintiff]. Nevertheless, we are not permitted to speculate that misfortune was the result of negligence in the absence of any evidence as to how the physicians deviated from the standard of care.

Bowie v. Hearn, 292 S.C. 223, 355 S.E.2d 550 (Ct. App. 1987) (*Bowie I*), addresses this very point. This case was reversed based on the particular facts presented, but the reasoning employed by the court of appeals is instructive. Bowie sued the physician who delivered him via cesarean section because he was cut on the cheek during the procedure, resulting in a scar. Bowie's expert testified the standard of care required the physician not to cut the baby. In analyzing the sufficiency of this testimony, the court alluded to another oft-cited medical malpractice case [Cox v. Lund, 286 S.C. 410, 334 S.E.2d 116 (1985)] and stated: Under the plaintiff's reasoning in this case [*Bowie I*] the doctors in Cox could simply have testified that normally colons are not perforated during colonoscopies, the standard of care, therefore, is a doctor should not perforate the colon, and to do so violates the standard of care. Such reasoning would, in effect, make a doctor an insurer of perfect result in every surgical procedure. A doctor is not an insurer of health and negligence may not be inferred.

The analysis in *Bowie I* is precisely on point with this case, and we discern no factual basis that would cause the reasoning in that case to be inapplicable to the facts presented here. Therefore, we affirm the circuit court's granting of a directed verdict as Fletcher presented no evidence, only speculation, that MUSC's agents deviated from the standard of care.

Fletcher, 390 S.C. at 463-65, 702 S.E.2d at 374-75 (some internal citations and quotation marks omitted).

The reasoning in Fletcher is on point, and Dr. Wikas readily admitted that he was relying on the doctrine of *res ipsa loquitur* to opine that the injury itself demonstrates negligence. This reasoning, and Dr. Wikas's reliance on *res ipsa loquitur*, warrants excluding his testimony at trial.

Plaintiff contends that Dr. Wikas's testimony should not be excluded because Dr. Wikas did testify as to a breach in the standard of care regarding informed consent; however, Dr. Wikas agreed that informed consent can be verbal and that if a result or side effect of a Kenalog injection was not anticipated, there would be no need to inform the patient of that particular potential side effect. Specifically, he testified to the following:

Q: Now, we talked about informed consent, and you contend that Nurse Practitioner Hussey did not give informed consent; is that accurate?

A: Correct.

Q: And you would agree that informed consent can be oral; it doesn't have to be in writing; is that correct?

A: Correct.

Q: And you agree that informed consent is educating the patient about the procedure that's about to occur and telling them that you can have some pain, and potentially what some of the most common adverse reactions or side effects are; is that correct?

A: Correct.

Q: As part of informed consent, you're not required as a medical provider to tell a patient of every possible thing that could potentially happen to them; is that accurate?

A: Yes.

Q: And in fact, as you've explained, what ultimately occurred with Ms. Gurry would not be something that you would expect. You would not expect to have this large depression; is that, correct?

A: Correct.

Q: So that would not be something that you would advise a patient of because it wouldn't be something that would be expected?

A: Correct, if the proper therapy was given.

Q: All right. And do you agree that in the medical record, it is documented that there was a discussion about the procedure, that they reviewed causes, options, and the treatment that was recommended was an intralesional steroid to decrease hypertrophy, side effects were reviewed.

A: Correct.

Q: And that would be appropriate; is that correct?

A: Yes.

[Dr. Wikas *de bene esse* Dep. 88:21-25; 89: 1-25; 90:1-10]

Moreover, as previously noted, Dr. Wikas agreed that it would not be foreseeable that injecting 1 cc of 3.3 milligrams of Kenalog would cause the depression that Tara Gurry had, and in his discovery deposition, he testified that there was no evidence that had the Plaintiff been told about the potential for atrophy that she would have chosen not to get the injection. [Dr. Wikas *de bene esse* Dep. 65: 6-10; Discovery Dep. 111:23-25; 112:1-4]

In totality, this Court finds that Dr. Wikas's opinions are pure speculation solely relying on the doctrine of *res ipsa loquitur* and are impermissible under South Carolina law. See Watson, 389 S.C. at 452-453 (S.C. 2010) (noting that "Respondents may not rely solely on the fact that an accident occurred to prove their products liability case under a negligence theory since South Carolina does not follow the doctrine of *res ipsa loquitur*.") (citing Snow v. City of Columbia, 305

S.C. 544, n.7, 409 S.E.2d 797, n.7 (Ct. App. 1991) (noting that South Carolina does not recognize the rule of *res ipsa loquitur*)); see also Fletcher v. Med. Univ., 390 S.C. 458, 463-465, 702 S.E.2d 372 (S.C. Ct. App. 2010) (refusing to apply *res ipsa loquitur* in a medical malpractice action).

This Court has reviewed the entire *de bene esse* transcript of Dr. Wikas, and portions of his discovery deposition which were attached to Defendants' Motion in Limine, and based upon that review, this Court finds that his entire opinion is based on a theory of *res ipsa loquitur*. Dr. Wikas repeatedly testified that Plaintiff's condition alone indicates that there was a breach in the standard of care. Dr. Wikas had no evidence that the Kenalog was injected improperly, that an excessive dose was used, or that an excessive concentration of medication was used. Additionally, Dr. Wikas had no evidence that the injection of Kenalog actually caused the Plaintiff's alleged atrophy, and because Dr. Wikas could not explain the Plaintiff's atrophy other than that it had to have occurred because of something wrong the Defendants did and that there had to be a breach because the condition of atrophy exists, Dr. Wikas has failed to offer any proof of negligence. Dr. Wikas's testimony was essentially that the element of causation was based on the existence of an injury, which is in fact, the very definition of *res ipsa loquitur* which is not recognized in South Carolina. As the case law in South Carolina has borne out, it is not enough to opine that because a medication has a known side effect, and the Plaintiff allegedly experienced that known side effect, that the result must have been due to the medication/Kenalog.

Dr. Wikas's opinions regarding the occurrence of Plaintiff's alleged injury from an intralesional Kenalog injection are not based upon reliable medicine or science making them unreliable. To be reliable, Dr. Wikas's opinions must be based upon reliable medicine or science. See State v. White, 382 S.C. 265, 270 (2009); see also Daubert v. Merrill Dow Pharmaceuticals, Inc., 509 U.S. 579, 125 L.Ed. 2d 469, 113 S. Ct. 2786 (1993) (holding trial judges must act as

gatekeepers to “ensure that any and all scientific testimony...is not only relevant, but reliable”). As our state supreme court has reaffirmed time and again, “reliability is a central feature of Rule 702 admissibility, and our jurisprudence is in complete accord.” White, 382 S.C. at 270. “The Court suggested four factors to consider in deciding reliability in scientific evidence cases: (1) scientific methodology; (2) peer review; (3) consideration of general acceptance; and (4) the rate of error of a particular technique.” State v. Council, 335 S.C. 1, 20, 515 S.E.2d 508, 518 (1999) (internal citation omitted). Dr. Wikas’s singular reliance on his own hypothetical depiction of this event is too speculative, and therefore, is inadmissible under Rule 702, SCRE. Dr. Wikas personally gives these types of injections in the same amount/volume and has never experienced this type of result. However, he has suggested that the intralesional steroid being injected by NP Hussey was in an improper location, in an improper concentration, and/or in improper volume and caused the Plaintiff’s atrophy. However, he has failed to conduct any research to establish that such an improper location, concentration, or volume would even create the alleged injury. Similarly, he has not identified any peer review literature which indicates such is even a possibility. See Daubert, 509 U.S. at 593 (stating that whether there is peer-reviewed and published literature on a theory is “pertinent consideration” because “submission to the scrutiny of the scientific community is a component of ‘good science,’ in part because it increases the likelihood that substantive flaws in methodology will be detected.”). “[I]n order to qualify as ‘scientific knowledge.’ An inference or assertion must be derived by the scientific method. Proposed testimony must be supported by appropriate validation, i.e., ‘good ground’ based on what is known.” Id.

Furthermore, under a Rule 403, SCRE analysis, this Court finds that his opinions are inadmissible on the basis that any probative value is substantially outweighed by the danger of unfair prejudice and would only confuse or mislead the jury as he testified that he gives the exact

same injection which was used in this case without any problems, yet when NP Hussey gave the injection, it inexplicitly caused Plaintiff's alleged atrophy with no basis for his reasoning other than that an injury occurred.

Because Dr. Wikas's opinions are based purely on speculation, and he has failed to provide any research or medical literature to suggest that what the Plaintiff complains of is even a possibility, his opinions are wholly unreliable and his testimony is excluded from the trial of this case.

Accordingly, the Court hereby grants the Defendants' Motion to Exclude Dr. Wikas's testimony from trial and finds that the testimony of Plaintiff's expert Dr. Wikas is not reliable and is not admissible at the trial of this case.

IT IS SO ORDERED.

[Electronic Signature Page to follow.]



Horry Common Pleas

Case Caption: Tara Gurry VS Myrtle Beach Dermatology LLC , defendant, et al

Case Number: 2018CP2605438

Type: Order/Exclude

Presiding Circuit Court Judge

s/Benjamin H. Culbertson, Judge Code 2148

Electronically signed on 2021-07-01 15:12:02 page 21 of 21

STATE OF SOUTH CAROLINA	)	IN THE COURT OF COMMON PLEAS
	)	
COUNTY OF HORRY	)	C/A No.: 2018-CP-26-05438
	)	
Tara Gurry,	)	
	)	
Plaintiff,	)	ORDER GRANTING DEFENDANTS'
	)	MOTION FOR SUMMARY JUDGMENT
v.	)	
	)	
Myrtle Beach Dermatology, LLC,	)	
Shannon Hussey, and Richard Hussey,	)	
M.D.	)	
	)	
Defendants.	)	
_____	)	

This matter came before the Court upon a motion for summary judgment by the Defendants following the Court's granting of Defendants' Motion in Limine to Challenge, Limit, and/or Exclude the testimony of Plaintiff's sole expert Dr. Schield Wikas from trial. Present at the hearing were counsel for Defendants Marian Scalise, Esquire and Lydia Magee, Esquire, and Plaintiff Tara Gurry represented herself *pro se*¹.

This case involves allegations of medical malpractice against the Defendants, specifically that Defendant Nurse Practitioner Shannon Hussey improperly injected Kenalog into a hypertrophic scar on Plaintiff's thigh (which was a sequela of a melanoma excision), resulting in atrophy and systemic effects.

Prior to the start of trial and selection of a jury, counsel for Defendants sought an Order to Challenge, Limit, and/or Exclude Plaintiff's dermatology expert Dr. Shield Wikas's testimony. This Court granted the Defendants' Motion in Limine to Exclude Dr. Wikas's testimony for trial

¹ This hearing was held just prior to the selection of a jury in this case, and Plaintiff intended to represent herself *pro se* throughout the course of the trial.

on the basis that Dr. Wikas's opinions regarding the occurrence of atrophy was not supported by any research or medical literature and should be excluded by this Court under the Court's gatekeeping function, laws of South Carolina, and on the basis that his testimony amounted to *res ipsa loquitur* which is not recognized in South Carolina.

After ruling on the Defendant's Motion in Limine regarding Dr. Wikas, counsel for the Defendants then made a motion for summary judgment on the ground that because Dr. Wikas's testimony was excluded from trial that Plaintiff could not proceed without an expert to support her medical malpractice case. The Court recognizes that in South Carolina, with few exceptions, expert opinion is required in medical malpractice actions. See David v. McLeod Reg'l Med. Ctr., 367 S.C. 242, 247, 626 S.E.2d 1, 3 (2006). Specifically, a Plaintiff must demonstrate and provide evidence of the following via an expert witness: (1) the generally recognized and accepted practices and procedures that would be followed by average, competent practitioners in the Defendant's field of medicine under the same or similar circumstances, and (2) the defendant departed from the recognized and generally accepted standards. Id. 367 S.C. at 247-248, 626 S.E.2d at 4 (citing Pederson v. Gould, 288 S.C. 141, 143-44, 341 S.E.2d 633, 634 (1986); Cox v. Lund, 286 S.C. 410, 414, 334 S.E.2d 116, 118 (1985)). The Plaintiff must also establish that the Defendants' departure from such generally recognized practices and procedures was the proximate cause of the Plaintiff's alleged injuries and damages. See id. 367 S.C. at 248, 626 S.E.2d at 4 (citing Green v. Lilliewood, 272 S.C. 186, 193, 249 S.E.2d 910, 913 (1978)). Failure to prove any one of these elements is fatal to recovery.

However, in light of the Plaintiff's *pro se* status and because the Court had only reviewed the testimony of one of Plaintiff's witnesses, her expert Dr. Schield Wikas, the Court felt inclined to allow the case to go forward and allow Plaintiff to present her case to the jury and denied the

Defendants' Motion for Summary Judgment. However, before this Court issued its final ruling, the Plaintiff then voiced her clear intention to the Court that she did "not want to waste anyone's time" in going forward in the case, she wanted to immediately appeal the Court's ruling excluding her expert Dr. Wikas's testimony, and she wanted to know who she should go to about filing an immediate appeal and how that needed to be done. Upon hearing the Plaintiff's request and demand that she be allowed to immediately appeal the case, and that she had no intention of going forward with the trial of the case and was abandoning prosecution of her case, the Court granted the Defendants' Motion for Summary Judgment so Plaintiff could immediately appeal this Court's ruling regarding the exclusion of her expert Dr. Wikas.

Accordingly, the Court hereby grants the Defendants' Motion for Summary Judgment with prejudice.

IT IS SO ORDERED.

[Electronic Signature Page to follow.]



Horry Common Pleas

Case Caption: Tara Gurry VS Myrtle Beach Dermatology LLC , defendant, et al

Case Number: 2018CP2605438

Type: Order/Summary Judgment

Presiding Circuit Court Judge

s/Benjamin H. Culbertson, Judge Code 2148

Electronically signed on 2021-07-01 15:14:02 page 4 of 4

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

JUDGMENT IN A CIVIL CASE

CASE NO. 2018CP2605438

Tara Gurry
PLAINTIFF(S)

Myrtle Beach Dermatology LLC et al
DEFENDANT(S)

DISPOSITION TYPE (CHECK ONE)

- ☐ **JURY VERDICT.** This action came before the court for a trial by jury. The issues have been tried and a verdict rendered.
- ☒ **DECISION BY THE COURT.** This action came to trial or hearing before the court. The issues have been tried or heard and a decision rendered.
- ☐ **ACTION DISMISSED (CHECK REASON):** ☐ Rule 12(b), SCRCP; ☐ Rule 41(a), SCRCP (Vol. Nonsuit); ☐ Rule 43(k), SCRCP (Settled);
☐ Other
- ☐ **ACTION STRICKEN (CHECK REASON):** ☐ Rule 40(j), SCRCP; ☐ Bankruptcy;
☐ Binding arbitration, subject to right to restore to confirm, vacate or modify arbitration award;
☐ Other
- ☐ **STAYED DUE TO BANKRUPTCY**
- ☐ **DISPOSITION OF APPEAL TO THE CIRCUIT COURT (CHECK APPLICABLE BOX):**
☐ Affirmed; ☐ Reversed; ☐ Remanded;
☐ Other

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

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

The defendants' pre-trial Motion In Limine to exclude the deposition testimony of plaintiff's expert, Shield M. Wikas, D.O., is GRANTED.

The defendants' pre-trial Motion to Dismiss is GRANTED.

Attorney Marian W. Scalise is to prepare an order.

ORDER INFORMATION

This order ☒ ends ☐ does not end the case.

☐ See Page 2 for additional information.

For Clerk of Court Office Use Only

This judgment was electronically entered by the Clerk of Court as reflected on the Electronic Time Stamp, and a copy mailed first class to any party not proceeding in the Electronic Filing System on 06/28/2021 .

Marian Williams Scalise for Myrtle Beach Dermatology LLC, Shannon Hussey, Richard Hussey
Lydia Lewis Magee for Myrtle Beach Dermatology LLC, Shannon Hussey, Richard Hussey
Tara Gurry for Tara Gurry
Catherine Hunter Holland for Myrtle Beach Dermatology LLC, Shannon Hussey, Richard Hussey
Tara Gurry for Tara Gurry

NAMES OF TRADITIONAL FILERS SERVED BY MAIL

Court Reporter:

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



Horry Common Pleas

Case Caption: Tara Gurry VS Myrtle Beach Dermatology LLC , defendant, et al

Case Number: 2018CP2605438

Type: Order/Electronic Form 4

Presiding Circuit Court Judge

s/Benjamin H. Culbertson, Judge Code 2148

Electronically signed on 2021-06-28 15:58:13 page 3 of 3

COUNTY OF HorryTara Gurry

Plaintiff

vs.

Myrtle Beach Dermatology LLC, Shannon Hussey,
Richard Hussey M.D.

Defendants

Submitted By: Tara GurryAddress: 711 A 3rd Ave. South, North Myrtle Beach, SC 29582

IN THE COURT OF COMMON PLEAS

CIVIL ACTION COVERSHEET

2018-CP - 26 - 054382018 CP26 05438

SC Bar #:

Telephone #: 843-877-5839

Fax#:

Other:

E-mail: photo7721@gmail.com

NOTE: The coversheet and information contained herein neither replaces nor supplements the filing and service of pleadings or other papers as required by law. This form is required for the use of the Clerk of Court for the purpose of docketing. It must be filled out completely, signed, and dated. A copy of this coversheet must be served on the defendant(s) along with the Summons and Complaint.

DOCKETING INFORMATION (Check all that apply)

*If Action is Judgment/Settlement do not complete

- ☒ JURY TRIAL demanded in complaint. ☐ NON-JURY TRIAL demanded in complaint.
- ☐ This case is subject to ARBITRATION pursuant to the Court Annexed Alternative Dispute Resolution Rules.
- ☒ This case is subject to MEDIATION pursuant to the Court Annexed Alternative Dispute Resolution Rules.
- ☐ This case is exempt from ADR. (Proof of ADR/Exemption Attached)

NATURE OF ACTION (Check One Box Below)

☐ Contracts ☐ Constructions (100) ☐ Debt Collection (110) ☐ General (130) ☐ Breach of Contract (140) ☐ Fraud/Bad Faith (150) ☐ Failure to Deliver/Warranty (160) ☐ Employment Discrim (170) ☐ Employment (180) ☐ Other (199)	☐ Torts - Professional Malpractice ☐ Dental Malpractice (200) ☐ Legal Malpractice (210) ☒ Medical Malpractice (220) Previous Notice of Intent Case # 2018-NI- <u>26-00016</u> ☐ Notice/ File Med Mal (230) ☐ Other (299)	☐ Torts - Personal Injury ☐ Conversion (310) ☐ Motor Vehicle Accident (320) ☐ Premises Liability (330) ☐ Products Liability (340) ☐ Personal Injury (350) ☐ Wrongful Death (360) ☐ Assault/Battery (370) ☐ Slander/Libel (380) ☐ Other (399)	☐ Real Property ☐ Claim & Delivery (400) ☐ Condemnation (410) ☐ Foreclosure (420) ☐ Mechanic's Lien (430) ☐ Partition (440) ☐ Possession (450) ☐ Building Code Violation (460) ☐ Other (499)
☐ Inmate Petitions ☐ PCR (500) ☐ Mandamus (520) ☐ Habeas Corpus (530) ☐ Other (599)	☐ Administrative Law/Relief ☐ Reinstate Drv. License (800) ☐ Judicial Review (810) ☐ Relief (820) ☐ Permanent Injunction (830) ☐ Forfeiture-Petition (840) ☐ Forfeiture-Consent Order (850) ☐ Other (899)	☐ Judgments/Settlements ☐ Death Settlement (700) ☐ Foreign Judgment (710) ☐ Magistrate's Judgment (720) ☐ Minor Settlement (730) ☐ Transcript Judgment (740) ☐ Lis Pendens (750) ☐ Transfer of Structured Settlement Payment Rights Application (760) ☐ Confession of Judgment (770) ☐ Petition for Workers Compensation Settlement Approval (780) ☐ Other (799)	☐ Appeals ☐ Arbitration (900) ☐ Magistrate-Civil (910) ☐ Magistrate-Criminal (920) ☐ Municipal (930) ☐ Probate Court (940) ☐ SCDOT (950) ☐ Worker's Comp (960) ☐ Zoning Board (970) ☐ Public Service Comm. (990) ☐ Employment Security Comm (991) ☐ Other (999)
☐ Special/Complex /Other ☐ Environmental (600) ☐ Automobile Arb. (610) ☐ Medical (620) ☐ Other (699) ☐ Sexual Predator (510) ☐ Permanent Restraining Order (680)	☐ Pharmaceuticals (630) ☐ Unfair Trade Practices (640) ☐ Out-of State Depositions (650) ☐ Motion to Quash Subpoena in an Out-of-County Action (660) ☐ Pre-Suit Discovery (670)		

Submitting Party Signature: Tara GurryDate: September 27, 2018

Note: Frivolous civil proceedings may be subject to sanctions pursuant to SCRCF, Rule 11, and the South Carolina Frivolous Civil Proceedings Sanctions Act, S.C. Code Ann. §15-36-10 et. seq.

Effective January 1, 2016, Alternative Dispute Resolution (ADR) is mandatory in all counties, pursuant to Supreme Court Order dated November 12, 2015.

SUPREME COURT RULES REQUIRE THE SUBMISSION OF ALL CIVIL CASES TO AN ALTERNATIVE DISPUTE RESOLUTION PROCESS, UNLESS OTHERWISE EXEMPT.

Pursuant to the ADR Rules, you are required to take the following action(s):

1. The parties shall select a neutral and file a "Proof of ADR" form on or by the 210th day of the filing of this action. If the parties have not selected a neutral within 210 days, the Clerk of Court shall then appoint a primary and secondary mediator from the current roster on a rotating basis from among those mediators agreeing to accept cases in the county in which the action has been filed.
2. The initial ADR conference must be held within 300 days after the filing of the action.
3. Pre-suit medical malpractice mediations required by S.C. Code §15-79-125 shall be held not later than 120 days after all defendants are served with the "Notice of Intent to File Suit" or as the court directs.
4. Cases are exempt from ADR only upon the following grounds:
 - a. Special proceeding, or actions seeking extraordinary relief such as mandamus, habeas corpus, or prohibition;
 - b. Requests for temporary relief;
 - c. Appeals
 - d. Post Conviction relief matters;
 - e. Contempt of Court proceedings;
 - f. Forfeiture proceedings brought by governmental entities;
 - g. Mortgage foreclosures; and
 - h. Cases that have been previously subjected to an ADR conference, unless otherwise required by Rule 3 or by statute.
5. In cases not subject to ADR, the Chief Judge for Administrative Purposes, upon the motion of the court or of any party, may order a case to mediation.
6. Motion of a party to be exempt from payment of neutral fees due to indigency should be filed with the Court within ten (10) days after the ADR conference has been concluded.

**Please Note: You must comply with the Supreme Court Rules regarding ADR.
Failure to do so may affect your case or may result in sanctions.**

STATE OF SOUTH CAROLINA
COUNTY OF HORRY

Tara Gurry,

Plaintiff,

v.

Myrtle Beach Dermatology LLC, Shannon
Hussey, Richard Hussey M.D.,

Defendants.

IN THE COURT OF COMMON PLEAS
FIFTEENTH JUDICIAL CIRCUIT
C.A. No. 2018-CP-26-

20 18 CP26 05438

SUMMONS
(Jury Trial Demanded)

RECEIVED
CLERK OF COURT
HORRY COUNTY, SC
2018 SEP 27 PM 12:47
HORRY COUNTY

TO: DEFENDANTS ABOVE NAMED:

YOU ARE HEREBY SUMMONED AND REQUIRED to answer the Complaint in this action. A copy of the Complaint is attached to this Summons and is herewith served upon you. Your answer must be in writing and signed by you or by your attorney and must state your address or the address of your attorney if signed by your attorney. Your answer must be served upon the Plaintiff within thirty (30) days after the service hereof, exclusive of the day of service, at 711A 3rd Avenue South, North Myrtle Beach, South Carolina 29582.

You are hereby given notice further that, if you fail to appear and defend and fail to answer the Complaint as required by this Summons within thirty (30) days after the service hereof, judgment by default will be rendered against you for the relief demanded in the Complaint.



Tara Gurry
Pro Se Plaintiff
711 A 3rd Ave South
North Myrtle Beach, South Carolina 29582
(843) 877-5839
photo7721@gmail.com

September 27, 2018
North Myrtle Beach, South Carolina

STATE OF SOUTH CAROLINA

COUNTY OF HORRY

Tara Gurry,

Plaintiff,

v.

Myrtle Beach Dermatology, Shannon
Hussey, Richard Hussey, M.D.,

Defendants.

IN THE COURT OF COMMON PLEAS
FIFTEENTH JUDICIAL CIRCUIT
C.A. No. 2018-CP-26-

20 18 CP26 05438

COMPLAINT
(Jury Trial Demanded)

HORRY COUNTY
2018 SEP 27 PM 12:47
RECEIVED
CLERK OF COURT
HORRY COUNTY, SC

Plaintiffs, complaining of the above-named Defendants, alleges as follows:

1. Plaintiff is a citizen and resident of Horry County, South Carolina.
2. That, upon information and belief, Defendant Myrtle Beach Dermatology LLC, is a healthcare practice and is operating by virtue of laws of the State of South Carolina with its principal place of business in Horry County, County, South Carolina.
3. That, upon information and belief, Richard Hussey is a citizen and resident of Horry County, South Carolina, and at all relevant times herein was acting within the course and scope of his agency and employment as a medical doctor with Myrtle Beach Dermatology.
4. That, upon information and belief, Shannon Hussey is a citizen and resident of Horry County, South Carolina, and at all relevant times herein was acting within the course and scope of her agency and employment as a nurse practitioner with Myrtle Beach Dermatology.
5. That, upon information and belief, at all relevant times herein all Defendants were acting by and through their agents and employees who at all such times were acting within the course and scope of their agency and employment making such Defendants liable for their actions and omissions pursuant to the doctrines of *respondeat superior*, apparent or ostensible agency, non-delegable duty, or other law.

6. That this is a medical malpractice action brought pursuant to S.C. Code § 15-36-100.
7. The Plaintiff has filed and served Notice of Intent to File Suit to comply with S.C. Code § 15-79-125 . That mediation was held pursuant to S.C. Code§ 15-36-100 on August 6, 2018 and the parties were unable to reach a settlement.
8. At all relevant times, a health care provider-patient relationship existed between the Plaintiff and Defendants at Myrtle Beach Dermatology. Defendant Mrs. Hussey licensed under the laws of the state of South Carolina, was required to provide reasonable and prudent medical care to Plaintiff Ms. Gurry.
9. Ms. Gurry was diagnosed with malignant melanoma Clarks Level 4 on her right lateral thigh, it was surgica removed by a wide local excision on January 27, 2016. Due to the seriousness of her malignant skin cancer diagnosis Ms. Gurry established a relationship with Myrtle Beach Dermatology and had her first appointnent with Mrs. Hussey on February 22, 2016.
10. Ms. Gurry returned on May 3, 2016, for a scheduled appointment with Mrs. Hussey for a routine skin check. After the skin check Mrs. Hussey looked at the incision site, and stated, "I have something that'll make that look better, I do it all the time" She left the room and returned a few minutes later with full syringe, and injected "kenalog" into a normal healing scar.
11. Upon first injection Ms. Gurry immediately told Mrs. Hussey it hurt, yet she continued injecting along the entire scar 5 inch scar.
12. Ms. Gurry was not informed by Mrs. Hussey of any new "diagnosis", nor about the drug kenalog in any capacity. There was no explanation of the invasive treatment of the kenalog injection, nor were first line non-invasive treatments mentioned. The universal "gold standard" is always non-invasive treatments first not invasive treatments. EXHIBIT D
13. Ms. Gurry become very ill with various systemic side effects and diseases. She endured painful major atrophy, that destroyed subcutaneous tissue, nerves, veins, skin, hair, sweat glands, damaging her iliotibial band, and permanent disfigurement of her leg. Ms. Gurry suffered mental and emotional anguish, pain, and loss of enjoyment of life. Prior to the Date of Loss she was an elite athlete, yoga instructor, and gifted runner that was training for a half marathon yet that all changed as she became encumbered physically, and due to ITB syndrome and pain had to give up her passion for running.

14. Coastal Cancer Center medical records on March 3, 2016 show Ms. Gurry was in great health, on no medication, and the incision was healing normally. Oncologist Dr. Maskow wrote: "Overall, the patient's condition is unchanged...The patient notes no other significant modifying or associated signs or symptoms especially related to location, severity, duration, timing, context or quality...This patient reports not taking external medications."

Dr. Markow thoroughly examined Ms. Gurry's incision both visually and manually, as melanoma is known to return to the primary tumor site. He documents in the medical records : "Right healing incision on the thigh. No significant erythema. Color and texture normal with no subcutaneous masses palpable. No rashes. No petechiae, ecchymosis or purpura. "

15. Ms. Gurry PET/CT scan February 25, 2016 show she was healing well with no loss of subcutaneous tissue from her WLE surgery. PET/CT scan September 21, 2016 show drastic change with major subcutaneous loss and injury from the "kenalog" injections. EXHIBIT F

Ms. Gurry had to go to many medical providers, and the medical records document the many serious side effects of kenalog she suffered including hypothyroidism, menstrual irregularities, severe malaise, muscle loss, bone loss, and mental and emotional anguish. She was diagnosed with diseases and disorders including osteopenia, hypothyroidism, PTSD, major depression single episode, and ITB syndrome. Ms. Gurry went from being a vibrant, happy, healthy, fit and active athlete, to a sick, disfigured, depressed lady that had to take medication, and go to physical therapy.

**FOR A FIRST CAUSE OF ACTION
(Negligence – Medical Malpractice)**

16. Plaintiff realleges all prior allegations as if repeated verbatim herein.

17. Defendants undertook the duty to render medical care to Plaintiff in accordance

with the generally recognized medical practices and procedures which would be exercised by medical providers under the same or similar circumstances.

18. Defendants had a duty to use the reasonable care, skill, and learning that a prudent medical care provider would use under like circumstances in regard to the medical care provided to Plaintiff.

19. Defendants failed to exercise that degree of care and skill ordinarily exercised by medical care providers generally under the same or similar circumstances and like surrounding conditions (the “standard of care”) and were thereby negligent, grossly negligent, reckless, and/or willful and wanton at the time and place hereinabove mentioned in the following particulars:

- a. In failing to give Plaintiff proper care and treatment;
- b. Failure to conduct a thorough examination of the Plaintiff, and the incision site, both visually and manually, no manual exam was performed ;
- c. In failing to have proper policies and procedures in place regarding the administration of an invasive treatment and if such policies exist, in failing to follow them to provide the necessary medical care to the Plaintiff;
- d. In failing to consider, check and refer to intake form, prior medical records and obtain the necessary understanding of Plaintiff’s medical history;
- e. In failing to properly care for Plaintiff’s medical condition of melanoma skin cancer and overall health and wellbeing;
- f. Performing procedure without physician's approval of an invasive injection treatment;
- g. In Misdiagnosing the Plaintiff;

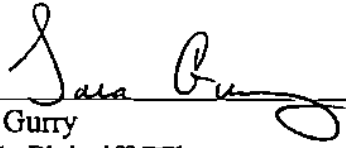
- g. In failing to disclose to the Plaintiff Mrs. Hussey's "diagnosis" of "hypertrophic";
- h. In negligence and incompetence to distinguish a normal healing incision from abnormal scar tissue.
- i. In failing to give any consideration and care to Ms. Gurry's cancer diagnosis of Clarks Level 4 Melanoma and tumor removal surgery just 13 weeks prior;
- j. In failing to inform the Plaintiff of the "gold standard" first line of non-invasive treatment" for a hypertrophic scar, this option was not given to her:
- k. In failing to inform the Plaintiff of the invasive procedure;
- l. In failing to inform the Plaintiff about Kenalog's contraindications, warnings, and side effects;
- m. In failing to take into consideration Ms. Gurry's age at the time, she just turned 49, signifying perimenopausal time may be near, and kenalog is know to cause menstrual irregularities and bone loss.
- n. In failing to obtain an informed consent from the patient prior to procedure;
- o. In negligence to not use a first line non-invasive treatment, silicone sheets are the universal 'gold standard', for both the prevention and the treatment of hypertrophic scars EXHIBIT D ;
- p. Negligent to treat a not fully matured scar with an invasive treatment with many adverse side effects;
- q. Improper administration of kenalog;
- r. In negligence of injecting an immunosupressant drug into a recent melanoma cancer site;
- s. In failing to take necessary precautions to protect Ms. Gurry from injuries including, atrophy and systemic injuries;
- t. In negligence to perform an invasive treatment for superficial aesthetic reasons rather than consider patient's welfare, and well being;
- u. In prescribing metformin without informing of the drug's side effects nor documenting it in medical records, and in prescribing tretonin without informing of the drug's side effects nor documenting it in medical records;

- v. In failing to keep accurate credible medical records, there are inaccuracies in the Plaintiff's medical records;
- w. In deviating from the standard of care for patients such as the Plaintiff;
- x. In failing to take that degree of skill and care which a reasonable person would have done under same or similar circumstances; and,
- z. In such other and further particulars as the evidence compiled in discovery and at trial may disclose.

20. As a direct and proximate result of the negligence, gross negligence, carelessness, recklessness, and/or willful and wantonness of Defendants, the Plaintiff has been injured, and has suffered and will suffer, chronic pain and discomfort, humiliation, disability, fear, anxiety, mental anguish and emotional distress, loss of enjoyment of life, otherwise unnecessary medical, and surgical costs. Ms. Gurry has permanent disfigurement, necrosis, and scarring in her right leg, suffers daily pain with permanent limitations to the range of motion and capabilities of her right leg, and will for the rest of her life. She is unable to enjoy all the activities she did before, including running, and is forced to undergo reconstructive surgeries.

21. The Plaintiff is informed and believes that she is entitled to compensation from Defendants for the aforesaid damages, injuries and losses, jointly and severally, in addition to an award of punitive damages for Defendants' reckless, willful and wanton disregard of Ms. Gurry's health, well-being and life.

WHEREFORE, Plaintiff demands a jury trial and judgment against Defendants, jointly and severally, for actual, and punitive damages, the costs of this action and such other and further relief as this Court deems appropriate.


Tara Gurry
Pro Se Plaintiff ~~771~~
771 A 3rd Ave South
North Myrtle Beach, South Carolina 29582
(843) 877-5839
photo7721@gmail.com

September 27, 2018

North Myrtle Beach, South Carolina

STATE OF SOUTH CAROLINA	)	IN THE COURT OF COMMON PLEAS
	)	
COUNTY OF HORRY	)	C/A NO.: 2018-CP-26-05438
	)	
Tara Gurry,	)	
	)	
Plaintiff,	)	
	)	ANSWER ON BEHALF OF
-vs-	)	DEFENDANTS TO COMPLAINT
	)	
Myrtle Beach Dermatology, LLC, Shannon	)	
Hussey, and Richard Hussey, M.D.	)	
	)	
Defendants.	)	
	)	

The Defendants Myrtle Beach Dermatology, LLC, Shannon Hussey, and Richard Hussey, M.D., answering the Complaint of the Plaintiff, will respectfully show unto the Court as follows:

FOR A FIRST DEFENSE

1. Thee Defendants deny each and every allegation of Plaintiff's Complaint not hereinafter specifically admitted, modified, or explained. Strict proof is demanded.

2. The Defendants admit the allegations of paragraphs one (1), two (2), three (3), and four (4) of the Complaint.

3. With regard to the allegations of paragraph five (5) of the Complaint, the Defendants state that these allegations call for a legal conclusion to which no admission or denial is required. However, if a response is required, the Defendants deny same and demand strict proof thereof. The Defendants specifically deny that there were any deviations from the standard of care or that their alleged actions or inactions proximately caused injury or damage to Plaintiff. Strict proof is demand.

4. With regard to the allegations of paragraphs six (6) and seven (7) of the Complaint, the Defendants state that these allegations call for a legal conclusion to which no

admission or denial is required. However, if a response is required, the Defendants deny same and demand strict proof thereof. Defendants deny all allegations raised in the Notice of Intent to File Suit and the Complaint as well as the expert witness Affidavits and demand strict proof thereof.

5. Answering the allegations of paragraph eight (8) of the Complaint, Defendants deny that Richard Hussey, M.D. had a physician-patient relationship with Ms. Gurry. Strict proof is demanded. The remaining allegations of paragraph eight (8) of the Complaint call for a legal conclusion to which no admission or denial is required. However, if a response is required, the Defendants deny same and demand strict proof thereof.

6. Answering the allegations of paragraph nine (9) of the Complaint, the Defendants crave reference to the medical records and the testimony of the healthcare providers involved for a complete and accurate recitation of the care and treatment provided. All allegations of this paragraph inconsistent with the medical records and the testimony of the healthcare providers involved are denied, and strict proof is demanded.

7. The Defendants deny the allegations of paragraph ten (10) of the Complaint as stated. Defendants crave reference to the medical records and/or medical testimony as to the care and treatment rendered on May 3, 2016. Defendants deny that a “full syringe” of Kenalog was injected into the scar, and Defendants deny that the scar was normal. Strict proof is demanded.

8. The Defendants deny the allegations of paragraphs eleven (11), twelve (12), and thirteen (13) of the Complaint and demand strict proof thereof.

9. Answering the allegations of paragraph fourteen (14) of the Complaint, the Defendants crave reference to the medical records and the testimony of the healthcare providers

involved for a complete and accurate recitation of the care and treatment provided. All allegations of this paragraph inconsistent with the medical records and the testimony of the healthcare providers involved are denied, and strict proof is demanded.

10. The Defendants deny the allegations of paragraph fifteen (15) of the Complaint and demand strict proof thereof.

11. In responding to the allegations of paragraph sixteen (16) of the Complaint, the Defendants incorporate by reference its responses to the allegations of paragraphs one (1) through fifteen (15) of the Complaint as if repeated verbatim.

12. The Defendants admit the allegations of paragraph seventeen (17) of the Complaint, and Defendants admit that they met that duty and acted in accordance at all times with the applicable standard of care. Any allegation to the contrary is denied, and strict proof is demanded.

13. The Defendants admit the allegations of paragraph eighteen (18) of the Complaint.

14. The Defendants deny the allegations of paragraphs nineteen (19) including all subparagraphs, twenty (20), twenty-one (21), and the “wherefore” clause of the Complaint and demand strict proof thereof.

FOR A SECOND DEFENSE

15. The care and treatment administered by Defendants Shannon Hussey and Richard Hussey, M.D. conforms to and was in full compliance with the applicable standard of care. All care and treatment administered by Defendants Shannon Hussey and Richard Hussey, M.D. was within the acceptable medical standards and methods and, at no time pertinent thereto, did Defendants Shannon Hussey and Richard Hussey, M.D. deviate from any medical standard while

caring for or tending to Tara Gurry. Consequently, the Plaintiff is barred from recovery against these Defendants or their employer Myrtle Beach Dermatology, LLC.

FOR A THIRD DEFENSE

16. Defendant Myrtle Beach Dermatology, LLC alleges that its employees and personnel properly cared for, treated, and attended to Tara Gurry under the existing circumstances, and that in the handling of Tara Gurry, they followed proper standards recognized and practiced by similar employers and their employees. This Defendant further alleges that in the handling of Tara Gurry by its employees and personnel, they rendered and practiced that degree of knowledge, care, and skill equal to that of similarly qualified employees and personnel. This Defendant further alleges that the treatment, care, and service rendered to Tara Gurry under the circumstances then existing were in accordance with the standards recognized and practiced by medical offices and employers. Consequently, the Plaintiff is barred from recovery from Myrtle Beach Dermatology, LLC.

FOR A FOURTH DEFENSE

17. That any alleged negligence on the part of the Defendants, which negligence is specifically denied, was not the proximate cause of any alleged injury or damage to Plaintiff.

FOR A FIFTH DEFENSE

18. The alleged injuries of Tara Gurry were, upon information and belief, the result of her underlying medical condition and disease processes which constitute an unavoidable accident by virtue of which the Defendants are not responsible to the Plaintiff in any sum whatsoever.

FOR A SIXTH DEFENSE

19. The Defendants allege, upon information and belief, that any injuries and/or damages sustained by Plaintiff were due to, caused, and occasioned by a natural disease process

over which the Defendants had no control and, as such, plead such natural disease process as a complete bar to this action.

FOR A SEVENTH DEFENSE

20. Whatever injuries the Plaintiff sustained, which are specifically denied herein, were the result of Plaintiff's predisposition to medical conditions, whether disclosed or undisclosed, and were not related to the incidents complained of in the Complaint.

FOR AN EIGHTH DEFENSE

21. Whatever injuries the Plaintiff sustained, which are specifically denied herein, were the result of pre-existing medical conditions of the Plaintiff, whether disclosed or undisclosed, and were not related to the incidents complained of in the Complaint.

FOR A NINETH DEFENSE

22. The Defendants allege, upon information and belief, that any injuries and/or damages sustained by Plaintiff were due to, caused, and occasioned by a natural disease process over which the Defendants had no control and, as such, plead such natural disease process as a complete bar to this action.

FOR A TENTH DEFENSE

23. Defendants allege, as an affirmative defense, that even if Defendants were negligent, careless, grossly negligent, reckless, willful or wanton, which they specifically deny, the Plaintiff's negligent, careless, grossly negligent, reckless, willful and wanton conduct was greater than Defendants' alleged negligence, so this cause of action is barred.

Alternatively, if Plaintiff's negligence was less than Defendants' alleged negligence, the Plaintiff's amount of recovery, if any, should be reduced in proportion to the amount of the Plaintiff's negligence based on the doctrine of comparative negligence.

FOR AN ELEVENTH DEFENSE

24. That the case should be dismissed pursuant to South Carolina Rules of Civil Procedure Rule 12(b)(6) for failure to state facts sufficient to constitute a cause of action against the Defendants.

FOR A TWELFTH DEFENSE

25. The Defendant Dr. Hussey asserts that he did not have a previous doctor/patient relationship with Plaintiff. As such, Dr. Hussey may not be held liable pursuant to S.C. Code Ann. § 15-32-230(B), and this case should be dismissed against him.

FOR A THIRTEENTH DEFENSE

26. Because the alleged acts of negligence occurred after July 1, 2005, this case is subject to the limitations of liability and provisions outlined in the S.C. Noneconomic Damage Awards Act of 2005, S.C. Code Ann. § 15-32-200, et seq.

FOR A FOURTEENTH DEFENSE

27. The Defendants assert that this action is governed by the S.C. Noneconomic Damage Awards Act of 2005, S.C. Code Ann. §15-32-200, et seq. Therefore, if Plaintiff is entitled to any recovery, which the Defendants specifically deny, recovery for any alleged noneconomic damages is capped pursuant to S.C. Code Ann. § 15-32-220.

FOR A FIFTEENTH DEFENSE

28. The Defendants would affirmatively assert that they would be entitled to any and all benefits, joint and several liability protections, emergency situations limitations on liability, any and all monetary limitations or caps of liability and/or damages under the Economic Development, Citizen and Small Business Protection Act and the South Carolina Medical Malpractice Reform Statutes including, but not limited to §15-38-15; §15-32-200; §15-32-210;

§15-32-220; §15-32-230; §15-32-240; §15-36-100; and §15-79-125 and any other applicable provisions under the acts.

FOR A SIXTEENTH DEFENSE

29. Plaintiff's claim for punitive damages should be dismissed pursuant to S.C. Code Ann. § 15-32-520 and S.C. Code Ann. § 15-32-530 in that there is no evidence which would support an award of punitive damages, and the Defendants assert all defenses and limitations of liability provided by statute and case law.

FOR A SEVENTEENTH DEFENSE

30. That any claim for punitive or exemplary damages as set forth in the Plaintiff's Complaint against the Defendants would violate the Defendants' constitutional rights under the due process clause in the Fifth and Fourteenth Amendments to the Constitution of the United States of America, Excessive Fines Clause in the Eighth Amendment to the Constitution of the United States of America, the Double Jeopardy Clause in the Fifth Amendment to the Constitution of the United States of America, and similar provisions in the Constitution of the State of South Carolina and/or the common law and public policies of the State of South Carolina, and/or applicable statutes and court rules, and the Defendants raise these defenses as a complete bar to the imposition of punitive or exemplary damage against them.

FOR A EIGHTEENTH DEFENSE

31. The Defendants reserve any additional and further defenses as may be revealed by additional information during the course of discovery and investigation, as is consistent with the South Carolina Rules of Civil Procedure.

WHEREFORE, having fully responded to the Complaint of the Plaintiff, the Defendants request that the same be dismissed with prejudice together with the costs and disbursements in

the defense of this matter and from such other and further relief as this Court deems just and proper.

Respectfully submitted,

s/Marian Williams Scalise

Marian Williams Scalise, Esquire (SC Bar No. 6744)

Lydia L. Magee, Esquire (SC Bar No. 16584)

Richardson, Plowden & Robinson, P.A.

2103 Farlow Street, P. O. Box 3646

Myrtle Beach, SC 29578

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Attorneys for Defendants Dr. Richard Hussey, Shannon
Hussey, and Myrtle Beach Dermatology, LLC

October 25, 2018.

Myrtle Beach, South Carolina

STATE OF SOUTH CAROLINA	)	IN THE COURT OF COMMON PLEAS
	)	FOR THE FIFTEENTH JUDICIAL CIRCUIT
COUNTY OF HORRY	)	DOCKET NO.: 2018-CP-26-05438
	)	
Tara Gurry,	)	
	)	
Plaintiff,	)	
	)	AMENDED SUMMONS
V.	)	
	)	
Myrtle Beach Dermatology LLC,	)	
Shannon Hussey, Richard Hussey M.D.,	)	
	)	
Defendants.	)	

TO THE DEFENDANTS ABOVE NAMED, AND THEIR ATTORNEY OF RECORD,
 MARIAN WILLIAMS SCALISE, ESQUIRE:

YOU ARE HEREBY SUMMONED and required to answer the Complaint in this action, a copy of which is herewith served upon you, and to serve a copy of your Answer to said Complaint on the subscribed, McKenzie Law Firm PC, PO Box 1686, 204 N. 1st Ave, Dillon, South Carolina 29536, within THIRTY (30) DAYS after the service hereof, exclusive of the date of such service; and if you fail to answer the Complaint within the time aforesaid, judgement by default will be rendered against you for the relief demanded in the Complaint.

MCKENZIE LAW FIRM PC

BY: s/ E. Leary McKenzie
 Attorney for the Plaintiff
 SC Bar No.: 101808
 PO Box 1686
 204 N. 1st Ave.
 Dillon, SC 29536
 (843) 627-4235

Dillon, South Carolina

February 17, 2020

STATE OF SOUTH CAROLINA	)	IN THE COURT OF COMMON PLEAS
	)	FOR THE FIFTEENTH JUDICIAL CIRCUIT
COUNTY OF HORRY	)	DOCKET NO.: 2018-CP-26-05438
	)	
Tara Gurry,	)	
	)	
Plaintiff,	)	
	)	AMENDED COMPLAINT
V.	)	
	)	
Myrtle Beach Dermatology LLC,	)	
Shannon Hussey, Richard Hussey M.D.,	)	
	)	
Defendants.	)	

Plaintiff, complaining of the above-named Defendants, alleges as follows:

1. Plaintiff is a citizen and resident of Horry County, South Carolina.
2. That, upon information and belief, Defendant Myrtle Beach Dermatology LLC, is a healthcare practice and is operating by virtue of laws of the State of South Carolina with its principal place of business in Horry County, South Carolina.
3. That, upon information and belief, Richard Hussey is a citizen and resident of Horry County, South Carolina, and at all relevant times herein was acting within the course and scope of his agency and employment as a medical doctor with Myrtle Beach Dermatology.
4. That, upon information and belief, Shannon Hussey is a citizen and resident of Horry County, South Carolina, and at all relevant times herein was acting within the course and scope of her agency and employment as a nurse practitioner with Myrtle Beach Dermatology.
5. That, upon information and belief, at all relevant times herein all Defendants were acting by and through their agents and employees who at all such times were acting within the course and scope of their agency and employment making such Defendants liable for their actions and omissions pursuant to the doctrines of respondeat superior, apparent or ostensible agency, non-delegable duty, or other law.

6. That this is a medical malpractice action brought pursuant to S.C. Code § 15-36-100.

7. The Plaintiff has filed and served Notice of Intent to File Suit to comply with S.C. Code § 15-79-125. That mediation was held pursuant to S.C. Code § 15-36-100 on August 6, 2018 and the parties were unable to reach a settlement.

8. At all relevant times a health care provider-patient relationship existed between the Plaintiff and Defendants at Myrtle Beach Dermatology. Defendant Mrs. Hussey licensed under the laws of the state of South Carolina, was required to provide reasonable and prudent medical care to Plaintiff Ms. Gurry.

9. Ms. Gurry was diagnosed with malignant melanoma Clark's Level 4 on her right lateral thigh, it was surgically removed by a wide local excision on January 27, 2016. Due to the seriousness of her malignant skin cancer diagnosis Ms. Gurry established a relationship with Myrtle Beach Dermatology and had her first appointment with Mrs. Hussey on February 22, 2016.

10. Ms. Gurry returned on May 3, 2016, for a scheduled appointment with Mrs. Hussey for a routine skin check. After the skin check Mrs. Hussey looked at the incision site, and stated, "I have something that'll make that look better, I do it all the time" She left the room and returned a few minutes later with a full syringe, and injected "Kenalog" into a normal healing scar.

11. Upon first injection Ms. Gurry immediately told Mrs. Hussey it hurt, yet she continued injecting along the entire 5 inch scar.

12. Ms. Gurry was not informed by Mrs. Hussey of any new "diagnosis", nor about the drug Kenalog in any capacity. There was no explanation of the invasive treatment of the Kenalog injection, and nothing else was offered including noninvasive treatments nor letting time heal the incision site.

13. Ms. Gurry become very ill with various systemic side effects and diseases. She endured painful major atrophy, that destroyed subcutaneous tissue, nerves, veins, skin, hair; sweat glands, damaging her iliotibial band, and permanent disfigurement of her leg Ms. Gurry suffered mental and emotional anguish, pain, and loss of enjoyment of life. Prior to the Date of Loss she was an elite athlete, yoga instructor, and gifted runner that was training for a half marathon yet that all changed as she became encumbered physically ,and due to ITB syndrome and pain had to give up her passion for running.

14. Coastal Cancer Center medical records on March 3, 2016 show Ms. Gurry was in great health, on no medication, and the incision was healing normally. Oncologist Dr. Maskow wrote: “[o]verall, the patient's condition is unchanged...[t]he patient notes no other significant modifying or associated signs or symptoms especially related to location, severity, duration, timing, context or quality ... This patient reports not taking external medications.”

Dr. Markow thoroughly examined Ms. Gurry's incision both visually and manually, as melanoma may return to the primary tumor site. He documents in the medical records : “Right healing incision on the thigh. No significant erythema. Color and texture normal with no subcutaneous masses palpable. No rashes, No petechiae, ecchymosis or purpura.”

15. Ms. Gurry’s PET/CT scan February 25, 2016 show she was healing well with no loss of subcutaneous tissue from her WLE surgery, PET/CT scan September 21, 2016 show drastic change with major subcutaneous loss and injury from the “Kenalog” injections. Ms. Curry had to go to many medical providers, and the medical records document the many serious side effects of Kenalog she suffered including cutaneous and subcutaneous atrophy, menstrual irregularities, severe malaise, mental and emotional anguish. She was diagnosed with diseases and disorders including PTSD, major depression single episode, general anxiety, and ITB syndrome. Ms. Gurry

went from being a vibrant, happy, healthy, fit and active athlete, to a sick, disfigured, depressed lady that had to take medication, and go to physical therapy.

FOR A FIRST CAUSE OF ACTION

(Negligence-Medical Malpractice)

16. Plaintiff realleges all prior allegations as if repeated verbatim herein.

17. Defendants undertook the duty to render medical care to Plaintiff in accordance with the generally recognized medical practices and procedures which would be exercised by medical providers under the same or similar circumstances.

18. Defendants had a duty to use the reasonable care, skill, and learning that a prudent medical care provider would use under like circumstances in regard to the medical care provided to Plaintiff.

19. Defendants failed to exercise that degree of care and skill ordinarily exercised by medical care providers generally under the same or similar circumstances and like surrounding conditions (the "standard of care") and were thereby negligent, grossly negligent, reckless, and/or willful and wanton at the time and place hereinabove mentioned in the following particulars:

- a. In failing to give Plaintiff proper care and treatment;
- b. Failure to conduct a thorough examination of the Plaintiff. and the incision site, both visually and manually, no manual exam was performed ;
- c. In failing to have proper policies and procedures in place regarding the administration of an invasive treatment and if such policies exist, in failing to follow them to provide the necessary medical care to the Plaintiff;
- d. In failing to consider, check and refer to intake form, prior medical records and obtain the necessary understanding of Plaintiff's medical history;

- e. In failing to properly care for Plaintiff's medical condition of melanoma skin cancer and overall health and wellbeing;
- f. In negligence of performing an invasive treatment that was not necessary;
- g. In Misdiagnosing the Plaintiff;
- h. In failing to disclose to the Plaintiff Mrs. Hussey's "diagnosis" of "hypertrophic";
- i. In negligence and incompetence to distinguish a normal healing incision from abnormal scar tissue.
- j. In failing to give any consideration and care to Ms. Gurry's cancer diagnosis of Clarks Level 4 Melanoma and tumor removal surgery just 13 weeks prior;
- k. In failing to inform the Plaintiff that hypertrophic scars go away with time and the first line of noninvasive treatment for a hypertrophic scar;
- l. In failing to inform the Plaintiff of the invasive procedure of Kenalog injection;
- m. In failing to inform the Plaintiff about Kenalog's side effects;
- n. In failing to take into consideration Ms. Gurry's age at the time, she just turned signifying perimenopausal time may be near, and Kenalog is known to cause menstrual irregularities and bone loss.
- o. In failing to obtain an informed consent from the patient prior to procedure;
- p. Negligent to treat a not fully matured scar with an invasive treatment with many adverse side effects;
- q. Improper administration of Kenalog;
- r. In failing to take necessary precautions to protect Ms. Gurry from injuries including, atrophy and systemic injuries;

- s. In negligence to perform an invasive treatment for superficial aesthetic reasons rather than consider patient's welfare, and well being;
- t. In failing to keep accurate credible medical records, there are inaccuracies in the Plaintiff's medical records;
- u. In deviating from the standard of care for patients such as the Plaintiff;
- v. In failing to take that degree of skill and care which a reasonable medical provider would have done under same or similar circumstances; and,
- w. In such other and further particulars as the evidence compiled in discovery and at trial may disclose.

FOR A SECOND CAUSE OF ACTION

(Negligent Hiring, Supervision and Retention)

20. Plaintiff realleges all prior allegations as if repeated verbatim herein.

21. At all times hereto, Defendants Richard Hussey, M.D. and Myrtle Beach Dermatology LLC had a duty to provide competent healthcare consistent with the accepted standard of care existing under the same or similar circumstances.

22. At all times relevant hereto, Defendants Richard Hussey, M.D. and Myrtle Beach Dermatology LLC failed to perform the aforesaid duty and were negligent in the following respects:

- a. In the hiring of Defendant Shannon Hussey;
- b. In the supervision of Defendant Shannon Hussey;
- c. In the retention of Defendant Shannon Hussey; and
- d. Being otherwise negligent;

23. As a direct and proximate result of the negligence, gross negligence, carelessness, recklessness, and/or willful and wantonness of Defendants, the Plaintiff has been injured, and has suffered and will suffer, chronic pain and discomfort, humiliation, disability, fear, anxiety, mental anguish and emotional distress, loss of enjoyment of life, otherwise unnecessary medical, and surgical costs. Ms. Gurry has permanent disfigurement, necrosis, and scarring in her right leg, suffers daily pain with permanent limitations to the range of motion and capabilities of her right leg, and will for the rest of her life. She is unable to enjoy all the activities she did before, including running, and is forced to undergo reconstructive surgeries.

24. The Plaintiff is informed and believes that she is entitled to compensation from Defendants for the aforesaid damages, injuries and losses, jointly and severally, in addition to an award of punitive damages for Defendants' reckless, willful and wanton disregard of Ms. Gurry's health, well-being and life.

WHEREFORE, Plaintiff demands a jury trial and judgment against Defendants, jointly and severally, for actual, and punitive damages, the costs of this action and such other and further relief as this Court deems appropriate.

MCKENZIE LAW FIRM PC

BY: s/ E. Leary McKenzie

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(843) 627-4235

Dillon, South Carolina

February 17, 2020

STATE OF SOUTH CAROLINA	)	IN THE COURT OF COMMON PLEAS
	)	
COUNTY OF HORRY	)	C/A NO.: 2018-CP-26-05438
	)	
Tara Gurry,	)	
	)	
Plaintiff,	)	
	)	ANSWER ON BEHALF OF
-vs-	)	DEFENDANTS TO AMENDED
	)	COMPLAINT
Myrtle Beach Dermatology, LLC, Shannon	)	
Hussey, and Richard Hussey, M.D.	)	
	)	
Defendants.	)	
	)	

The Defendants Myrtle Beach Dermatology, LLC, Shannon Hussey, and Richard Hussey, M.D., answering the Amended Complaint of the Plaintiff, will respectfully show unto the Court as follows:

FOR A FIRST DEFENSE

1. The Defendants deny each and every allegation of Plaintiff's Amended Complaint not hereinafter specifically admitted, modified, or explained. Strict proof is demanded.
2. The Defendants admit the allegations of paragraphs one (1), two (2), three (3), and four (4) of the Amended Complaint.
3. With regard to the allegations of paragraph five (5) of the Amended Complaint, the Defendants state that these allegations call for a legal conclusion to which no admission or denial is required. However, if a response is required, the Defendants deny same and demand strict proof thereof. The Defendants specifically deny that there were any deviations from the standard of care or that their alleged actions or inactions proximately caused injury or damage to Plaintiff. Strict proof is demand.
4. With regard to the allegations of paragraphs six (6) and seven (7) of the Amended

Complaint, the Defendants state that these allegations call for a legal conclusion to which no admission or denial is required. However, if a response is required, the Defendants deny same and demand strict proof thereof. Defendants deny all allegations raised in the Notice of Intent to File Suit, the Complaint, and the Amended Complaint as well as the expert witness Affidavits and demand strict proof thereof.

5. Answering the allegations of paragraph eight (8) of the Amended Complaint, Defendants deny that Richard Hussey, M.D. had a physician-patient relationship with Ms. Gurry. Strict proof is demanded. The remaining allegations of paragraph eight (8) of the Amended Complaint call for a legal conclusion to which no admission or denial is required.

6. Answering the allegations of paragraph nine (9) of the Amended Complaint, the Defendants crave reference to the medical records and the testimony of the healthcare providers involved for a complete and accurate recitation of the care and treatment provided. All allegations of this paragraph inconsistent with the medical records and the testimony of the healthcare providers involved are denied, and strict proof is demanded.

7. The Defendants deny the allegations of paragraph ten (10) of the Amended Complaint as stated. Defendants crave reference to the medical records and/or medical testimony as to the care and treatment rendered on May 3, 2016. All allegations of this paragraph inconsistent with the medical records and the testimony of the healthcare providers involved are denied, and strict proof is demanded. Defendants deny that a “full syringe” of Kenalog was injected into the scar, and Defendants deny that the scar was normal. Strict proof is demanded.

8. The Defendants deny the allegations of paragraphs eleven (11), twelve (12), and thirteen (13) of the Amended Complaint and demand strict proof thereof.

9. Answering the allegations of paragraph fourteen (14) of the Amended Complaint, the Defendants crave reference to the medical records and the testimony of the healthcare providers involved for a complete and accurate recitation of the care and treatment provided. All allegations of this paragraph inconsistent with the medical records and the testimony of the healthcare providers involved are denied, and strict proof is demanded.

10. The Defendants deny the allegations of paragraph fifteen (15) of the Amended Complaint and demand strict proof thereof.

11. In responding to the allegations of paragraph sixteen (16) of the Amended Complaint, the Defendants incorporate by reference their responses to the allegations of paragraphs one (1) through fifteen (15) of the Amended Complaint as if repeated verbatim.

12. The Defendants admit the allegations of paragraph seventeen (17) of the Amended Complaint as it pertains to NP Hussey, and Defendants admit that NP Hussey met that duty and acted in accordance at all times with the applicable standard of care. Any allegation to the contrary is denied, and strict proof is demanded. The allegations are denied as to Dr. Hussey as he did not provide any care or treatment to Plaintiff. Strict proof is demanded.

13. The Defendants admit the allegations of paragraph eighteen (18) of the Amended Complaint.

14. The Defendants deny the allegations of paragraphs nineteen (19) including all subparagraphs of the Amended Complaint and demand strict proof thereof.

15. In responding to the allegations of paragraph twenty (20) of the Amended Complaint, the Defendants incorporate by reference their responses to the allegations of paragraphs one (1) through nineteen (19) of the Amended Complaint as if repeated verbatim.

16. The Defendants deny the allegations of paragraph twenty-one (21) of the

Amended Complaint as it pertains to Dr. Hussey as he did not provide any care or treatment to Plaintiff. Strict proof is demanded. Defendants admit that NP Hussey and the practice acted in accordance at all times with the applicable standard of care. Any allegation to the contrary is denied, and strict proof is demanded.

17. The Defendants deny the allegations of paragraphs twenty-two (22), twenty-three (23), twenty-four (24), and the “wherefore” clause of the Amended Complaint, and strict proof is demanded.

FOR A SECOND DEFENSE

18. The care and treatment administered by Defendant Shannon Hussey conforms to and was in full compliance with the applicable standard of care. All care and treatment administered by Defendant Shannon Hussey was within the acceptable medical standards and methods and, at no time pertinent thereto, did Defendant Shannon Hussey deviate from any medical standard while caring for or tending to Tara Gurry. Consequently, the Plaintiff is barred from recovery against Defendant Shannon Hussey or her employer Myrtle Beach Dermatology, LLC.

FOR A THIRD DEFENSE

19. Defendant Richard Hussey, M.D. denies that he provided any care or treatment or had a physician-patient relationship with Tara Gurry, but if he did, he acted at all times within the acceptable medical standards and methods and, at no time pertinent thereto, did Defendant Richard Hussey, M.D. deviate from any medical standard while caring for or tending to Tara Gurry. Consequently, the Plaintiff is barred from recovery against Defendant Richard Hussey, M.D. or his employer Myrtle Beach Dermatology, LLC.

FOR A FOURTH DEFENSE

20. Defendant Myrtle Beach Dermatology, LLC alleges that its employees and personnel properly cared for, treated, and attended to Tara Gurry under the existing circumstances, and that in the handling of Tara Gurry, they followed proper standards recognized and practiced by similar employers and their employees. This Defendant further alleges that in the handling of Tara Gurry by its employees and personnel, they rendered and practiced that degree of knowledge, care, and skill equal to that of similarly qualified employees and personnel. This Defendant further alleges that the treatment, care, and service rendered to Tara Gurry under the circumstances then existing were in accordance with the standards recognized and practiced by medical offices and employers. Consequently, the Plaintiff is barred from recovery from Myrtle Beach Dermatology, LLC.

FOR A FIFTH DEFENSE

21. That any alleged negligence on the part of the Defendants, which negligence is specifically denied, was not the proximate cause of any alleged injury or damage to Plaintiff.

FOR A SIXTH DEFENSE

22. The alleged injuries of Tara Gurry were, upon information and belief, the result of her underlying medical condition and disease processes which constitute an unavoidable accident by virtue of which the Defendants are not responsible to the Plaintiff in any sum whatsoever.

FOR A SEVENTH DEFENSE

23. The Defendants allege, upon information and belief, that any injuries and/or damages sustained by Plaintiff were due to, caused, and occasioned by a natural disease process over which the Defendants had no control and, as such, plead such natural disease process as a complete bar to this action.

FOR AN EIGHTH DEFENSE

24. Whatever injuries the Plaintiff sustained, which are specifically denied herein, were the result of Plaintiff's predisposition to medical conditions, whether disclosed or undisclosed, and were not related to the incidents complained of in the Amended Complaint.

FOR A NINETH DEFENSE

25. Whatever injuries the Plaintiff sustained, which are specifically denied herein, were the result of pre-existing medical conditions of the Plaintiff, whether disclosed or undisclosed, and were not related to the incidents complained of in the Amended Complaint.

FOR A TENTH DEFENSE

26. The Defendants allege, upon information and belief, that any injuries and/or damages sustained by Plaintiff were due to, caused, and occasioned by a natural disease process over which the Defendants had no control and, as such, plead such natural disease process as a complete bar to this action.

FOR AN ELEVENTH DEFENSE

27. Defendants allege, as an affirmative defense, that even if Defendants were negligent, careless, grossly negligent, reckless, willful or wanton, which they specifically deny, the Plaintiff's negligent, careless, grossly negligent, reckless, willful and wanton conduct was greater than Defendants' alleged negligence, so this cause of action is barred.

Alternatively, if Plaintiff's negligence was less than Defendants' alleged negligence, the Plaintiff's amount of recovery, if any, should be reduced in proportion to the amount of the Plaintiff's negligence based on the doctrine of comparative negligence.

FOR A TWELFTH DEFENSE

28. That the case should be dismissed pursuant to South Carolina Rules of Civil

Procedure Rule 12(b)(6) for failure to state facts sufficient to constitute a cause of action against the Defendants.

FOR A THIRTEENTH DEFENSE

29. The Defendant Dr. Hussey asserts that he did not have a doctor/patient relationship with Plaintiff. As such, Dr. Hussey may not be held liable, and this case should be dismissed against him.

FOR A FOURTEENTH DEFENSE

30. Because the alleged acts of negligence occurred after July 1, 2005, this case is subject to the limitations of liability and provisions outlined in the S.C. Noneconomic Damage Awards Act of 2005, S.C. Code Ann. § 15-32-200, et seq.

FOR A FIFTEENTH DEFENSE

31. The Defendants assert that this action is governed by the S.C. Noneconomic Damage Awards Act of 2005, S.C. Code Ann. §15-32-200, et seq. Therefore, if Plaintiff is entitled to any recovery, which the Defendants specifically deny, recovery for any alleged noneconomic damages is capped pursuant to S.C. Code Ann. § 15-32-220.

FOR A SIXTEENTH DEFENSE

32. Should evidence of failure by Plaintiff to mitigate damages be developed during discovery, Defendants plead Plaintiff's failure to mitigate as a bar to all applicable claims and damages herein.

FOR A SEVENTEENTH DEFENSE

33. The Defendants would affirmatively assert that they would be entitled to any and all benefits, joint and several liability protections, emergency situations limitations on liability, any and all monetary limitations or caps of liability and/or damages under the Economic

Development, Citizen and Small Business Protection Act and the South Carolina Medical Malpractice Reform Statutes including, but not limited to §15-38-15; §15-32-200; §15-32-210; §15-32-220; §15-32-230; §15-32-240; §15-36-100; and §15-79-125 and any other applicable provisions under the acts.

FOR AN EIGHTEENTH DEFENSE

34. Plaintiff's claim for punitive damages should be dismissed pursuant to S.C. Code Ann. § 15-32-520 and S.C. Code Ann. § 15-32-530 in that there is no evidence which would support an award of punitive damages, and the Defendants assert all defenses and limitations of liability provided by statute and case law.

FOR A NINETEENTH DEFENSE

35. That any claim for punitive or exemplary damages as set forth in the Plaintiff's Amended Complaint against the Defendants would violate the Defendants' constitutional rights under the due process clause in the Fifth and Fourteenth Amendments to the Constitution of the United States of America, Excessive Fines Clause in the Eighth Amendment to the Constitution of the United States of America, the Double Jeopardy Clause in the Fifth Amendment to the Constitution of the United States of America, and similar provisions in the Constitution of the State of South Carolina and/or the common law and public policies of the State of South Carolina, and/or applicable statutes and court rules, and the Defendants raise these defenses as a complete bar to the imposition of punitive or exemplary damage against them.

FOR A TWENTIETH DEFENSE

36. The Defendants reserve any additional and further defenses as may be revealed by additional information during the course of discovery and investigation, as is consistent with the South Carolina Rules of Civil Procedure.

WHEREFORE, having fully responded to the Amended Complaint of the Plaintiff, the Defendants request that the same be dismissed with prejudice together with the costs and disbursements in the defense of this matter and from such other and further relief as this Court deems just and proper.

Respectfully submitted,

s/Marian Williams Scalise
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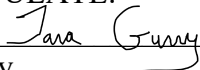
Attorneys for Defendants Dr. Richard Hussey, Shannon
Hussey, and Myrtle Beach Dermatology, LLC

February 25, 2020.
Myrtle Beach, South Carolina

STATE OF SOUTH CAROLINA	)	IN THE COURT OF COMMON PLEAS
	)	
COUNTY OF HORRY	)	C/A NO.: 2018-CP-26-05438
	)	
Tara Gurry,	)	
	)	
Plaintiff,	)	
	)	STIPULATION OF DISMISSAL
-vs-	)	AS TO SECOND CAUSE OF
	)	ACTION IN AMENDED
Myrtle Beach Dermatology, LLC, Shannon	)	COMPLAINT
Hussey, and Richard Hussey, M.D.	)	
	)	
Defendants.	)	
	)	

The Plaintiff herein dismisses the second cause of action in the First Amended Complaint filed in the above-referenced lawsuit against the Defendants pursuant to Rule 41(a)(1)(ii) of the South Carolina Rules of Civil Procedure. The case will proceed as to first cause of action only. Each side will bear its own costs, expenses, and attorneys' fees.

I SO STIPULATE:


 Tara Gurry
 711A 3rd Avenue South
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Photo7721@gmail.com
 Pro Se Plaintiff

WE CONSENT:

s/ Marian W. Scalise

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 Attorney for Defendants Dr. Richard Hussey, Shannon Hussey,
 and Myrtle Beach Dermatology, LLC

Jun 20 2022

SC Court of Appeals

Certificate of Counsel

The undersigned counsel for Appellant certifies that, in accordance with Rule 210(c), SCACR, this **Record on Appeal** contains all material proposed to be included by any party that was presented to the lower court and not any other material. The undersigned also certifies that this **Record on Appeal** complies with the Supreme Court of South Carolina's Revised Order Concerning Personal Identifying Information and Other Sensitive Information in Appellate Court Filings issued April 15, 2014.

Respectfully submitted,

Tara Gurry

A handwritten signature in cursive script, reading "Tara Gurry", is written over a horizontal line.

North Myrtle Beach, South Carolina

711 A 3rd Avenue South

June 20, 2022

North Myrtle Beach, SC 29582

843-877-5839

Appellant-Pro Se Litigant