

THE STATE OF SOUTH CAROLINA
In The Court of Appeals

APPEAL FROM CHARLESTON COUNTY
Court of Common Pleas

Bentley D. Price, Circuit Court Judge

Case No. 2017-CP-10-02758
Appellate Case No. 2019-001716

Jeane Whitfield,

Appellant,

v.

Dennis K. Schimpf, M.D. and
Sweetgrass Plastic Surgery,
LLC,

Respondents.

RECORD ON APPEAL – VOLUME III

Daniel S. Slotchiver
Andrew J. McCumber
Slotchiver & Slotchiver, LLP
751 Johnnie Dodds Boulevard, Suite 100
Mount Pleasant, South Carolina 29464
(843) 577-6531

Brent S. Halversen
Brent Souther Halversen, LLC
751 Johnnie Dodds Blvd., Suite 200
Mount Pleasant, South Carolina 29464
(843) 284-5790

Jesse Sanchez
The Law Office of Jesse Sanchez, LLC
98 ½ Broad Street, Suite B
Charleston, South Carolina 29401
(843) 814-8181
Attorneys for Appellant

Todd Smyth
Joshua S. Whitley
Kevin Horton
Smyth Whitley, LLC
126 Seven Farms Drive
First Citizens Plaza, Suite 260
Charleston, South Carolina 29492
(843) 606-5635
Attorneys for Respondents

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1 next witness is plaintiff's expert Dr. Rosenberg. We had
2 previously filed a motion in limine concerning a certain
3 aspect of his testimony.

4 When he gave his deposition testimony in this case
5 earlier he offered the opinion on a couple of occasions that
6 the defendant's actions were reckless. And it is our
7 contention that that is beyond the scope of testimony that an
8 expert should be able to offer in a case because it goes to a
9 matter of law. And we think it is outside of Rule 702 of
10 Rules of Evidence.

11 And we would cite you to a case that we believe -- we can
12 hand up -- it is the Dawkins versus Fields. And if you need a
13 cite it is -- do you ever use South Carolina Reporter or
14 S.C.2d?

15 LAW CLERK: Either way.

16 THE COURT: What is your question?

17 MR. SMYTH: Either way? The cite is Dawkins versus
18 Fields, 354 S.C. 58. I have got a copy. The section of the
19 opinion we are relying on, Your Honor, is found on Page 608,
20 Head Note 4.

21 It essentially stands for the proposition that in general
22 expert testimony on issues of law is inadmissible because it
23 is outside of 702.

24 So we believe it is okay for this witness to talk about
25 breaching the standard of care in negligence, but for him to

1 take the additional step of trying to impugn the defendants
2 with an allegation of recklessness is outside the scope of his
3 purview.

4 THE COURT: Okay.

5 What is your position?

6 MR. SLOTCHIVER: It is interesting, in light of the fact
7 that their expert has testified that Dr. Kalus was dumb, dumb,
8 dumb, unethical, and went on and on and on. But regardless --
9 and that is in his testimony.

10 But regardless of that, he is not testifying as to an
11 issue of law. He is an expert in the medical field. He is
12 testifying that in his opinion that the conduct of -- that the
13 conduct was beyond negligent, it was reckless.

14 And in fact this is a case -- it is not bifurcated. So
15 there is a punitive component to the case, the one we are
16 moving forward with. And under the punitive component, one of
17 the elements that we will need to move forward to the jury is
18 going to be that of reckless conduct. And his opinion and his
19 -- and his -- based on his training in the medical field and
20 what he has seen and what he sees.

21 THE COURT: Well, what -- Mr. Smyth, the unique aspect of
22 it is I mean these people are testifying as to the breach of
23 the duty of standard of care, which obviously is a matter of
24 law as well; and one of the jury charges that we are going to
25 have, I assume, potentially may be recklessness for the

1 purposes of the punitive damages. And the charge that they
2 would get if he did testify to his -- if I did let it in,
3 would be recklessness is the knowing failure to exercise
4 reasonable care under all of the surrounding circumstances.
5 An act is reckless if it is committed in a manner and under
6 circumstances which a person of ordinary reason and prudence
7 would know would invade the rights of the injured person.

8 So, I mean, I think they're going to get -- I mean, I --
9 we haven't had the charge conference; but I think we're going
10 to end up charging this one, because this is recklessness
11 under the negligence charges.

12 And your position is is that it goes above and beyond
13 what the negligence standard is, which is duty and breach of
14 the duty of standard of care. And your contention is that
15 this is an issue of law?

16 MR. SMYTH: Yes, sir, Your Honor.

17 And it's outside the scope of Rule 702. So 702 is
18 designed to help the trier of fact understand technical
19 issues. It's not designed to give them legal conclusions.
20 That's the job for the jury to do.

21 Mr. Slotchiver certainly is capable and willing to argue
22 recklessness in his closing argument, and they've got that
23 evidence in there. I think it's a different matter to let an
24 expert opine as to the legal standard associated with it.

25 MR. SLOTCHIVER: Your Honor, he is not giving a legal

1 opinion. He's giving his opinion about the conduct of the
2 doctor in the medical profession, as a medical professional
3 who -- as a medical professional who is himself an expert in
4 the field.

5 The jury is not going -- the jury obviously is going to
6 be instructed they can consider part, all, some, or none of
7 the expert's testimony and that the experts are just witnesses
8 like everyone else. And if they've understood from your
9 opening remarks then they'll understand from your closing
10 remarks and your charges that they are the fact finders to
11 determine it.

12 But he's not giving a legal opinion. He can't give a
13 legal opinion. But he can give an expert opinion in the field
14 of medicine. And this -- and it really dovetails directly
15 into the charge that you just read a moment ago. Because
16 that's exactly what he's saying. And that's exactly what he
17 will be saying.

18 I'm not sure how we could ever really get to punitive
19 damages. I would have to think ---

20 THE COURT: Well, it says if a scientific, technical,
21 or -- this is Rule 702. If scientific, technical, or other
22 specialized knowledge will assist the trier of fact to
23 understand the evidence or to determine a fact in issue, a
24 witness qualified as an expert by knowledge, skill,
25 experience, training, or education, may testify thereto in the

1 form of an opinion or otherwise.

2 And your contention is that the fact that he believes his
3 actions to be reckless is not a factual issue, but a issue of
4 law?

5 MR. HORTON: Yes, Your Honor. And that's one for the
6 Court to decide, not the ---

7 THE COURT: Well, I mean, punitive damages are going to
8 be involved in this. And if he wants to say that his acts
9 were reckless and it's a -- it's a fact for the jury to
10 determine and consider, I'll allow him to do it.

11 All right. Are you ready to call your next witness?

12 MR. SLOTCHIVER: Yes, sir.

13 THE COURT: Is the jury ready?

14 THE BAILIFF: Yes, sir.

15 THE COURT: All right. Mr. Robinson, if you'll grab them
16 for me, please. I appreciate it.

17 [Whereupon, the jury enters the courtroom 8/28/19, 1:39
18 p.m.]

19 THE COURT: All right. Thank you very much.

20 All right. We're getting closer. I was ready at 1:30
21 and the microphones went out, so that one -- you can't blame
22 me for that one. We were ready. So we were trying to get the
23 microphones fixed.

24 Obviously, as I discussed yesterday with the witness -- I
25 mean, I have the opposite issue; you can hear me from a mile

1 away. But I'll make sure the witness speaks up. If y'all
2 have any problems hearing, just let the bailiffs know and
3 they'll tell me. All right?

4 All righty. Call your next witness.

5 MR. HALVERSEN: Your Honor, the plaintiff would like to
6 call Dr. Michael Rosenberg to the stand.

7 THE COURT: All right.

8 [Whereupon, Dr. Rosenberg comes forward]

9 [Whereupon, the witness is sworn by the clerk of court,
10 8/28/19, 1:40 p.m.]

11 THE CLERK OF COURT: You may be seated.

12 [Whereupon, the witness takes the witness stand]

13 THE CLERK OF COURT: And for the record, please state
14 your full name, spelling your last.

15 THE WITNESS: My name is Michael Howard Rosenberg. Last
16 name is spelled R-O-S-E-N-B-E-R-G.

17 MR. HALVERSEN: Good afternoon, Dr. Rosenberg.

18 THE WITNESS: Good afternoon.

19 MICHAEL H. ROSENBERG, M.D., Having Been First Duly Sworn, was
20 Examined and Testified as Follows:

21 **DIRECT EXAMINATION BY MR. HALVERSEN OF DR. MICHAEL ROSENBERG:**

22 Q. For the benefit of the jury, where did you go to college
23 and medical school?

24 A. So I went to college at Columbia College in the City of
25 New York; and then I went to medical school at the Columbia

1 College of Physicians and Surgeons, also in New York.

2 Q. And could you please tell the jury about your residency
3 and your training?

4 A. Fair enough. I completed five years of general surgery
5 training at Columbia Presbyterian Medical Center. And then I
6 did an additional two and a half years of training in plastic
7 surgery, also at Columbia Presbyterian Medical Center.

8 Q. And what year did you start practicing?

9 A. I began my practice in 1995.

10 Q. And have you been in practice since then?

11 A. Continuously, other than army service.

12 Q. And what -- what did you do in the Army?

13 A. I'm now a retired colonel. I worked in the medical
14 corps, and I was called away from my practice during Iraqi
15 Freedom and the Afghan conflict.

16 Q. Where are you licensed, Dr. Rosenberg?

17 A. I'm licensed in the state of New York.

18 Q. Have you ever had any complaints taken against your
19 license?

20 A. No, I have not.

21 Q. Have you ever had any actions taken against your hospital
22 privilege or any limitations placed on you?

23 A. No, I have not.

24 Q. Have you ever been asked to leave a hospital before?

25 A. No.

1 Q. Have you ever been told by a hospital that you could
2 never be rehired by them?

3 A. No, I have not.

4 Q. Do you hold any board certifications?

5 A. Yes, I do.

6 Q. What are they?

7 A. So I am certified by the American Board of Plastic
8 Surgery. It's a ten-year certification, so I re-certified in
9 2008 and then re-certified again in 2018. And I hope to
10 retire before I need to do it a fourth time. I also have
11 boards in cosmetic surgery, which is a non-ABMS Board.

12 Q. Are you a member of any surgical societies or groups?

13 A. Yes, I am.

14 Q. And what are those?

15 A. The American Society of Plastic Surgeons. I'm a fellow
16 of the American College of Surgeons and a member of local
17 societies, state, AMA; that type of thing.

18 Q. And who is your current employer?

19 A. I work for Northwell Health. It's a conglomeration of 22
20 hospitals, a medical school, and 5,200 physicians in New York.

21 Q. And is your practice -- where in -- where in New York is
22 it?

23 A. So I'm located just north of the city in Westchester
24 County, New York, a town called Chappaqua.

25 Q. How many physicians are in your practice?

1 A. Well, there's the large group that I'm part of. But
2 specifically in my own practice there are four.

3 Q. What about the entire group of physicians?

4 A. It's about 5,200 physicians.

5 Q. How would you describe the scope of your current
6 practice?

7 A. I am a practicing plastic surgeon. That's where I spend
8 the majority of my time. And then I'm also the associate
9 medical director at my hospital.

10 Q. What about specifically in terms of the types of
11 procedures that you do in terms of cosmetic or any other
12 different kind?

13 A. Sure. So my practice is pretty much divided into
14 cosmetic surgery and reconstructive surgery; cosmetic being
15 surgery to improve appearance, and reconstructive being
16 surgery to kind of restore appearance in a broad sense.
17 That's pretty much where I am.

18 Q. What kind of procedure did Mrs. Whitfield undergo with
19 the defendants in this case?

20 A. Well, it was an augmentation mastopexy, technically
21 removing implants and replacing them, and then doing a breast
22 lift at the same time.

23 Q. And have you performed that kind of surgery before?

24 A. Many times.

25 Q. How many times in your career do you think you've

1 performed that type of surgery?

2 A. About, I don't know, twenty, twenty-five a year. So
3 maybe four or five hundred; somewhere in that range.

4 Q. Have you ever taught in an academic setting procedure
5 that is -- that Mrs. Whitfield underwent, the one you just
6 described?

7 A. So my hospital is not an academic teaching hospital, but
8 we do actually have a postgraduate fellowship, surgeons that
9 have already trained but want to learn more about breast
10 surgery in particular. And I am the associate director of
11 that program. So, yes, I've taught -- pretty much taught
12 trained surgeons, not so much medical students or residents.

13 Q. I understand. Thanks.

14 MR. HALVERSEN: Your Honor, at this time we would like to
15 offer Dr. Rosenberg as an expert in the field of plastic
16 surgery.

17 THE COURT: All right. Any objection?

18 MR. SMYTH: No objection, Your Honor.

19 THE COURT: All right. And, again, members of the jury,
20 experts are qualified as experts because they can give their
21 opinion, unlike a lay witness. So that's what we have done in
22 this situation.

23 Q. And I know you just told us about your background. And
24 you're also here today. And explain to the jury in what
25 capacity you're here today for.

1 A. So I'm here today as an expert witness, as the judge
2 said, to give my opinion on the facts of what happened. And
3 I've been retained by the plaintiff in this particular
4 situation. And so I'm an expert; but my opinions, actually
5 after I reviewed them, coincide with the plaintiff.

6 Q. And how long have you been doing this type of work?

7 A. I'd say about fifteen, sixteen years.

8 Q. And have you been retained in different jurisdictions in
9 the country, or just this state?

10 A. No, I've been to this -- to Carolina. I've been to West
11 Virginia, Ohio, Colorado, Florida, probably around seven or
12 eight states - Connecticut - altogether.

13 Q. Have you been retained to represent and defend doctors as
14 well as patients?

15 A. Oh, yeah.

16 Q. Have you ever testified in a trial before?

17 A. I have a few times. Maybe four or five times.

18 Q. And are you being paid by Mrs. Whitfield to be present
19 here today?

20 A. Yes, I am.

21 Q. And did you leave your plastic surgery practice in New
22 York to be with us here today?

23 A. So I left my practice around twelve o'clock yesterday,
24 and I hope to be back at work tomorrow morning. We'll see how
25 it goes.

1 Q. All right. We'll try. I think you will be alright.

2 If you hadn't been here today, is it fair to say you
3 probably would have had a surgery scheduled for this day?

4 A. Oh, yeah. I pretty much either operate or see patients
5 five days a week.

6 Q. Okay. And what percentage of your income is derived from
7 doing this type of work?

8 A. Somewhere over the last fifteen, sixteen years it's
9 between two to five percent.

10 Q. And for to be here today, how much -- how much has Mrs.
11 Whitfield paid you to be here today?

12 A. \$12,000 for travel and being here.

13 Q. And is that your going rate to attend a trial?

14 A. Yeah. That's the same for defense, plaintiff, anybody.

15 Q. Okay. And does that -- it could be here or it could be
16 in Washington State or California; is the rate the same?

17 A. It really depends on how much time I need to be away from
18 my practice. So if it was local and I could only be away half
19 a day, it would be \$7,000.

20 Q. Okay. But since you're here a full day, you've
21 charged ---

22 A. \$12,000.

23 Q. And you came into town when?

24 A. Yesterday. I think the flight arrived around 4:30.

25 Q. And you're planning on leaving this afternoon or tonight?

1 A. I'm hoping to leave tonight, yes.

2 Q. Okay. Doctor, what was your understanding of why Mrs.
3 Whitfield went to Dr. Schimpf?

4 A. So from the online form that I saw, and also from her
5 testimony, I think it was related to an abdominal complaint.

6 Q. Were there any medical records that were taken by the
7 defendants preoperatively that documented why Mrs. Whitfield
8 came to Dr. Schimpf's care?

9 A. Unfortunately, there were no records that I saw.

10 Q. That would be the preoperative consults?

11 A. Preoperative consults, assessment of what the issues
12 were, plan on what to do, photographs. All I saw was
13 essentially, I think it was some consent forms and billing
14 forms for the proposed surgery that were taken prior to
15 surgery.

16 Q. Did -- was there any kind of documentation by the
17 defendants, Dr. Schimpf or Sweetgrass, as to why they believed
18 a mastopexy augmentation would be an appropriate procedure to
19 relieve her pain?

20 A. I did not see any documentation done pre-operatively that
21 described what her complaints were what -- that were taken by
22 the defendant that described her complaints, or assessment or
23 plan or anything like that.

24 Q. Do you believe in this case that would have been an
25 appropriate thing for a plastic surgeon in that situation to

1 do?

2 A. Well, I think it's very clear that the standard of care
3 requires that one take medical and record medical records from
4 a patient that you're going to treat.

5 Q. And with -- and I'm talking specifically with regard to
6 documenting why she was there and the rationale that the
7 physician might have had for undertaking the procedure he
8 undertook in the face of a complaint of pain.

9 A. That's absolutely critical. In fact, that's something
10 that we first learn as medical students. At Columbia they
11 taught us when you see a patient you do a SOAP note, they
12 called it: subjective, what's going on, what they're
13 complaint is; objective, what your exam is; assessment, you've
14 got to come up with something; and then a plan, even if the
15 plan is no further treatment needed, come see me next year,
16 but some kind of plan. And I didn't see any of that.

17 Q. And is that kind of what you're telling us, so that's
18 something that you're taught in medical school?

19 A. Yes. In American medical schools.

20 Q. Do you know whether that's taught in foreign medical
21 schools in the Caribbean?

22 A. I have no idea.

23 Q. Do you believe that it's a deviation in the standard of
24 care for a plastic surgeon not to record their interactions
25 with the patient?

1 A. Yes.

2 Q. Explain to the jury what that means, the term deviation
3 and a standard of care. Put it in layman's terms.

4 A. Certainly. So my understanding of what the standard of
5 care means is that's what a prudent, similar specialty surgeon
6 or similar specialty doctor would do given similar
7 circumstances at the time something occurred. So it's
8 basically what -- what -- not necessarily the best physician
9 would do, but what a good physician would do.

10 Q. A reasonably prudent physician?

11 A. A competent physician.

12 Q. What, in your professional opinion, is it -- is it
13 appropriate to perform a surgery on a patient without their
14 consent?

15 A. Absolutely not.

16 Q. Does a physician have a duty or an obligation or a
17 standard of care to obtain a consent for a surgery that they
18 plan to undertake on a patient?

19 A. Certainly. I think that's -- that's as clear as day.

20 Q. Is it a deviation in the standard of care, as a
21 physician, to do a procedure on a patient that was not
22 consented to?

23 A. It is a deviation from the standard of care to operate on
24 someone without their permission.

25 Q. And what is your understanding as to the procedure that

1 the defendants undertook to Mrs. Whitfield's neck?

2 A. So according to the operative note, there was a
3 liposuction done on the patient's neck.

4 Q. And to do that without permission would be a deviation of
5 the standard of care?

6 A. Very much so.

7 Q. And part of that opinion is, do you believe, that the
8 defendants caused damage to Mrs. Whitfield based upon their
9 testi- -- based upon her testimony, performing the procedure
10 to her neck without her permission?

11 A. I think it's completely clear that if you operate on
12 someone without their permission, that it's going to do harm.
13 At the least, it's going to put a tremendous wedge in the
14 physician-patient relationship, which is critical if a
15 patient's having a problem.

16 I mean, trust, physician of the patient, patient of the
17 physician, is critically important. And if something like
18 that happens, I think it's going to affect the subsequent
19 relationship and subsequent care.

20 In addition, you know, if you've gone through a procedure
21 that you didn't want to have, you're going to have a scar
22 that -- you know, that's -- it could be small, it could be
23 whatever; but it's something that you didn't sign up for. So
24 I think it very much causes harm.

25 Q. What about psychological harm or psychological damage,

1 would you expect that a patient would have psychological
2 consequences for undergoing a procedure without their consent?

3 A. Let me put it this way. I'm not a expert in psychiatry;
4 but, you know, if I make my children wear something they don't
5 want to, they get upset. I can't imagine how having an
6 operation that you didn't agree to is not going to have
7 significant effect on someone going forward. It just stands
8 to reason.

9 Q. Do you believe that it's reckless for a physician to do a
10 surgery that's not consented to by the patient?

11 A. Yes, I do.

12 Q. Do you believe that it's reckless as a plastic surgeon to
13 do a liposuction to the neck without any permission?

14 A. Well, that's something I am an expert in. And in plastic
15 surgery, to do an operation, liposuction or -- on someone's
16 neck and not have permission, is a deviation from the standard
17 of care.

18 Q. And in your professional opinion, do you believe that Dr.
19 Schimpf was reckless in performing a procedure on Ms.
20 Whitfield's neck without her permission?

21 A. I do.

22 Q. And we all know what the word reckless means. But do you
23 have a -- from your perspective as being a plastic surgeon, as
24 being a physician, in evaluating the defendant's standard of
25 care, do you have a way you think of the word recklessness or

1 reckless?

2 A. Well, I ---

3 MR. SMYTH: Objection, Your Honor. I think that's
4 outside of the scope of the expert's area of expertise.

5 THE COURT: Ask the question again.

6 Q. Do you have an opinion as to how you define the word
7 reckless?

8 THE COURT: I'll sustain the objection. Move on.

9 Q. Do you believe Dr. Schimpf put his patient in harm's way,
10 despite knowing better?

11 A. Yes, I do. That's what I meant by reckless.

12 Q. In your review of the medical records did you see any
13 piece of paper at the defendant's medical office that
14 indicated that before the procedure the defendants had planned
15 to do a liposuction on Mrs. Whitfield's neck?

16 A. No, I did not. I didn't see a bill for it. I didn't see
17 any evidence of a discussion of it. I saw a lot of pages of
18 consents with a lot of different procedures on them, and none
19 of them said liposuction of the neck.

20 And I believe I remember in the defendant's deposition
21 that he answered a question that he has such a form that talks
22 about liposuction of the neck, and yet it wasn't used in this
23 situation.

24 Q. And if in fact the defendants did have permission to
25 operate on the neck, would you have expected the defendants to

1 have used that form for the liposuction of the neck?

2 A. Given what I saw with the other consents, absolutely.

3 Q. Now, and I'm going to ask you a slightly different
4 question. Did you see anything in what medical records are
5 available, that indicated that Mrs. Whitfield wanted anything
6 done to her neck or her chin?

7 A. I would have to say the opposite. I mean, the only thing
8 I saw was in her deposition where she was pretty clear that
9 she didn't want to have it done.

10 But I didn't see anything that says that it was going to
11 be done. The pre-opera- -- the the actual operative note, it
12 lists the procedures, the indications; but it didn't have
13 liposuction of the neck in it.

14 The anesthesia form did, because it was done. And the
15 actual description of the procedure had it in there, because
16 it was done. But it didn't look like there was a plan to do
17 it, that I could see.

18 And so I understand that there's a difference of opinion
19 between plaintiff and defendant on whether there was such a
20 discussion, but there's a lot of other evidence that suggests
21 there wasn't such a discussion.

22 Q. And could you tell the jury what that other evidence is?

23 A. Well, it's all the things that we've already talked
24 about. The multiple other consents, and yet the lack of this
25 one. The lack of a bill. I mean, you know, we -- I love what

1 I do, but I also charge for it. I mean, I don't go around
2 doing surgeries for free.

3 So if I was planning to do a liposuction on the neck,
4 there are risks involved, there are other issues; I would
5 charge for it.

6 So I guess I struggled with your question because the
7 evidence is negative evidence, for the most part. It's all
8 the things that should be there that aren't. Nowhere does it
9 say, I'm doing this procedure without permission.

10 Q. And for that procedure, liposuction to the neck, is that
11 something that you as a plastic surgeon would expect to be
12 compensated for?

13 A. Yes.

14 Q. It's something you would charge for?

15 A. Absolutely. It requires knowledge, skill, care; and it's
16 -- again, that's -- you know, we do charge for our work.

17 Q. And just -- I think you discussed it, but just I want to
18 make sure the jury understands. How do we actually know there
19 are any records that indicate that -- from the defendants that
20 the liposuction to the neck was performed, and what were those
21 records?

22 A. Well, the anesthesia note -- when there's surgery,
23 there's a note from the surgeon about what they did. And then
24 the anesthesiologist will also write a note on what happened.
25 And, again, that's the important of notes. That's what we do.

1 And in this situation the anesthesiologist mentioned in
2 their note that there was liposuction to the neck. And in
3 the -- I think it was right at the beginning of the operative
4 note it talked about putting fluid in the neck, which is how
5 you start liposuction of the neck, and then using a certain
6 cannula, three millimeters in diameter, to then do the
7 liposuction. And I think it said 100 was put in and 75 was
8 taken out.

9 So it was definitely done. There's no question that
10 there's evidence - let me put it that way - that it was done.
11 Q. Can you explain to the jury what a cannula is and whether
12 there are risks associating with inserting a cannula into
13 someone's neck?

14 A. So liposuction is actually pretty straightforward. We
15 put anesthesia in and fluid in, to the area that we want to
16 treat. Here it would be the fat under the neck; you know, the
17 area between the skin and the muscle, which has fat, under the
18 neck. And that fluid is medicine in it. So it prevents
19 bleeding and it controls pain. Lots of good stuff.

20 Then what we do is we actually use a hollow tube that we
21 call a cannula. And there are different sizes. I don't know
22 that I'd use a three millimeter in the neck. That seems a
23 little big. But that's fine. There are different sizes that
24 we use. And then we literally move this tube, this hollow
25 tube, back and forth. And it connects to a suction machine.

1 And so the movement breaks up the fat and the -- and the
2 suction machine pulls it out. So that's liposuction of the
3 neck. And that's what a cannula is.

4 And you asked me about risks with that?

5 Q. Yes, sir.

6 A. So it's a metal tube, and you're using a metal tube on
7 someone's neck. So the risks -- I mean, I would think they're
8 obvious; but you can -- you can cause bleeding that can
9 ultimately interfere with breathing. You can injure nerves
10 that are in the neck. You can have uneven filling there, so
11 cosmetically you're not happy with the result. I mean, there
12 are multiple risks there.

13 And remember, risks are not there to say, oh, there's a
14 risk there so I'm not responsible. The discussion of a
15 consent and risk is about explaining to someone what can
16 happen -- what can go wrong.

17 Because trust me, everyone who comes to see me thinks
18 that only good things are going to happen and they're going to
19 get what they want. And one of our jobs, as consent, is to
20 have a discussion and say, okay, here are all the benefits and
21 that's great, but here are the risks and these things could
22 happen, even if everything's done right, these things could
23 happen, so you have to decide do the benefits that you hope to
24 obtain are they more important to you than the risks of what
25 could happen.

1 And if you don't have that discussion with a patient and
2 do an operation, again, I think that's reckless. You're
3 putting someone in harm's way without -- without a really good
4 reason for it.

5 Q. I'd like to move on to the actual technical performance
6 of the procedure by Dr. Schimpf. Do you have any criticisms
7 of Dr. Schimpf's surgical technique that he used on Ms.
8 Whitfield in performing the mastopexy and augmentation?

9 A. So focusing on the mastopexy augmentation, there was too
10 much tension placed on that wound at the time of surgery. And
11 what we mean by that is -- I think you heard this earlier, but
12 you're removing extra skin in order to get a lift and then
13 you're placing an implant which stretches that same skin. So
14 when you close it you've got to make sure that it's not too
15 tight or it's going to interfere with blood flow to the skin
16 edges.

17 And that's how we all heal. We heal because we get
18 growth factors and immune cells and oxygen. And everything
19 that we need to heal gets to the area through the blood flow.
20 So if there's too much tension placed on it, it's going to
21 interfere with that blood flow and it's not going to heal
22 right.

23 Q. And what specifically can happen as a manifestation of
24 too much tension?

25 A. Well, the wound can -- we use the word dehiscence or open

1 up. It can cause damage to the underlying tissue, such as the
2 fat. So you can get fat death or fat necrosis. Dead -- dead
3 fat or -- and/or open wounds are prone to infection. I mean
4 certainly any wound can get infected. But when you have an
5 open wound it is more at risk. So there's that possibility.

6 And, remember, we've got tension. It's not healing.
7 It's opening up. And we have this implant underneath that can
8 potentially -- again, we call it extrude or become visible and
9 then either come out or need to come out.

10 Q. So the excess tension, or too much tension, can cause the
11 loss of an implant?

12 A. Oh, absolutely.

13 Q. And can it also require multiple corrective surgeries?

14 A. Well, I think we see that here. The failure of this
15 first operation, through the deviation from standard of care
16 of the surgeon, ultimately led to a situation where multiple
17 surgeries have already happened. And my understanding is if
18 she wants to get a result she -- Ms. Whitfield is comfortable
19 with, more surgeries will be done.

20 So all of that goes back to this initial deviation from
21 the standard of care. And that's the harm that was done.

22 Q. And you believe that the application of too much tension,
23 I believe you indicated, by Dr. Schimpf was a deviation in the
24 standard of care?

25 A. Well, having to -- a surgeon -- this operation, the key

1 to it is not having too much tension on that wound. Or that
2 is one of the keys. Because of the reasons we've said. I

3 And it's an error in judgment, I think as Dr. Kalus said,
4 to have too much tension on that wound. But I would say that
5 in my expert opinion, that's a deviation from the standard of
6 care. It's not just bad judgment; it's a surgical mishap
7 that's going to lead to opening of the wound, potentially
8 infection, potentially loss of the implant, which it did here.

9 Q. And you believe that within a reasonable degree of
10 medical certainty that that caused-- Mrs. Whit-- the
11 defendants caused Ms. Whitfield damage for doing the procedure
12 in that manner?

13 A. Yes, I do.

14 Q. Is there any indication in Dr. Schimpf's operative note
15 that he took care not to put too much tension on the wound?

16 A. There is no indication in the note that he used sizers or
17 did anything that would indicate that he was mindful of not
18 having too much tension on the wound. Of course, there's
19 nothing in there that says he put too much tension on the
20 wound; but I wouldn't expect a surgeon to put that in their
21 note that, you know, I did this wrong.

22 Q. And with a procedure of this type is it important for a
23 surgeon to take extra care not to place too much tension on
24 the wound?

25 A. Well, I think we would all agree that that's a potential

1 complication of this surgery. And that's what we tell
2 patients. But we also have to hear it ourselves, right?

3 So if we know that something is a potential complication,
4 wound opening because it's too tight, then we need to take
5 special care that it's not too tight.

6 Q. Okay. Did -- and I think you -- the jury now has seen
7 the testimony of Dr. Kalus. Was it his opinion that he
8 believed that the tension he observed was from Dr. Schimpf
9 placing too much tension on the wound?

10 MR. SMYTH: Objection, Your Honor. Bolstering.

11 MR. HALVERSEN: It's just a ---

12 THE COURT: I'll overrule it. You can ask the question.

13 A. I can answer it, I think.

14 Q. Okay.

15 A. Okay. I believe I heard Dr. Kalus say, and I thought I
16 read something about, this is not conjecture when I examined
17 her and took her to surgery there was too much tension on the
18 wound in my opinion.

19 And I think he said based on skin removal and implant --
20 and volume of implant, which is what you expect. Those are
21 the two factors. I think he said that pretty clearly.

22 Q. Is that evidence to you that Dr. Schimpf also -- is that
23 evidence that Dr. Schimpf performed the procedure incorrectly?

24 A. Well, I think that the observations of the treating
25 surgeon who operates on someone contemporaneously with the

1 injury is very important, sure. It colors my -- my opinion.

2 Q. Do you believe that the amount of excess tension that was
3 placed by Dr. Schimpf caused postoperative healing problems
4 for Mrs. Whitfield?

5 A. Yes, I do.

6 Q. And do you believe that within most probably to a
7 reasonable degree of medical certainty?

8 A. Yes, I do.

9 Q. And do you believe that that caused her damage?

10 A. Yes, I do.

11 Q. Let's talk about, Doctor, if you could explain to the
12 jury, what a dehiscence is?

13 A. So it's -- at its simplest level it's where a wound that
14 is closed and you would expect to stay closed, opens up. So
15 it's an opening up of a wound that should be closed, if all
16 things went the way you had planned and hoped they would.

17 Q. And what causes a dehiscence?

18 A. Well, I think the -- there are a couple of endpoints to
19 it. But one of them certainly is a lack of adequate blood
20 flow to healing edges. And there are different things that
21 can cause that. Certainly, an infection can cause that, can
22 cause a dehiscence. But tension on the wound, where you're
23 interfering with in this situation, is what most likely caused
24 this.

25 Q. Is there any evidence that Mrs. Whitfield herself caused

1 the dehiscence?

2 A. No, there is not. I didn't see anything in the records,
3 although there weren't a lot. And none of the deposition that
4 I see where anyone said it was her fault that this happened.

5 Q. Was that also the opinion of Dr. Kalus?

6 A. Yes. And it also is indicated in his exam note. So
7 trauma, like a hematoma, which is -- if you've ever gotten
8 black and blue, it's a little bit of blood under the skin.

9 There could be a lot in a breast. So that could have
10 been a problem. But then you'd see black and blue. When you
11 went to surgery, you'd see all the blood there. So there
12 really wasn't much of an indication that that was it.

13 Seroma build-up of fluid, but there was no evidence of
14 that. I was -- I saw -- Dr. Kalus had asked, a clogged drain,
15 could that be the cause. Well, I didn't see that any drains
16 were even used, so I don't know how being clogged could be a
17 problem.

18 So at the end of the day, if it's not traumatic and it's
19 caused by a buildup of fluid and it's not caused by the
20 patient having some trauma, car accident, then it's going to
21 be, more likely than not, due to tension.

22 And parenthetically, I think Dr. Kalus testified that
23 there was some wound opening on the left side as well. So,
24 again, now you would have to imagine trauma on both sides.

25 And then the fat necrosis, which indicates poor blood

1 supply, that was -- that was fairly significant on the left.
2 So you would have to imagine something happening to both sides
3 or, more likely than not, too much tension is placed on the
4 wound due to a misjudgment at the time of surgery.

5 Q. And I think what you're telling us is that if that would
6 represent a trauma that had happened to both breasts, it
7 probably would have been perhaps a significant event?

8 A. I -- I see -- let's put it this way. There's no evidence
9 in any of the records, nor did anyone put that forward as a
10 theory, as to why this happened.

11 Q. Is it a -- is a wound dehiscence a known or recognized
12 complication from this type of procedure?

13 A. Yes, it is.

14 Q. And could you explain to the jury what -- in your
15 professional opinion what that means ---

16 A. Sure.

17 Q. --- in terms of this case?

18 A. Sure. So a lot has been made that while it's a known
19 complication that you can have a wound dehiscence, you can
20 have problems with surgery, certainly the consent, it talks
21 about if -- in cases where it was given, it talks about these
22 things can happen, they are known complications. But just
23 because something is a known complication that can happen, in
24 usually a small number of percentage of procedures, that
25 doesn't mean that if it happens it just happened and nothing

1 was done that caused it.

2 I mean, I'll give you an example. You know, if I get
3 behind the wheel of my car and drive, I can get into an
4 accident. That's a known complication of driving. But if I
5 close my eyes and drive through a red light and get into an
6 accident, then I can't say, well, it's a known complication
7 when you drive that you can get into an accident.

8 It's not -- it's not something that means that you can
9 ignore it. And, in fact, I'd take it a step further. As a
10 surgeon, if you're dealing with a known complication then you
11 need to prepare for it. You need to take precaution against
12 it. You need to be mindful of it. If it's an unknown
13 complication, well, you know, how could you prepare for it?

14 But this, you know that tension is a problem with this
15 operation, potentially, and it can happen; so you need to be
16 extremely careful that it doesn't.

17 Q. Have you in your practice ever seen a patient develop a
18 wound dehiscence to the extent that Mrs. Whitfield has
19 developed?

20 A. From this type of surgery, no.

21 Q. And can you give us an idea as to the -- in your
22 professional opinion as to the frequency of this type of
23 complication?

24 A. So in this particular surgery you're talking about a rare
25 event; two percent, three percent. That's in the range we're

1 looking at.

2 Q. Was that also the opinion of Dr. Kalus?

3 A. I think I heard Dr. Kalus say that he had -- in this --
4 he had not had a patient in this particular operation with
5 that -- he had not seen a patient with this large a
6 dehiscence, except for another patient of Dr. Schimpf's.

7 MR. SMYTH: Objection, Your Honor. Can we approach?

8 THE COURT: Sure.

9 [Whereupon, an off-the-record bench conference is held]

10 Q. Doctor, in your practice, have you ever lost a whole
11 series of medical records before?

12 A. No.

13 Q. Did Dr. Schimpf attempt to recreate his care of Mrs.
14 Whitfield a year after his surgery?

15 A. Yes, he did.

16 Q. And can you explain to the jury your medical opinion as
17 to the adequacy of that note that he made over a year after
18 his surgery?

19 A. So that note has little to nothing to do with the care of
20 the patient. Which is why we take notes; right? So Ms.
21 Whitfield had problems from -- conservatively, from July going
22 forward. And in all that time there was no effort to make a
23 summary note, to define what had happened to make it clear.

24 All of a sudden, a year later there's this note that goes
25 back and tries to explain what happened. I think, first of

1 all, it's -- I'm not sure what the purpose is at this point in
2 time. But second of all, there are inaccuracies in it, as one
3 would expect.

4 I mean, I can't blame someone for not remembering
5 specifics a year after they happen. But isn't that the whole
6 point of why we take medical records at the time something
7 happens?

8 You know, other than an emergency, obviously, we take
9 care of a patient first. But that's why we take records so
10 that they describe at the time things are happening, what's
11 happening. A year later, I'm not sure what the motive is for
12 that.

13 Q. And what are the inaccuracies that you saw in the July
14 21st, 2015 note of Dr. Schimpf?

15 A. Well, I think the one that stands out in my mind is he
16 described visits after her surgery with Dr. Kalus, which
17 clearly hadn't happened. And I think when questioned about
18 that in his deposition he said, well, I misspoke.

19 Q. And your indication previously that that was simply could
20 have been either an error or intentional conduct?

21 MR. SMYTH: Objection, Your Honor. Calls for
22 speculation.

23 THE COURT: I'm going to allow it. I'll overrule the
24 objection.

25 You can answer the question.

1 THE WITNESS: Can I ask it to be repeated?

2 THE COURT: Absolutely. Repeat your question.

3 Q. Was the fact that there were inaccuracies on that July
4 21st note, I believe you indicated that Dr. Schimpf testified
5 that he, when confronted with that in his deposition, he said
6 he misspoke. But I think you indicated before, you said --
7 you -- there could -- I don't know what the motive was. Is it
8 fair to say that he was either trying to mislead the reader or
9 it was just an accident?

10 MR. SMYTH: Objection, Your Honor. The same, speculation
11 again. He said he doesn't know what the motive was.

12 THE COURT: I don't think he can testify as to the
13 mindset of Dr. Schimpf, so I'll sustain the objection.

14 MR. HALVERSEN: I will move on.

15 Q. Do you recall what Dr. Schimpf's testimony was about not
16 being aware that there was a requirement to make medical
17 records as you're contemporaneous with patient interactions?

18 A. I remember that statement. I think I've testified that
19 that's something we learn in medical school, that you need to
20 take records contemporaneous with what happens. So I don't
21 know how it is that he can say he didn't know that he needed
22 to keep medical records.

23 Q. Is that one of the first things you learn in medical
24 school?

25 A. It is.

1 Q. Did Dr. Schimpf correctly document the size of the
2 implants that he inserted into Mrs. Whitfield?

3 A. I think he mislabeled which size went into which side.

4 Q. And could you explain that, how you came to that
5 determination?

6 A. So that in the operative note there was the talk of
7 differential size implants. And then when it came to them
8 being removed it turned out that the -- that the implant that
9 was removed matched to what he had said but not with what was
10 written, is the way that I recall it.

11 Q. So what was documented -- what he documented in the -- in
12 his records, what he had documented, that the implants were
13 installed backwards?

14 A. Correct. The documentation was backwards. I think the
15 implants was installed the way he had intended.

16 Q. And that's because the pathology report indicated that
17 the implants had actually been placed where they were
18 intended?

19 A. Correct.

20 Q. Doctor, do physicians have a duty to record medical
21 records of their observations of the patient?

22 A. And to preserve them for a specified amount of time.

23 Q. And they have a duty to record the treatments they render
24 to their patients?

25 A. Correct.

1 Q. Did Dr. Schimpf do that in this case?

2 A. No. He breached that standard of care, and he did it
3 multiple times.

4 Q. Is that a deviation of the standard of care for a
5 physician?

6 A. Yes, it is.

7 Q. Is it a deviation of the standard of care for any
8 physician, not just a plastic surgeon?

9 A. Yes, it is.

10 Q. Do you believe that Dr. Schimpf and Sweetgrass were
11 reckless in failing to keep medical records of their treatment
12 of Mrs. Whitfield?

13 MR. SMYTH: Objection, Your Honor. Asked and answered.

14 THE COURT: Did you ask that as to the procedure
15 previously, or as to -- or as to keeping the records?

16 MR. HALVERSEN: I apologize if I asked that question
17 before. I didn't think I had, but ---

18 THE COURT: It's okay. You can answer the question.

19 A. I'm sorry. Could you repeat it again?

20 Q. Did you believe -- do you believe that Dr. Schimpf was
21 reckless in failing to keep medical notes of his treatment of
22 Mrs. Whitfield?

23 A. Again, my understanding of what reckless means, I would
24 have to answer yes. And to differentiate, putting too much
25 pressure at surgery is a misjudgment, it's a deviation from

1 the standard of care; but I wouldn't define that as reckless.

2 Consistently not taking notes, I read in depositions
3 about tape machines that didn't work, that were -- couldn't be
4 found, records that either weren't done or were lost over a
5 long period of time, of over months, and apparently not -- not
6 caring for records, either not taking them or not preserving
7 them, that's being reckless and putting someone in harm's way
8 for no reason.

9 Q. Does that appear to be a pattern of behavior in this
10 case?

11 A. Yes. There's no record of a pre-surgical visit. Even
12 going back as far as December 13 there was no record I saw.
13 As we already said, the preoperative, the postoperative visit.
14 This is something that went on for at least eight months.

15 Q. And was there testimony that -- from the defendants that
16 this medical-records issue affected not just Mrs. Whitfield
17 but affected other patients?

18 A. I was going to say that before.

19 MR. SMYTH: Objection, Your Honor.

20 A. I thought I remembered that ---

21 THE COURT: Yeah, we've discussed that one. I'm going to
22 sustain the objection.

23 MR. HALVERSEN: That's a different issue. Just for the
24 record.

25 THE COURT: No, it's not. I've already ruled on that.

1 Let's move it on to the next one.

2 Q. Do you have an opinion, Doctor, as to whether the
3 defendant's failure to keep medical records caused Mrs.
4 Whitfield damages in this case?

5 A. So I -- my opinion is that it did. When another surgeon
6 operates on someone, it changes the anatomy; it changes the
7 circumstance that you as the next surgeon have to face going
8 forward. And also, the progression of care postoperatively,
9 not knowing what things looked like at different points in
10 time, how it's progressing also affects your care as a
11 treating surgeon. So -- and going forward. So it absolutely
12 is harmful for patients when their records are lost.

13 Q. And in this case do you believe that it caused Mrs.
14 Whitfield damage?

15 A. I do.

16 Q. Let's talk about the -- and do you -- that's an opinion
17 you hold most probably to a reasonable degree of medical
18 certainty?

19 A. Yes.

20 Q. Let's talk about the postoperative care of Dr. Schimpf.
21 I think we've discussed the performance of the procedure
22 already. Let's talk about the postoperative care. Did -- do
23 you believe that Dr. Schimpf treated Mrs. Whitfield
24 appropriately when she presented to him on July 11th?

25 A. So I think there were two ways in which this -- there

1 were deviations from the standard of care related to the point
2 at which Dr. Kalus saw her as a second opinion with an open
3 wound now and potentially an impending loss of implant.

4 I know that Dr. Kalus called Dr. Schimpf and tried to
5 have the patient follow with her first physician. That's a
6 very good thing to do. Presumably, your initial surgeon knows
7 a lot more about the particular anatomy and the issues that
8 are faced than someone who's coming in new. So that if you're
9 able to keep that bond between surgeon and patient, it's a
10 good thing. Let's leave it at that.

11 Dr. Kalus was pretty clear that he thought that patient
12 needed to be seen that day or the next day and that the
13 patient needed to be taken to surgery within forty-eight
14 hours. What exactly was to be done at surgery, there's some
15 discussion of. But that needed to happen.

16 So it turns out that that didn't happen. The patient was
17 seen the next day and then sent out. And then, what is it;
18 two days later, returns to the emergency room because things
19 have gotten worse.

20 So I think one deviation was failure to intervene in a
21 timely fashion in a developing problem. So on the 11th, that
22 patient needed to be -- Ms. Whitfield needed to be scheduled
23 for surgery and she wasn't.

24 But another deviation is apparently rather than take her
25 to surgery and wash out the wound, debride any dead tissue and

1 most likely take out the implant, he elected to put sutures in
2 to close it.

3 So this is an open wound now. There's an implant
4 underneath. It's two-and-a-half-by-one centimeter. And it's
5 open because it was too tight. So it didn't heal. It pulled
6 apart. There's tension there.

7 So to think that the solution is to then place sutures
8 and tighten it up again, it doesn't make a lot of sense.
9 It's -- it just -- even from a practical point of view, that
10 doesn't make sense. So that's a deviation from the standard
11 of care.

12 So there was the failure to treat and the treating with
13 the wrong treatment. So I think there are two separate
14 things.

15 Q. And ---

16 A. Related. I mean, related, but.

17 Q. And what you're telling me is it's the failure to do the
18 right thing and then also, in fact, doing the wrong thing?

19 A. That's exactly - thank you - what I'm trying to say.

20 Q. And those things that you just described for the jury,
21 you believe that those are deviations in the postoperative
22 care of Mrs. Whitfield by Dr. Schimpf?

23 A. Yes.

24 Q. And do you believe that most probably to a reasonable
25 degree of medical certainty that those deviations caused Mrs.

1 Whitfield damage?

2 A. Yes.

3 Q. And specifically what kinds of damages did those
4 deviations cause?

5 A. So I think both in Ms. Whitfield's deposition and in Dr.
6 Kalus' deposition, when she came back to see him three days
7 after he had initially seen her with the open wound and
8 thought she needed surgery, the wound had gotten worse.

9 According to Ms. Whitfield, there was now an odor to it,
10 there was some drainage from it, it was painful. According to
11 Dr. Kalus, it was larger.

12 Either way you look at it -- and it -- let's say all of
13 those things are true. Let's say one of those things are
14 true. Clearly there was a progression from one day to the
15 next, as you would expect. Right? If there's too much
16 tension and it's not healing and you not only -- you both not
17 relieve the tension and do something that makes the tension
18 greater, it's going to cause more damage.

19 So -- and when I mean damage, I mean more fat necrosis,
20 more tissue loss, you have to debride more. Would the implant
21 still have needed to come out whether the operation was the
22 11th or -- yes. That operation it probably didn't affect.

23 And I think that's what Dr. Kalus was trying to say, that
24 that delay of those days didn't affect the operation on the
25 14th. But it did affect the entire subsequent course.

1 Because now when she had to go -- when she elected to go back
2 to surgery to have the implant removed, she also had pain in
3 the breast from the fat necrosis.

4 The requirements, the tightness of the skin, the need for
5 more reconstruction, all of this more likely than not, would
6 have been better -- wouldn't have disappeared, but it would
7 have been better had both action -- appropriate action been
8 taken in a timely fashion, and inappropriate action not been
9 taken.

10 Q. And I think you maybe started to allude to Mrs.
11 Whitfield's left breast. Was there evidence that Dr. Schimpf
12 placed too much tension on the left breast as well?

13 A. Well, I think we heard from Dr. Kalus that the left-
14 breast wound was open. Not as much, but that it was opened.
15 We also know from Dr. Kalus' testimony that there was
16 extensive fat necrosis on the left side, which indicates poor
17 blood flow; in my opinion, due to too much tension at the time
18 of surgery.

19 And we also actually have an objective test that doesn't
20 require anyone's testimony, and that was an MRI that I believe
21 was done in November. And that's Magnetic Resonance Imaging.
22 That's a fancy x-ray that can look at soft tissue. And it
23 actually is really good at differentiating fat necrosis from
24 cancer or other things. So we use it extensively to diagnose
25 fat necrosis. And it showed fat necrosis actually in both

1 breasts.

2 But left is the one you're asking me about. So that's
3 objective evidence that there was damage to the left breast.

4 Q. And do you recall how much fat necrosis was detected in
5 the left breast?

6 A. I apologize. The best answer I could give you is a lot.
7 I don't remember what they said. But indirectly, we know that
8 Dr. Kalus -- and I think a big deal was made of how much
9 tissue was removed from the left side, like a 275 implant and
10 then 450 of tissue. So all of this, a pound and a half. I
11 think you all heard that.

12 Well, almost a pound of that was fat necrosis that, in my
13 opinion, needed to come out because it was causing pain and
14 interfering with her life.

15 Q. So if Mrs. Whitfield decided, as she decided, to take out
16 that implant with Dr. Kalus, are you in any way critical of
17 her of making that decision?

18 A. Oh, absolutely not. I think patients when they've had a
19 problem with something, and in particular an implant on one
20 side as opposed to both, many, many patients will say, okay,
21 let me keep the good one and then when I'm ready I'll go back
22 and replace the one that was taken out. And that's fair and
23 good and reasonable. And if enough time has passed and
24 there's no signs of a problem, I would certainly do that.

25 But many women say, you know what, I've had enough of

1 implants at this point in time in my life, I've had so much
2 trouble with it, I just want it out and I'll have two breasts
3 without implants.

4 And if not for the problem of the fat necrosis, it might
5 have ended there with somewhat of asymmetry between the two
6 sides.

7 Q. Would you have recommended for Mrs. Whitfield after the
8 right was taken out, ex-planted, would you have recommended
9 her to re-augment just the right?

10 A. Well, I wouldn't say it's unreasonable or a deviation to
11 do that. But you have got a big problem. You've got a lot of
12 fat necrosis on the left side that's not going away. And if
13 it's starting to be painful, it's going to need to be
14 addressed surgically.

15 So if you put an implant on the right side and leave the
16 fat necrosis on the left, you may end up doing surgery later
17 and now the left side is going to be smaller than the right.
18 So I don't think I would take that approach.

19 Q. And is that what you're saying is from a symmetry
20 perspective?

21 A. Well, in my experience, twenty-four years now, symmetry
22 may be the most important aspect of breast health for women.
23 It's very important to them to look similar in a bathing suit,
24 in a bra, in a dress. So I understand about symmetry. That
25 seems to be extremely important.

1 Q. Is Mrs. Whitfield's symmetry -- does she have symmetry
2 today?

3 A. Not from the photographs I've seen.

4 Q. Do you believe Dr. Kalus treated her appropriately after
5 he took the right implant out that was done on the emergent
6 basis?

7 A. So I -- the short answer to that is, yes. The longer
8 answer to that is it's a really tough situation that he
9 inherited. You've got a patient that's already had
10 significant problems. You have to remove that right-sided
11 implant at this point. And now you're left with an abnormal
12 situation. You've got fat necrosis. You've got scarring.
13 You've got asymmetry. There's not one answer as to how best
14 to address that situation.

15 And I may not have chosen fat transfer as the way to go,
16 but -- let me even take a step back. I may not have -- you
17 know, I think I've already testified that removing the left
18 implant and the fat necrosis there was very reasonable, so I
19 have no criticism there.

20 I think trying to address this and avoid implants, and
21 certainly avoid big operations that we do, like, you know,
22 abdominal flaps, deep --- all this stuff that, if you want, we
23 could talk about. But avoiding big surgery is not
24 unreasonable, so I think fat transfer -- again, I wouldn't
25 have chosen it, but it's not unreasonable.

1 And I think we're in a situation now where if this is
2 something that she feels uncomfortable living with, needs to
3 still be addressed.

4 Q. So if Dr. Kalus would have recommended either to do a
5 fat-grafting procedure or a re-augmentation to get her back to
6 having symmetry and attempt to recreate how she was before, do
7 you have any -- take any issue with those procedures?

8 A. No, in the sense of -- when you say take any issue, I
9 don't think there's anything wrong with that. Again, might
10 not be what I would choose. But -- but there's -- those are
11 reasonable plans.

12 Q. Well, tell the jury what you would recommend for Mrs.
13 Whitfield.

14 A. So I think that with all the damage that has been done
15 and the scarring that's there already, it would be very hard
16 to get a good match either with fat or just putting an implant
17 in or differential implants.

18 Because from the pictures I've seen, the bottom of the
19 breast, what we call the inframammary fold, is different from
20 side to side. You want to try to, you know, improve that.
21 You need to stretch that skin in order -- in my opinion, in
22 order to be able to then go back and put an implant in.
23 Because you certainly don't want to have the same problem
24 again, put an implant in too tight.

25 So I would actually almost look at this as a breast

1 reconstruction rather than a breast augmentation mastopexy and
2 say, okay, let's do one of the things we do in situations
3 where people have had mastectomies even. We put an expander
4 in, we stretch the tissue, allow it to assume the shape we
5 want, then we go back and put an implant in. And it also
6 allows us to get to a point where we can pick and choose a
7 little bit what size we use, rather than immediately put an
8 implant in.

9 Just to explain -- I guess I used a term. An expander,
10 as opposed to an implant, an implant, in its simplest terms is
11 a balloon that's filled with either saline, you know, like
12 water, salt water, or silicone. An expander is like a balloon
13 that you can stretch over time and fill in order to stretch
14 the tissue.

15 So even though my plan would involved at least two more
16 procedures, placement of an expander, expansion in the office,
17 then replacement of the expander with an implant - because you
18 can't leave an expander in - that would be my recommendation.

19 But even -- you know, I think -- I think we're in a
20 situation where it's just going to be very difficult to get
21 her to a symmetrical point. And, again, nobody is exactly
22 symmetrical; but I mean to a point where it's not obvious and
23 she's comfortable.

24 Q. And in your experience what does the type of procedure
25 you just described cost?

1 A. Well, again, it's two operations. We're probably talking
2 in the -- in the 20 to 30,000 range.

3 Q. Do you believe that in the condition Mrs. Whitfield is in
4 now, in your professional opinion as a plastic surgeon, that
5 that is a result that most women would accept?

6 A. Well, I would almost have to -- to answer you, I'd almost
7 have to say it the opposite way. If a woman was accepting of
8 that, that's great. More power to her. Whatever, you know,
9 makes her comfortable.

10 There's no requirement to do more surgery. But I think
11 it's very reasonable that someone would look at that and say,
12 you know, I need to do something, I need to be more similar.
13 And in that case I think I would say this is totally
14 appropriate for her if that's what she wants to do.

15 Q. Okay. Do you have an opinion within a most probably to a
16 reasonable degree of medical certainty as to whether all of
17 these subsequent procedures that she undertook with Dr. Kalus,
18 and whatever future surgery she's going to undertake, whether
19 that be something you're describing now or like Dr. Kalus
20 suggested, whether those procedures are can be traced back to
21 Dr. Schimpf's procedure that was performed on June 6, 2014?

22 A. Yes. It's my opinion that most probably, more likely
23 than not, however the specific term is, that it's -- from a
24 layman's point of view, yes, this all happened because that
25 surgery was done in a negligent fashion.

1 Q. I'm almost finished, Doctor.

2 Is there any evidence to you, as a plastic surgeon, that
3 Mrs. Whitfield's own psychiatric history made her situation
4 worse?

5 A. Not that I could see.

6 Q. You've seen the preoperative -- or, I'm sorry, the
7 photographs that were taken of Mrs. Whitfield after the
8 surgery that Dr. Schimpf had; correct?

9 A. Yes.

10 Q. As a plastic surgeon, do you think she was -- it was
11 appropriate for her to be seeking out a second opinion when
12 she was being dismissed by Dr. Schimpf?

13 A. [No response]

14 Q. In other words, were those -- were those pictures
15 concerning to you as a plastic surgeon?

16 A. Yes, very much so. I was going to say the short answer
17 to the question is, you know, I think -- you know, you can't
18 ever argue with a second opinion. It's a good idea sometimes
19 to get another view, especially when you're having a problem.

20 But here I think the key points, and I think I've already
21 made them, are, number one, there's that sense that no one's
22 listening to her, that she described in her deposition quite
23 well. So that it's just not getting better and no one is
24 helping her is a feeling I think she had. So to get another
25 opinion is very reasonable.

1 And I think going back to what I said about the surgery
2 on her chin without permission, I think that put a big seed in
3 there of, you know, a harmful take on the physician-patient
4 relationship. That also made it very reasonable to get a
5 second opinion.

6 But, of note, she did go back to him the day after. And
7 I think had he, in my expert opinion, not done the wrong
8 thing, and in my expert opinion, done the right thing, I have
9 to assume she was prepared to go to surgery with him. I think
10 that's why she went back. I assume.

11 Q. Do you have any opinions about the standard of practice
12 for removing basal cancer cells?

13 A. Yeah, I've done -- in this case, I would say a couple of
14 thousand of those.

15 Q. And the size of the removals of the -- the incisions that
16 Mrs. Whitfield had with Dr. Kalus, do you have any criticisms
17 of Dr. Kalus for removing those?

18 A. So first of all, if you think something is a basal cell
19 carcinoma, you take it out. And if it turns out that it
20 wasn't, that's a good thing. That doesn't mean you did
21 something wrong. That's a really good thing.

22 Second of all, basal cell carcinoma, of all the ones we
23 treat, is most known for having little roots or shoots that
24 come off that you don't necessarily see. So it's very
25 reasonable to take a wide area around it. Now, I don't know

1 how wide three centimeters is.

2 But it's very reasonable to do that because you don't
3 want to -- if you think this is a basal cell, you don't want
4 to come back and find, hey, I cut through the root, there's
5 some left, we've got to do another surgery.

6 Now, I would qualify that by saying, look, if it's on
7 someone's nose or eyelid where every millimeter is critical,
8 then I would look for another approach. Maybe take it out
9 as -- you know, as little as possible, have it looked at under
10 the microscope.

11 But on the chest, on the arm, I don't -- I don't know
12 that it's worth it to do that.

13 So I am very comfortable with treating basal cell, what
14 you think is a basal cell, with an excision around it with
15 some normal skin being removed, because you don't want to
16 leave behind any roots.

17 MR. HALVERSEN: Just one moment.

18 Q. Doctor, are all the opinions you expressed this afternoon
19 most probably to a reasonable degree of medical certainty?

20 A. Yes.

21 MR. HALVERSEN: Okay. I'm going to have -- Mr. Smyth may
22 want to ask you some questions. And depending on his
23 questions I may have some follow-up. But I don't anticipate
24 much.

25 THE WITNESS: Okay.

1 **CROSS-EXAMINATION BY MR. SMYTH OF DR. MICHAEL ROSENBERG:**

2 Q. Good afternoon, Doctor.

3 A. Good afternoon, Mr. Smyth.

4 Q. And I heard you say you are from Chappaqua; did I say
5 that right?

6 A. Chappaqua, New York.

7 Q. Chappaqua. That's where he -- President Clinton is from
8 or ---

9 A. Yes, it is.

10 Q. --- where the house is?

11 A. That's where they live.

12 Q. And you've always practiced in New York; is that correct?

13 A. Other than military service, that's correct.

14 Q. You've never been licensed to practice medicine in South
15 Carolina, have you?

16 A. No, I have not.

17 Q. And I understand you're a plastic and reconstructive
18 surgeon; is that correct?

19 A. Yes.

20 Q. And about half of your practice is for cosmetic
21 procedures; correct?

22 A. At this point in time, yeah.

23 Q. And about a third of that is breast surgery?

24 A. That's correct.

25 Q. And I think when I asked you earlier in your deposition,

1 when I had a chance to talk with you, you estimated that you
2 did about fifteen to twenty of the mastopexies. But you said
3 today that you do twenty to twenty-five a year. Which one is
4 it?

5 A. Let's say twenty.

6 Q. And you have a website; correct?

7 A. Yes.

8 Q. All right. Do you have any pictures of a mastopexy with
9 implant exchange posted on your website?

10 A. I don't know.

11 Q. You've got five surgeons, correct, in your practice?

12 A. Currently we have four. We did have five.

13 Q. All right. And to your knowledge there are no pictures
14 of this type of surgery or examples of your work related to
15 that surgery, are there?

16 A. I don't manage my web page, so I honestly don't know.

17 Q. Okay. And you've never published any articles pertaining
18 to any of the procedures at issue in this case, have you?

19 A. Nothing that directly related to this surgery.

20 Q. And you've actually been where Dr. Schimpf is now, you've
21 been sued three times before; is that correct?

22 A. That's correct.

23 Q. And one of your patients sued you because you got -- they
24 got an infection following a thigh lift; correct?

25 A. After massive weight loss. Yes.

1 Q. All right. And they alleged that you didn't properly
2 take care of them; is that correct?

3 A. That's correct.

4 Q. And you settled that case?

5 A. My attorney settled it, yes.

6 Q. And then you got a second patient sued you just three or
7 four years ago because she was unhappy about the scars and the
8 appearance of her breasts following surgery you performed;
9 correct?

10 A. That was following a different operation, a breast
11 reconstruction.

12 Q. All right. And you settled that case?

13 A. Yes.

14 Q. All right. And you still have a current case pending, as
15 I understand it; is that correct?

16 A. Yes. A nasal reconstruction where under anesthesia the
17 patient stopped breathing temporarily. We were able to get it
18 started and get the patient able to walk out the door. But
19 they're suing the anesthesiologist and myself.

20 Q. And you've been working as an expert witness like you're
21 doing now, coming into courtrooms and testifying, for about
22 fifteen years?

23 A. That sounds about right.

24 Q. And you review at least two of these cases every year?

25 A. That sounds about right.

1 Q. And you make about \$50,000 a year doing that kind of
2 work?

3 A. That sounds right.

4 Q. And I counted it up earlier. I think you may have
5 undersold your -- the number of states you've been in. I
6 counted seventeen different states where you've testified in
7 medical malpractice cases. Do you dispute that?

8 A. I don't dispute it. I don't know.

9 Q. And of the last fifteen cases on the list that you
10 provided me where you've given testimony, isn't it true that
11 thirteen of those you were testifying for the patient and
12 against the doctor?

13 A. That's correct.

14 Q. And the only three times that you've been reviewed
15 -- or, excuse me -- been retained to work as an expert in
16 South Carolina, that was, again, for the patient and against
17 the doctor; is that correct?

18 A. Right. I'm about forty percent for the doctor, sixty
19 percent for plaintiff. And in South Carolina I've only been
20 retained for a plaintiff.

21 Q. A hundred percent?

22 A. In South Carolina.

23 Q. Right. And you're charging \$12,000 a day for your
24 testimony here?

25 A. I did testify to that.

1 Q. And you've been working on this file for how long?

2 A. Guessing about a year and a half.

3 Q. And how much have you billed for your time spent on this
4 file?

5 A. I think I've spent about twenty hours on this file.

6 Q. At what hourly rate?

7 A. \$500 an hour.

8 Q. Okay. And you also charged \$5,000 for your deposition in
9 the case; correct?

10 A. Correct.

11 Q. And prior to flying in last night, you've never met or
12 spoken to Ms. Whitfield before; have you?

13 A. No, not that I recall.

14 Q. I believe when I took your deposition you agreed with me
15 that it's important for patients to be honest with their
16 surgeons when it comes to giving a medical history. You agree
17 with that, don't you?

18 A. I would agree with that.

19 Q. And you reviewed the medical histories that Ms. Whitfield
20 gave Dr. Schimpf when she signed up to have surgery, haven't
21 you?

22 A. I did.

23 Q. Okay. And you saw in there where she did not check that
24 she had any psychological or emotional problems or was taking
25 any medication relating to any psychiatric conditions, didn't

1 you?

2 A. I didn't see anything that described a psychiatric
3 problem.

4 Q. And she was asked specifically whether she had anxiety,
5 bipolar, depression, those kinds of things, on that form;
6 correct?

7 A. I don't remember that.

8 Q. You don't dispute it?

9 A. Do you have the form? I'll ---

10 Q. Sure.

11 A. --- give you an answer.

12 Q. Be glad to show you. This is previously in evidence as
13 Defendant's Exhibit 2. Highlighted the bottom there.

14 A. It says no anxiety, no bipolar disorder, no borderline
15 disorder, no emotional problems. Other medical problems, no.
16 And it seems to have been written by ---

17 Q. Those are just multiple copies.

18 A. Oh. Same thing. See who signed this. I don't know who
19 wrote that, but that's what it says on this form.

20 Q. And that wouldn't be accurate, based on the records
21 you've reviewed in this case; would it?

22 A. What wouldn't be accurate?

23 Q. That she doesn't have those problems.

24 A. My understanding - I don't know the timeframe of it - is
25 that she has anxiety disorder. I'm not -- I don't remember

1 reading about a bipolar disorder.

2 Q. Have you read the deposition of her treating
3 psychiatrist?

4 A. I have not.

5 Q. Or any of her psychiatry records?

6 A. I have not seen any of her psychiatry records. I think
7 you asked me at the deposition.

8 Q. Okay. We talked a little bit about the consent form. Do
9 you agree that the consent form that Ms. Whitfield signed in
10 this case, for the mastopexy and for the breast implant
11 exchange, was appropriate and met the standard of care;
12 correct?

13 A. The consent form did meet the standard of care for the
14 mastopexy.

15 Q. All right. And it talked about all of the complications
16 that can come along with this surgery; correct?

17 A. Yes, it did.

18 Q. And those are complications that can happen and do happen
19 even when the surgeon does everything correctly?

20 A. I think we spoke about that.

21 Q. And you saw that Ms. Whitfield signed those forms?

22 A. Yes, I think I remember seeing that.

23 Q. And she signed similar forms for the exchange of
24 implants, and the blepharoplasty, and two liposuction forms,
25 and a scar revision form; correct?

1 A. That's my recollection.

2 Q. And let's talk a little bit about the missing notes.

3 You've given some opinions today that it was below the
4 standard of care I think to have notes missing from the chart;
5 is that correct?

6 A. Yes.

7 Q. All right. And you agree that if you noticed a record
8 was missing from your chart, you would feel an obligation to
9 do your best to record what happened?

10 A. I would.

11 Q. And you agree that if you did not realize that note was
12 missing, you wouldn't have known to go back and do it;
13 correct?

14 A. [No response]

15 Q. In other words, you only know to go back and do a note
16 once you realize it's missing?

17 A. Right. Although I would add, if I have a patient that's
18 having a problem I would look at my notes and see what's going
19 on and if I saw I didn't have any, it wouldn't be a year until
20 I noticed.

21 Q. And you think it's appropriate, though, to go back and
22 try to give people who are requesting records a summary of
23 what happened?

24 A. If you have no records and they're requested, you can
25 give a summary. But I think it should have been noted sooner

1 and it should have been corrected sooner. And it's hard to
2 believe that with all this going on nobody thought to look at
3 if there are any records.

4 Q. And you were in here when Dr. Kalus' video deposition was
5 being played; correct?

6 A. I was.

7 Q. All right. And you heard his testimony that the lack of
8 records did not prevent him from giving Ms. Whitfield any care
9 in this case; correct?

10 A. So I heard him say that, and that was -- that was his
11 opinion.

12 Q. And you also know that Dr. Kalus was able to speak to Dr.
13 Schimpf on July the 10th when Ms. Whitfield had come to see
14 him; correct?

15 A. I think you're mischaracterizing there. When he spoke to
16 Dr. Schimpf on that date, it wasn't to get information in
17 order to treat her; it was to impart information because he
18 was a second opinion, he was -- he was calling her doctor to
19 say what he found.

20 So I don't know that he would have even gone over what's
21 going on, you know, from the doctor's point of view. He was
22 giving his view.

23 Q. Fair to say you weren't a part of that call and you don't
24 know what information the two of them exchanged?

25 A. I'm telling you for twenty-four years of practice, if I'm

1 a second opinion I'm calling the doctor to give my opinion.

2 Q. And it certainly was an opportunity, though, if Dr. Kalus
3 had questions about what had been done or what the plan was
4 going to be, he could have asked those questions of Dr.
5 Schimpf while he had him on the phone?

6 A. He could have, but why would he? He wasn't planning on
7 treating her.

8 Q. Right. And he could have called him two days later when
9 he took over the care?

10 A. That he could have done.

11 Q. So if Dr. Kalus needed any specific information, we know
12 he knew how to get in touch with Dr. Schimpf; correct?

13 A. That's correct. He knew how to get in touch with him.

14 Q. All right. Let's talk a little bit about the liposuction
15 procedure done on the chin. You understand there's a
16 difference in the testimony of the party as to whether consent
17 was given; correct?

18 A. I think I testified that the defendant said it was, and
19 the plaintiff said that it was never discussed.

20 Q. Right. And you read Dr. Schimpf's sworn testimony in
21 this case; correct?

22 A. His deposition, you mean?

23 Q. Right.

24 A. Yes, I read his deposition.

25 Q. And he testified there that he wouldn't do a procedure on

1 a patient without their consent; correct?

2 A. As did I, as did the defense expert. I think none of us
3 would do an operation on someone without permission.

4 Q. Right.

5 A. And that's what makes this so reckless, that ---

6 Q. No reasonable ---

7 A. --- he did it.

8 Q. No reasonable surgeon would do that, would they?

9 A. I think it's very reckless for anyone to do that.

10 Q. Right. You also agreed that it's possible that they
11 discussed the risks and he went over it and she agreed to it
12 and he never charged her for it?

13 A. Is it possible that that happened?

14 Q. Yes, sir.

15 A. Yes, it's possible. Is it more likely than not? No.

16 I think the opposite it's more likely than not; he didn't
17 charge her because they didn't discuss it.

18 Q. Well, if it's possible and it happened do you agree
19 that's okay as long as the patient is aware of the risk?

20 A. If it's possi- -- it is possible that it happened. I
21 can't say that I'm certain. I can just tell you within what
22 makes sense to me. And if that did happen, then she gave
23 permission.

24 Q. And, in fact, there are times when that's happened in
25 your practice, correct, when you've had a conversation with a

1 patient, they've asked for an additional procedure, and you've
2 agreed to do it and not charge them for it?

3 A. On the morning of surgery; is that what you're asking me?

4 Q. At other times. Have you ---

5 A. Have I ever done a surgery and not charged someone for
6 some ---

7 Q. Correct.

8 A. --- for it?

9 Q. Right.

10 A. Yes. If it's part of a whole series of surgeries, if I
11 had a reason I wanted to do that; sure, it's possible to
12 not -- and I've done that. I've not charged people.

13 Q. And you were also asked some questions about whether
14 there was any indication that there was a plan to do
15 liposuction on Ms. Whitfield's chin; correct? Any indication
16 in the medical record. Do you remember being asked that
17 question?

18 A. Yes, I do.

19 Q. All right. I'm going to show you what's been previously
20 marked and admitted as Defendant's Exhibit 9. This is a page
21 from the nursing operative note. And I've got a highlighted
22 portion there under the procedure name, procedure number four.
23 What does that say, please?

24 A. Liposuction abdomen, medial thigh, axilla, and neck.

25 Q. And that would be evidence that there's a plan to do

1 liposuction in the procedure; correct?

2 MR. HALVERSEN: Objection, Your Honor. That's
3 speculation. That's just a form.

4 A. When was this form written? Is there a date on it?

5 Q. Yes, this is the date of the surgery. It's the operative
6 note. You can see it right here, June the 6th ---

7 THE COURT: All right, before you answer, ask the
8 question again.

9 MR. SMYTH: I'm sorry. Which question, Your Honor?

10 THE COURT: Well, he just -- he was just asking about the
11 form. But the -- he objected to the question that you asked
12 and I said restate the question so I'll know what to rule.

13 MR. SMYTH: I'm trying to remember which one it was, Your
14 Honor.

15 THE COURT: What's your objection?

16 MR. SLOTCHIVER: I believe he said I believe there is
17 evidence that they had a plan to do it. And my objection was,
18 no, it's just a form. It's speculation.

19 THE COURT: Rephrase your question.

20 Q. So ---

21 MR. SMYTH: Sure.

22 Q. Is this part of the operative record that you reviewed in
23 this case ---

24 A. So ---

25 Q. --- from Dr. Schimpf's office?

1 A. I think I've already testified that the anesthesia record
2 mentioned it, this mentions it, the operative note mentioned
3 it. Nowhere does it say it was mentioned prior to surgery.

4 Where does this form say that this was discussed before
5 surgery? You've just shown me something, a third thing, that
6 says it was done. It doesn't say it was discussed.

7 Q. Do you in your practice use a record like this prior to
8 surgeries?

9 A. No. We use a different record.

10 Q. And if -- in terms of where this notation appears on the
11 page, is it before the start of anesthesia time?

12 A. Where it appears on the page?

13 Q. Right.

14 A. What's the relevance ---

15 MR. SLOTCHIVER: Once again, I believe it's ---

16 Q. Chronology.

17 MR. SLOTCHIVER: I believe it's speculation. I don't
18 believe the form tells you when things took place. It just
19 shows you the top of the page to the bottom of the page.

20 THE COURT: He's asking about also in his practice how he
21 maintains records and how those records are maintained.

22 I'll overrule the objection and allow him to testify.

23 THE WITNESS: Okay. And may I have the question again,
24 Judge?

25 THE COURT: Yes, sir.

1 MR. SMYTH: Sure.

2 Q. Does this form -- does the mention of liposuction on the
3 neck appear before the operative record appears to start on
4 the page chronologically?

5 A. It appears just above.

6 Q. Thank you.

7 And I'm going to show you another document that's
8 previously been admitted as Defendant's Exhibit 12 and ask you
9 if you recognize that document.

10 A. Yes, I do.

11 Q. Okay. Can you tell the jury what it is, please?

12 A. It's the anesthesia evaluation.

13 MR. SMYTH: I'll be able to grab this before the week is
14 over, Judge, I think.

15 Q. Okay. Let's take a look at it. The name of the document
16 is what, sir?

17 A. The name of the document is pre-anesthesia evaluation.

18 Q. Okay. And pre-anesthesia means before the anesthesia is
19 given; correct?

20 A. That's what the word pre would mean, yes.

21 Q. Okay. And then underneath, it lists the procedures. And
22 I've highlighted here. Does that say liposuction of the chin?

23 A. It does.

24 Q. Thank you.

25 I'll show you what's been marked and admitted as

1 Defendant's Exhibit 11 and ask you if you recognize that
2 document.

3 A. This is the anesthesia -- I do recognize the document.

4 Q. Okay. Could you tell the jury what it is, please?

5 A. Yeah, this is the one I referenced before. Lipo abdomen
6 and thighs and chin and axilla. That's what you've
7 highlighted.

8 Q. All right. So this is the anesthesia record from the
9 procedure itself; correct?

10 A. That's correct.

11 Q. And it does list liposuction of the thighs, the chin,
12 axilla, and abdomen?

13 A. It does. And I don't dispute that that was done.

14 Q. Did you review any of Ms. Whitfield's journal notes that
15 she made in this case?

16 A. I don't believe I've ever seen her journal. I take that
17 back; I think I saw it last night.

18 Q. Last night? I want to show you what's been previously
19 marked as Defendant's Exhibit 13 and direct your attention to
20 the bottom of the page. Is this one of the notes that you
21 would have been shown last night?

22 A. Yeah, this is what I saw last night.

23 Q. Okay. And we went over this yesterday, but does it say
24 went for a consult -- you said scar tissue, implants, and
25 refined abdomen; set up surgeries for abs, breasts, neck,

1 eyes, at the same time?

2 MR. SLOTCHIVER: Your Honor, I believe that he misread
3 it; and I would object. It doesn't say set up surgeries for,
4 I don't believe.

5 MR. SMYTH: I didn't say for.

6 THE COURT: For the -- for the ---

7 MR. SMYTH: I said ---

8 THE COURT: You did. You did.

9 MR. SMYTH: Oh, did I? I'm sorry.

10 THE COURT: Yeah, for the record, it does not say for.
11 It says abdomen, set up surgeries. And then the subsequent
12 line says abs, breasts, neck, eyes, at the same time.

13 Just for the record.

14 MR. SMYTH: My apologies.

15 THE COURT: That's okay.

16 MR. SMYTH: I wasn't trying to mislead it at all.

17 THE WITNESS: To trick me? All right.

18 Q. But her note does indicate that she's setting up surgery
19 for her neck at the same time; correct?

20 A. Well ---

21 MR. SLOTCHIVER: Objection, Your Honor. This is
22 speculation. She's already testified these are two separate
23 events. She was recalling, and that's the testimony that's
24 before the record. It doesn't say she was setting up for
25 these things.

1 THE COURT: I don't know how he's going to testify to
2 this. He doesn't know what that is. I mean, he can say it's
3 a piece of paper that has some information on it.

4 THE WITNESS: I was going to say, Your Honor, this -- I
5 mean ---

6 Q. That's okay. We will move on.

7 A. I'm used to looking at medical records, not people's
8 journals, to decide what was discussed, what wasn't discussed.

9 Q. Did you read the other entry in her journal that talks
10 about surgery on that same day, June the 6th?

11 A. That one I don't think I saw.

12 Q. Does that also list the chin on the surgery she had that
13 day?

14 A. It says surgery, implant redux, scar remove, eyelids,
15 chin, belly, no stitches used on breasts. And I have never
16 seen this before. I don't even know what it is.

17 Q. Okay. You agree that Dr. Schimpf in his description of
18 how liposuction on the chin was done in his operative note,
19 that he described doing the procedure appropriately and
20 according to the standard of care?

21 A. I did.

22 Q. And so with the operative note and the records that we've
23 shown, there are several references in the documents we have
24 that do reflect a discussion of liposuction on the -- on the
25 chin; correct?

1 MR. SLOTCHIVER: Objection, Your Honor. I don't believe
2 that's accurate. They're just -- there are notes that have
3 reference to it. They don't -- they don't discuss a
4 conversation.

5 MR. SMYTH: Your Honor, may we approach, please?

6 THE COURT: Sure.

7 [Whereupon, an off-the-record bench conference is held]

8 THE COURT: All right.

9 Q. Dr. Rosenberg, did you -- were you aware that Ms.
10 Whitfield left Dr. Schimpf's office that day wearing a -- they
11 call a jaw bra?

12 A. I'm sorry, what day are we talking about?

13 Q. The day of surgery. June 6th.

14 A. I don't remember that.

15 Q. Okay. You weren't aware of that?

16 A. I don't know if it happened or it didn't.

17 Q. Do you know what a jaw bra is?

18 A. Would you describe that for me?

19 Q. Sure. Actually I will -- I'll do better. I'll show you
20 a picture. This is Defendant's Exhibit 15.

21 A. Yeah, I don't think I saw this before.

22 Q. Okay. Is that -- are you familiar with the product,
23 though?

24 A. Yes. I use this product.

25 Q. You do use it. What is it -- what do you use it for?

1 A. This is for -- mostly for liposuction of the neck.

2 Q. And does it have anything to do with the eyes or
3 blepharoplasty?

4 A. No, it does not.

5 Q. Thank you.

6 In your experience do patients typically experience some
7 bruising and swelling from liposuction?

8 A. Yes, they do.

9 Q. And you agreed, I believe, when I asked you this question
10 earlier, that Ms. Whitfield didn't suffer any of the
11 complications associated with this liposuction on her chin;
12 correct?

13 A. Not that I'm aware of.

14 Q. And she has not required any treatment of it?

15 A. Again, I don't know that required is the right word; but
16 she's not had any treatment of her neck since, that I'm aware
17 of.

18 Q. Has there been any reference in any of her plastic
19 surgeon's records to any complaints about her chin since 2014?

20 A. Not that I remember seeing.

21 Q. You've also testified in this courtroom that it was
22 reckless of Dr. Schimpf to have not obtained consent, in your
23 opinion, prior to doing this procedure; correct?

24 A. Yes, I did.

25 Q. All right. And you were here for Dr. Kalus' trial video?

1 A. Yes, I was.

2 Q. And did you see where I questioned him about whether he
3 obtained proper consent from Ms. Whitfield during his October,
4 2015 surgery?

5 A. I was here, and I also read the transcript of that.

6 Q. Do you believe Dr. Kalus was reckless in not listing the
7 knees as a place that he performed liposuction on and not
8 getting consent for that?

9 A. No. I think the two are not comparable.

10 Q. Okay. Do you believe he was reckless for not getting
11 consent to take an excision off of her chest without getting
12 consent for that?

13 A. First of all, I'm not sure I would agree that he didn't
14 get consent for it. Second of all, you know, when you're
15 talking about taking a cancer off the shoulder-chest area,
16 I -- it's not clear to me that there was no discussion of it.
17 I don't recall ever hearing the plaintiff say that she had
18 surgery that she didn't think she asked for or was prepared
19 for. So I don't know how you can compare the two. Or I don't
20 see the comparison.

21 Q. Okay. You would agree -- let's move on to the breast
22 surgery, the mastopexy and implant exchanges. You agree that
23 the surgical technique that Dr. Schimpf used, using the Y's
24 pattern approach, is a medically accepted approach for
25 performing this surgery?

1 A. Y's pattern is a medically acceptable. I've done it that
2 way, too. Sure.

3 Q. And you agree that the description of the way Dr. Schimpf
4 performed the procedure in his operative note is appropriate
5 and meets the standard of care?

6 A. I didn't see anything in his description that indicated
7 he did not meet the standard of care.

8 Q. All right. It's your opinion the only violation, in
9 terms of the way he did the surgery, was you believe he put
10 too much tension on the wound?

11 A. "Only" is a strange word to use for that. I mean, that's
12 what the operation is about. And if you put too much tension
13 in an augment mastopexy, you're going to have all the problems
14 that we saw.

15 Q. And you agreed that the operative note is silent as to
16 how much tension is applied to any of the sutures?

17 A. Yes. That was one of the criticism I had when we talked
18 in the deposition.

19 Q. But you also agreed that there's no device or mechanism
20 by which you can measure how much tension is placed on a given
21 suture?

22 A. No, that's what being a plastic surgeon means, being able
23 to make those judgments.

24 Q. Right. And you agree that the wound separation that Ms.
25 Whitfield sustained is a well-known complication of the

1 surgery?

2 A. Yeah, we've talked about that. It's a well-known
3 complication that you need to take precaution so it doesn't
4 happen.

5 Q. And it's one that she was informed about prior to having
6 the surgery?

7 A. Yes, that I agree with.

8 Q. And you agree that there are several factors when
9 performing a surgery like this, that the surgeon cannot
10 control in terms of the way the patient responds to the
11 procedure?

12 A. What are you referencing? I don't understand the
13 question.

14 Q. Sure. There are a number of outside factors. You
15 certainly can't control the results of every surgery; correct?

16 A. That's correct. I would agree with that.

17 Q. There are a number of factors that influence the result
18 that ---

19 A. Sure.

20 Q. --- are beyond your control?

21 A. Sure.

22 Q. Okay. And some of those would be things such as
23 hematomas, like you mentioned; that's a collection of blood?

24 A. Well, first of all, there was no indication that there
25 was a hematoma here; so I'm not sure what you're referencing.

1 But second of all, hematomas contribute to tension; but
2 sometimes they're the fault of the surgeon, and sometimes
3 they're not the fault of the surgeon.

4 Q. Right. The same would be true with seromas, which is a
5 collection of fluid?

6 A. Again, seroma can increase tension in a wound. But
7 you've got an exam done by another treating physician that
8 showed no evidence of a seroma. I didn't see any notes from
9 Dr. Schimpf describing fluid wave, tension.

10 I mean, those are things we look for because if we see
11 them, we can treat them. We can put a needle in and take the
12 fluid out.

13 So, again, I don't see that that's relevant here.

14 Q. Other potential causes of swelling or tension in a wound
15 would be a patient that doesn't follow postoperative
16 instructions and is active too soon?

17 A. Yes, that's for sure.

18 Q. Or a trauma?

19 A. I think we talked about trauma before. There was no
20 evidence that there was any trauma here.

21 Q. Did you read the testimony of Ms. Whitfield and her
22 daughter about her having blacked out in the shower?

23 A. I did.

24 Q. And having to be dragged out of the shower, actually?

25 A. I did.

1 Q. And you don't find that to be any evidence of any trauma?

2 A. That's four -- that's three days after she saw Dr. Kalus
3 for a second opinion.

4 Q. Well, you also ---

5 A. That's ---

6 Q. I'm sorry. Go ahead.

7 A. --- one day -- that's two days after she saw Dr. Schimpf.
8 The shower incident, as I recall, was prior to her going to
9 the emergency room.

10 Q. And she wasn't bleeding when she got into the shower but
11 she was bleeding when she got out of the shower?

12 A. That's correct.

13 Q. You agree that in terms of injury to skin, that it would
14 only take about four hours before you would start to notice
15 that if it was due to too much tension?

16 A. I don't know that I would agree with that. I think there
17 are early signs of tension that you might see. You might not.
18 You might have a bandage on and not see it. You would have to
19 examine the patient.

20 And I actually agree with you it would be critically
21 important to do that. And there's no evidence that that was
22 done.

23 Q. And you agree that, in terms of that same question, that
24 it would take about twenty-four hours if there was too much
25 tension, for it to show injury to the fat?

1 A. I don't agree on that. I think what you're doing is
2 you're quoting -- it depends on the amount of tension, how
3 serious it is. I've seen fat necrosis four or five weeks
4 after surgery. I've seen it early after surgery. I've seen
5 tissue loss within a day after surgery. I've seen it a long
6 time afterwards. There's no one way that it presents.

7 Q. You agree that it's a pretty basic skill for a plastic
8 surgeon performing this operation to know how to -- not --
9 excuse me, to close the wound without too much tension and
10 that is something that every plastic surgeon should know;
11 correct?

12 A. I think that's, really, as I've said, the fundamental
13 part of this operation and plastic surgeons need to take care
14 to close it without too much tension.

15 Q. And I believe I asked you this question in your
16 deposition about the left breast; and you said there's not
17 enough evidence to conclude that Dr. Schimpf applied too much
18 tension on the sutures on the left breast, correct?

19 A. You would have to show me that. I remember saying that
20 it was not -- there's not enough evidence to say it was a
21 deviation from the standard of care. And it's not the same
22 thing. That there was not enough evidence for me to say for
23 certain that there was a deviation from the standard of care.

24 I believe I did take the time to say there were
25 indications that there was fat necrosis that was the open in

1 the wound.

2 So, you know, show me where I said that there was no
3 indication of any damage to the left side.

4 Q. Well, the left breast never required explantation (ph) or
5 developed any of the same problems the right breast did;
6 correct?

7 A. That's not the same question that you asked me earlier.

8 Q. Well, there's no evidence -- there's not enough evidence
9 to say that Dr. Schimpf applied too much tension on the left
10 breast, is there?

11 A. So I'm going to disagree with you. I'm going to say that
12 there's evidence that he did apply too much tension on the
13 left side. I think that the open area that Dr. Kalus
14 described, I think the fat necrosis that was present and made
15 up 450-something grams, the MRI; I think those are all
16 indications. But I don't have enough evidence to say that on
17 the left side there was a deviation from the standard of care.

18 Q. Have you read the pathology report from the tissue that
19 Dr. Kalus removed from the left breast on this surgery?

20 A. I don't recall reading it.

21 Q. Would you like to see that? Left breast is the bottom
22 there. This is the second page, if you need it.

23 [Whereupon, the witness reviews documents]

24 A. I'm ready.

25 Q. Okay. You would agree with me that there's no mention of

1 fat necrosis in the description of the sample that was
2 received by a pathologist from Dr. Kalus' surgery?

3 A. I would agree with that.

4 Q. Moving forward to the surgery of March of 2015, is it
5 your understanding that Ms. Whitfield is the one who asked Dr.
6 Kalus to remove her left implant?

7 A. That's my understanding from the deposition testimony I
8 recall.

9 Q. And you're not testifying that Dr. Schimpf did something
10 that was below the standard of care or a deviation from the
11 standard of care with regard to the left breast, are you?

12 A. Can you repeat the question? Did you say Dr. Schimpf?

13 Q. Yes.

14 A. Please tell me the question again.

15 Q. Sure. You're not -- you're not testifying that Dr.
16 Schimpf deviated from the standard of care with regard to the
17 left breast now, are you?

18 A. Oh, as of today? No, I did not say that.

19 Q. I just -- I didn't go back and follow up further, so I
20 wanted to make sure we are clear.

21 A. I did say that there were problems with the surgery and
22 indications of too much tension, ---

23 Q. But not ---

24 A. --- but not enough for me to say that it was, more likely
25 than not, a deviation.

1 Q. Okay. And you've seen the postoperative photos from Dr.
2 Kalus' surgery; correct?

3 A. I've seen many photos postoperatively. Which one are you
4 referencing?

5 Q. The one after the March -- the second surgery that he did
6 in March of 2015.

7 A. Could I see that now to remind me?

8 Q. Okay. I'll actually bring two for you since we've
9 already used these. So do you remember seeing this picture
10 from February of 2015?

11 A. Yes, I remember seeing that picture.

12 Q. And you would agree with me that her left breast is
13 healed and so is the right at this point?

14 A. I would agree that the left breast is healed, the right
15 breast is healed, there is significant asymmetry there that
16 most people would not find acceptable.

17 Q. Right. And this is before she had surgery with Dr.
18 Kalus; correct?

19 A. That's correct.

20 Q. And then we move forward in time. This is after she had
21 surgery with Dr. Kalus; correct?

22 [Whereupon, displaying photograph]

23 A. Correct.

24 Q. Right. And you would agree with me that Dr. Kalus'
25 surgery left her with a much bigger and much more noticeable

1 asymmetry than she had preoperatively?

2 A. I would say that the asymmetry is not acceptable for most
3 patients in either case. And Dr. Kalus was trying to remedy a
4 very bad situation.

5 Q. Do you agree that Dr. Kalus' result was not acceptable?

6 A. No. I couldn't possibly agree with that. Because Dr.
7 Kalus was operating on someone who had a significant problem
8 and trying to make it better. Unacceptable in that situation
9 is way too strong a word. I think that she's not done, and
10 after that surgery would benefit from more.

11 Q. Did he make her better from both -- from one picture to
12 the next?

13 A. I don't think it's better.

14 Q. And you agree that that's part of the practice of
15 medicine, that it's an inexact science; correct?

16 A. I think that the methodology chosen to try to make it
17 better, the fat transfer, doesn't always work the way you want
18 it to. And it didn't here.

19 Q. And not every bad outcome is the result of medical
20 negligence, is it?

21 A. Oh, we've said that before.

22 MR. SMYTH: So are all of my questions. Thank you,
23 Doctor.

24 THE COURT: Mr. Halversen, how long do you think you'll
25 be?

1 MR. HALVERSEN: Five minutes, tops.

2 THE COURT: Y'all hold him to it.

3 THE WITNESS: Thank you, Your Honor.

4 **REDIRECT EXAMINATION BY MR. HALVERSEN OF DR. MICHAEL**
5 **ROSENBERG:**

6 Q. I'd like to show you what Mr. Smyth presented to you, the
7 anesthesia record, what you said the pre-anesthesia
8 evaluation. And he pointed out to you that on there it
9 said -- there is a notation about the chin and the neck?

10 A. Yes.

11 Q. Do you have any indication as to whether whoever wrote
12 that document indicated those notes, where they got that
13 information from, whether it was from Mrs. Whitfield or
14 whether it was from someone at the practice?

15 A. No. And I would add that there's no time on this note,
16 so we have no idea when this was written either.

17 MR. HALVERSEN: We'd like to next mark and introduce into
18 evidence the affidavit of Eloise Bradham ---

19 [Whereupon, Mr. Halversen confers with court reporter as
20 to next exhibit number]

21 THE COURT REPORTER: This will be Number 40.

22 MR. HALVERSEN: --- as Plaintiff's 40.

23 [Whereupon, Plaintiff's Exhibit Number 40, affidavit, is
24 marked for identification by the court reporter]

25 [Whereupon, no ruling by the Court as to Plaintiff's

1 Exhibit Number 40]

2 Q. And you may not have seen this document, but I'd just
3 like you to review it. And I'll submit to you that that is
4 the anesthesiologist that's noted on the O'Neill Plastic
5 Surgery records for the June 6th, 2014 surgery.

6 A. I would agree with that. And it looks like there's even
7 a signature here that is similar to the one here.

8 Q. And what does it indicate in Paragraph 6 as to whether or
9 not the anesthesiologist had any memory as to Mrs. Whitfield?

10 A. It says, I provided anesthesia care to the plaintiff,
11 Jeane Whitfield, on June 6th. I have no memory of Jeane
12 Whitfield, outside of what I documented in the written records
13 I prepared at the time of the June 6th, 2014 surgery in my
14 usual and customary procedures performed as an
15 anesthesiologist.

16 Q. All right. Mr. Smyth also showed you the O.R. record.
17 And remember his questions about where it was noted in the
18 O.R. records where the neck of the -- the name of the
19 procedure, the liposuction, was -- it's -- where it was
20 located on the form. Do you remember that question?

21 A. I do remember that.

22 Q. Could you also indicate for the record what the start of
23 the anesthesia time was on that page?

24 A. So the anesthesia start time is listed as 08:30.

25 Q. And what does -- what time does it say when the patient

1 entered the O.R.?

2 A. Patient enters room at 08:30.

3 Q. Do you have an opinion, within a reasonable degree of
4 medical certainty, as to whether or not the patient could have
5 even provided any consent into the O.R., given the record that
6 you have before you?

7 MR. SMYTH: Objection, Your Honor. It calls for
8 speculation.

9 THE COURT: Rephrase the question. He may be able to
10 answer.

11 Q. Doctor, what time is it indicated on the -- that sheet as
12 to when Mrs. Whitfield went into the O.R?

13 A. It indicates on this sheet that she went into the room at
14 8:30, anesthesia started at 8:30, but the anesthesia concerns
15 were discussed at 9:45.

16 Q. Is that possible that a patient can discuss things when
17 they're under anesthesia?

18 A. No. That would clearly be impossible. And of note,
19 relative to the earlier question, that's written above -- the
20 anesthesia concerns discussed, is written about the procedure
21 name. So it looks to me, based on what you're asking me, that
22 there is no chronology here of any meaning.

23 MR. HALVERSEN: Thank you, Dr. Rosenberg. No further
24 questions.

25 THE COURT: All right. Well, you are free to go. And I

1 hope you have a safe flight back and safe travels. And thank
2 you very much for being here.

3 THE WITNESS: Thank you, sir.

4 [Whereupon, the witness exits the witness stand]

5 THE COURT: Ladies and gentlemen of the jury, we're going
6 to go ahead and take our mid-afternoon break. Okay? I'll
7 bring you back in in about ten minutes. All right?

8 THE WITNESS: I can leave?

9 THE COURT: Absolutely. I hope you travel safe.

10 THE WITNESS: Thank you, sir.

11 [Whereupon, the jury begins to exit the courtroom
12 8/28/19, 3:35 p.m.]

13 THE COURT: All right. Have you got more? Dan, y'all
14 have got one more?

15 MR. SLOTCHIVER: Yes, sir.

16 THE COURT: All right.

17 [Off the record momentarily]

18 [Whereupon, the jury exits the courtroom 8/28/19, 3:35
19 p.m.]

20 [Whereupon, a recess is taken 8/28/19, 3:35 p.m.]

21 (Whereupon, resume 8/28/19, 3:55 p.m.)

22 MR. SMYTH: One thing, Your Honor.

23 THE COURT: Okay.

24 MR. SMYTH: This was another one of our motions to limit
25 the motions in limine that we have kind of punted until the

1 witness came forward. But we had moved in limine to excuse
2 this next witness who is the plaintiff's psychiatrist, from
3 being able to offer opinion testimony about the photographs at
4 issue. I

5 She's admitted she's not an expert in plastic surgery or
6 in the evaluation of post-surgical wounds. And so to the
7 extent that plaintiff intends to ask her questions about the
8 photo or what it means or what the significance of it is, we
9 believe that's beyond the scope of her expertise.

10 THE COURT: Okay.

11 MR. HALVERSEN: Your Honor, she has planned to testify
12 that she was shown these actual photos in her therapy with
13 Mrs. Whitfield. So it goes to their course of treatment of
14 what she observed, what Mrs. Whitfield told her about the
15 photographs, her psychological state. It's directly relevant
16 to her testimony.

17 THE COURT: Well, what's your objection; that she's going
18 to give opinion testimony as to the actual damages?

19 MR. SMYTH: Well, as to a critique of the photographs and
20 what they show. So the questions that they pose to her is
21 would you expect this image to cause this damage. And so
22 inherent in that is an opinion about whether this is a usual
23 or unusual wound following this surgery, which she's admitted
24 she's not an expert in plastic surgery ---

25 THE COURT: All right, ---

1 MR. SMYTH: --- and doesn't plan to opine about that.

2 So ---

3 THE COURT: All right. Why don't we qualify that prior
4 to asking her that; that you're not a medical doctor, you
5 can't testify as to the results of these, you can't testify as
6 to whether this was done, or it's outside the scope of care,
7 you know, anything along those lines; you're simply just able
8 to testify as to the psychological effect you have -- and that
9 you believe it had, and that you reasonably believed it had,
10 and give your opinion as to Ms. Whitfield.

11 MR. SMYTH: Right.

12 THE COURT: I mean ---

13 MR. SMYTH: But I think she offered the opinion that, you
14 know, this would upset anybody, kind of thing. And I think
15 that's a little over the line, and that's where I think the
16 problem is. Because this is an expert. She's going to be
17 qualified as an expert witness, ---

18 THE COURT: Yeah.

19 MR. SMYTH: --- and so it is a very high chance, high
20 probability, of misleading this jury to thinking that she's
21 got some knowledge about this particular wound that she's
22 admitted she doesn't have.

23 THE COURT: All right. I agree with you. I mean, she
24 doesn't need to talk about other ---

25 MR. HALVERSEN: Your Honor ---

1 THE COURT: --- I mean, what it would do to other people.
2 I mean, she can talk about what she perceived from Ms.
3 Whitfield pertaining to the photos.

4 But nobody is going to say that a psychiatrist has any
5 medical, you know -- can testify as to the standard of care of
6 a plastic surgeon. I don't think she's planning on doing
7 that. So and let's just ---

8 MR. HALVERSEN: Right, so she's ---

9 THE COURT: And let's -- and let's just stick -- yeah,
10 and let's don't draw -- or ask open-ended questions about
11 others. Just stick with what their treatment of Ms. Whitfield
12 was, based on what she showed her as her ultimate injuries.

13 All right with that? It is no difference than if she had
14 just pulled her shirt up and said, this is what -- this is
15 what they look like and this is why I'm upset and let's talk
16 about it.

17 MR. HALVERSEN: And she is a medical doctor. I mean,
18 she -- he's free to cross-examine her and say, hey, you're not
19 a plastic surgeon like my client, you're not a plastic surgeon
20 like everybody else. I mean, that's certainly something that
21 goes -- he can talk ---

22 THE COURT: You are going to qualify her as an expert in
23 psychiatry. She's not going to talk about anything to do with
24 plastic surgery.

25 MR. HALVERSEN: She is not going to testify about plastic

1 surgery.

2 THE COURT: Perfect.

3 MR. HALVERSEN: That's correct.

4 THE COURT: All right. And there we go.
5 Bring in the jury.

6 MR. SLOTCHIVER: Your Honor, she can talk about how this
7 could affect people from a psychiatric standpoint?

8 THE COURT: She's going to say how it affected Ms.
9 Whitfield from a psychiatric standpoint. Not others. She's
10 going to talk about Ms. Whitfield.

11 MR. HALVERSEN: Yes.

12 MR. SLOTCHIVER: Just would the same limitation apply to
13 our -- to their psychiatric expert when he wants to compare
14 her to other people?

15 THE COURT: Talk about Ms. Whitfield.

16 [Whereupon, the jury enters the courtroom 8/28/19, 3:59
17 p.m.]

18 THE BAILIFF: Your Honor, the jury is complete.

19 THE COURT: All right. Thank you so very much.
20 Call your next witness.

21 MR. HALVERSEN: Your Honor, the plaintiff would like to
22 call Dr. Sara Marcino.

23 THE COURT: Alright.

24 [Whereupon, Dr. Marcino comes forward]

25 [Whereupon, Dr. Marcino is sworn by the clerk of court]

1 THE CLERK OF COURT: You may be seated.

2 [Whereupon, the witness takes the witness stand]

3 THE CLERK OF COURT: And for the record, please state
4 your full name, spelling your last.

5 THE WITNESS: It's Sara Marcino. M-A-R-C-I-N-O.

6 THE COURT: All right. Ms. Marcino, Dr. Marcino, we are
7 having some problems with our microphones. You seem like you
8 have a very nice voice and you can project that well, so I
9 just make sure -- I want to remind you to speak up, if you
10 don't mind. We're having a hard time with the mics today.

11 THE WITNESS: Okay.

12 THE COURT: It's not working, so you can lay -- you can
13 sit back.

14 THE WITNESS: Oh, so it's not working at all?

15 THE COURT: That's the problem.

16 THE WITNESS: All right.

17 THE COURT: You are just going to have to talk really
18 loud like I do.

19 THE WITNESS: All right.

20 THE COURT: Thank you very much.

21 MR. HALVERSEN: And let me know if you can't hear me, if
22 I need to speak louder.

23 THE WITNESS: Okay.

24 MR. HALVERSEN: Good afternoon, Dr. Marcino.

25 SARA MARCINO, Having Been First Duly Sworn, was Examined and

1 Testified as Follows:

2 **DIRECT EXAMINATION BY MR. HALVERSEN OF DR. SARA MARCINO:**

3 Q. Could you please tell the ladies and gentlemen of the
4 jury where you went to college and to medical school?

5 A. I went to Davidson College and graduated in 1996, and
6 then Medical University of South Carolina and graduated in
7 2000.

8 Q. And could you tell us about your residency and any
9 fellowships you've done?

10 A. Yes. I did my residency in general adult psychiatry at
11 Yale University, and then I returned to Medical University of
12 South Carolina and completed a child and adolescent
13 fellowship.

14 Q. And so you're a -- you're a psychiatrist; correct?

15 A. I'm a psychiatrist.

16 Q. And could you explain to the jury what the difference is
17 between a psychiatrist and a psychologist?

18 A. Main difference is a psychiatrist went to medical school,
19 so we have the medical training, went through all the
20 different rotations; and psychologists tend to do more testing
21 and therapy. And psychiatrists do those things, but also more
22 diagnostic work and prescribe medications. So more the
23 medical aspect of it.

24 Q. So you are a medical doctor; correct?

25 A. Medical doctor, yes.

1 Q. And are you licensed?

2 A. I am licensed.

3 Q. By the State of South Carolina?

4 A. Yes.

5 Q. And when did you start practicing psychiatry?

6 A. I started practicing full-time in 2005 after completing
7 my fellowship.

8 Q. And where was that?

9 A. Where did I practice?

10 Q. Yes.

11 A. I've had a private practice in Charleston. Most recently
12 I've been in Mount Pleasant for about ten years, and before
13 that I was in West Ashley. And I've done some work for -- I'm
14 currently doing one day a week at a residential treatment
15 facility like a half day a week. But mostly I do private
16 practice. I'm self-employed.

17 Q. And your office is where?

18 A. It's in Mt. Pleasant on Anna Knapp Boulevard.

19 Q. Are you a board certified physician?

20 A. Yes, I am.

21 Q. What areas?

22 A. In psychiatry.

23 Q. Are you a member of any medical societies or groups?

24 A. American Psychiatrist Association.

25 Q. And you're self-employed; you have your own practice; is

1 that what I have heard?

2 A. Yes.

3 Q. And how would you describe the scope of your current
4 practice?

5 A. I treat people of all ages. I do a lot of kind of
6 diagnostic work and a lot of medication management and some
7 therapy, as well. But more the medical side of it.

8 Q. Okay.

9 MR. HALVERSEN: Your Honor, at this time we'd like to
10 propose to offer Dr. Marcino as a expert in the field of
11 psychiatry.

12 THE COURT: All right. Any objection?

13 MR. SMYTH: None, subject to our prior motion.

14 THE COURT: All righty. Ladies and gentlemen, she has
15 been qualified as an expert in psychiatry and can give her
16 opinion.

17 All right?

18 Q. Dr. Marcino, when did you start seeing and treating Mrs.
19 Whitfield?

20 A. It was approximately 2007, so I would say about twelve
21 years.

22 Q. And I know it looks like you might have brought your
23 chart. And I'm not asking for a specific number, but just to
24 give the ladies and gentlemen of the jury a feel for how often
25 you've treated -- or how many times do you think you've met

1 with her in the last twelve years, could you give an estimate?

2 A. Yes. I actually reviewed the chart, and it was at
3 least -- at least a hundred. Probably around a hundred or a
4 little bit more.

5 Q. And, I mean, how long do your therapy sessions usually
6 last with Mrs. Whitfield? Or any patient, for that matter.

7 A. I'd say they're most typically thirty minutes.
8 Occasionally we've had an hour. Occasionally we've only had
9 fifteen minutes just to do a check in. But usually thirty
10 minutes.

11 Q. Okay. Is it fair to say that you know Jeane Whitfield
12 pretty well?

13 A. It is.

14 Q. And when Jeane comes to you and tells you about her life
15 experiences, have you found them to be reliable and credible?

16 A. I have.

17 Q. Do you believe that she is telling you the truth?

18 A. Yes.

19 MR. SMYTH: Objection, Your Honor. May we approach?

20 [Whereupon, an off-the-record bench conference is held]

21 THE COURT: For the record, I am going to overrule the
22 objection.

23 Q. Do you believe she is telling you the truth when she --
24 when you meet with her?

25 A. I do.

1 Q. Have you ever had patients that come to you that -- where
2 you question whether they're being accurate and truthful?

3 A. Yes, I have.

4 Q. Is Jeane Whitfield one of those patients?

5 A. No, she's not; because she admits things that a lot of
6 patients wouldn't admit. She comes in and she readily will
7 tell me if she hasn't been taking her medications. And a lot
8 of patients do not do that. Or will say that she's been
9 drinking or is -- a lot of people will minimize or deny that.
10 And so I feel like she's been willing to kind of throw herself
11 under the bus, so to speak.

12 And also, her -- the things that she has told me over the
13 years, she's very consistent. It's the exact same every time.
14 Her story doesn't change. It doesn't waffle at all.

15 Q. Have you ever diagnosed her as being histrionic?

16 A. I have not diagnosed her with that personality disorder.

17 Q. Okay. And what is -- for the benefit of the jury, what
18 is -- what is a histrionic disorder? What does being
19 histrionic mean?

20 A. Well, so a personality disorder is when someone has a
21 certain number of personality characteristics that reach a
22 point that they cause impairment or distress and impair their
23 lives.

24 And with histrionic personality disorder you are going to
25 see a pattern of very dramatic behavior; also provocative,

1 flirtatious, attention-seeking behavior, and a tendency to be
2 very self-centered and to not have much care for other people.

3 Q. Do you believe that Jeane is an alcoholic?

4 A. No.

5 Q. Have there been times when Jeane has used alcohol to
6 excess?

7 A. Yes.

8 Q. And has she been forthright in telling you when that has
9 happened?

10 A. She has.

11 Q. Was it ever anything that brought to you a level of
12 clinical significance or rise to the level that you felt that
13 she needed some specialized treatment or intervention for it?

14 A. It never was to the point that she needed any specialized
15 treatment for it. We would talk about it. She was able to
16 curb it on her own easily.

17 Q. Can patients that don't have any psychological or
18 pathology in the normal population overindulge and not be
19 alcoholics?

20 A. Yes.

21 Q. Do you believe -- does Jeane use any illegal drugs?

22 A. No.

23 Q. Is she a functioning member of society, in your opinion?

24 A. She is, yes.

25 Q. What does Jeane do for a living?

1 A. She helps with her husband's real estate business.

2 Q. Are you aware of other activities that Jeane does, aside
3 from work-related functions?

4 A. She's been involved in a variety of volunteer
5 organizations over the years.

6 Q. Do you have -- do you have any recollection of
7 specifically what some of those are?

8 A. The SPCA I know is one that she's very interested in. I
9 think there was Hurricane Relief. And I believe there were --
10 have been some others at times. But the SPCA is the one that
11 stands out the most.

12 Q. Is it fair to say that Jeane has had a lot of traumatic
13 events in her life?

14 A. She has.

15 Q. And may I ask you -- and I know this is -- you know, some
16 of this is sensitive. But can you share with the jury some of
17 the things that's happened to her that have been significant
18 events in her life?

19 A. She -- when she was around nineteen or twenty, she was
20 raped. She has had quite a few losses, death of her parents,
21 very difficult stuff. Her sister from cancer. There was an
22 attack by a pit bull at one point. There's been some marital
23 stress. Her husband has had some pretty significant cardiac
24 issues. That's been a stress. And then there was a period of
25 time at which her husband's ex-wife was essentially stalking

1 them, and that was definitely a stressor.

2 Q. Do you remember when her mom died?

3 A. It was in the middle of all of this. I believe it was --
4 I believe it was in July of 2014.

5 Q. And before that surgery -- which I'll represent to you
6 what we're here for today was the June 6, 2014 surgery.

7 Before that time, did you have any psychological diagnoses
8 that you had made for Jeane?

9 A. Anxiety has been a big problem with panic attacks. We
10 call it panic disorder. So recurring panic attacks. And then
11 a depression. She has had depression that has had some
12 features of bipolar disorder, primarily that it has
13 fluctuated. Often in reactions to things that are going on
14 environmentally in her life. But it has fluctuated. I

15 So that's always been a question. I've seen some of
16 those features, but I've never -- I've never diagnosed bipolar
17 disorder. It's more of a depression that sort of comes and
18 goes. And then the anxiety.

19 Q. And to clarify, my question was about before the surgery.

20 A. That's before the surgery.

21 Q. Right.

22 A. That's ---

23 Q. Right. And after the surgery, had you ever diagnosed
24 Mrs. Whitfield as being bipolar?

25 A. No. No, it stayed the same. I think that the depression

1 certainly became more severe and more difficult to treat and
2 more problematic. There were some symptoms. For example,
3 suicidal thoughts as long as I've known her that was -- that
4 has never been an issue. That has never come up, no matter
5 what was going on in her life. And she has a lot going on
6 over the years. And it was after that time that she had
7 suicidal thoughts, pretty significant ones, at different
8 points.

9 Q. And for the benefit of the ladies and gentlemen of the
10 jury who might not know what a panic attack is, just very
11 briefly could you ---

12 A. Sure.

13 Q. --- or panic disorder, could you tell them kind of in a
14 nutshell what that means?

15 A. Sure. Yeah, I can do that. So it's tremendous horrible
16 anxiety that it escalates over the period of about ten
17 minutes; and it's very physical in nature, so a lot of times
18 people end up in the emergency room thinking they're having a
19 heart attack. In fact, that's sort of the tell-tell sign;
20 because it's so physical so there could be chest tightening,
21 chest pain, shortness of breath, tremor, sweating,
22 lightheadedness, just many physical symptoms like that. And
23 there's that feeling that you're going to die or completely go
24 crazy. It's a horrible experience. And, again, it's -- it
25 does tend to remit over a period of about an hour.

1 Q. It sounds like it's an anxiety attack?

2 A. It's an anxiety attack. It is.

3 Q. And she has had times when she has had some of those
4 episodes?

5 A. Yes, she has.

6 Q. And have you ever describe -- I'm sorry. Have you ever
7 diagnosed her with a somatization disorder?

8 A. No.

9 Q. Could you explain to the jury what a somatization
10 disorder is?

11 A. Somatization. So somatic means physical complaints of
12 the body. So somatic symptom disorder is what it's called
13 more recently, and it's when someone has a physical symptom
14 that they interpret as something much more severe than it
15 actually is and it creates a great deal of stress and it takes
16 a lot of your focus.

17 And so I have patients who have somatic symptom disorder.
18 And they come in and the focus is, I'm sure I've got a brain
19 tumor, I'm sure I've got -- you know, they're very sure they
20 have some horrible, horrible life-threatening illness. ALS is
21 one that I hear quite a bit. And it's very difficult to
22 reassure them. But they're very preoccupied with this
23 physical symptom, and it just consumes a lot of their
24 thoughts.

25 And we've never talked about any physical symptoms. Now,

1 she would say, gosh, I have this -- I was very anxious and I
2 had a lot of chest pressure. But she would describe it as
3 part of an understood panic attack.

4 Q. Anxiety related?

5 A. Yes, it was anxiety related. She never said that she
6 thought that she was having something more severe. So that
7 diagnosis really never even crossed my mind because she's
8 never -- she never talked about -- I mean physical complaints
9 didn't come up.

10 Occasionally, there would be something that she would
11 mention -- like she had diverticulitis and had a surgery, and
12 so she filled me in on that. She's kept me in the loop. But
13 that's never been a focus of our sessions.

14 Q. Did she ever -- did you ever get the sense she had any
15 mistrust of physicians or getting medical help or anything
16 like that?

17 A. No. No, there's never been any mention. I didn't even
18 know that -- I saw her a month before the surgery and it
19 didn't even come up. So, no.

20 Q. And before the surgery were you -- what were you managing
21 her anxiety and depression with?

22 A. Well, let me look at my records. Hold on ---

23 Q. And let me just ask -- I'm not -- if you can remember,
24 generally speaking. I don't need to know the exact name of a
25 medication, ---

1 A. Do I need to know these?

2 Q. --- but if you could tell me just to kind of move things
3 along ---

4 A. I mean an anti-anxiety medication ---

5 Q. Yeah. Certain kind of class of drugs or ---

6 A. At that time, it was -- well, let me just -- let me just
7 look.

8 Q. Okay.

9 A. I don't want to say it wrong.

10 At that point -- okay. It was Klonopin, which is an
11 anti-anxiety. And then we were using Risperdal, at like
12 point -- a very low dose, .05 milligrams at that time. And
13 Ambien for sleep, she was taking 10 to 20 milligrams at that
14 time.

15 Q. And with respect to Mrs. Whitfield, did some of these
16 medications work better than others?

17 A. Some worked better than others. Some were tolerated
18 better than others. So --

19 Q. And some of these medications have side effects?

20 A. All of them have side effects, potentially.

21 Q. And did she have side effects?

22 A. She's had some side effects.

23 Q. And what are those side effects?

24 A. Well, there's many. Weight gain is a big problem with
25 these, sexual side effects, gastrointestinal problems, rashes,

1 problems with skin. I mean, there's a long list of potential
2 side effects. Those are some that she did have. Rash and
3 weight gain was a problem with some of the medications.

4 Q. And has she gone on and off these medicines over the
5 course of the twelve years that you've been treating her?

6 A. Yes, she has. She's been doing much -- she's been much
7 more consistent over the recent -- the recent past. But, yes,
8 previously she would sometimes go off the medications. And
9 then she would come in and she would be honest about it and
10 let me know, and we'd get her back on track. But, yes, she
11 has.

12 Q. Is that -- is it uncommon for patients to go off of their
13 medicines, in your practice, when they feel better?

14 A. It's very common. I mean just in the general population,
15 not necessarily the psychiatrist population, but in the
16 general population, thirty to fifty percent of adults are
17 noncompliant with their medications. Sometimes they feel
18 better, sometimes it's because of side effects, sometimes
19 they'll just forget, and it's a nuisance, sometimes it's cost.
20 I mean, there's a lot of different reasons.

21 But, yeah, sometimes people feel better and then they
22 just kind of forget or feel like I don't need these
23 medications so much anymore.

24 Q. So as a clinician, that phenomena is not unique to Mrs.
25 Whitfield?

1 A. No. It's very common.

2 Q. So let's talk about the events of why we're all here
3 today. Do you recall when she had the doctor -- surgery with
4 Dr. Schimpf?

5 A. Um ---

6 Q. And I am not holding you to the date, although I've told
7 you the date.

8 A. Yeah, I mean I know it was June 6th of 2014.

9 Q. And do you recall -- and do you have an independent
10 recollection of when she came to you after you -- after it
11 happened the first time?

12 A. It was -- I have got it right here. It was July 29th of
13 2014.

14 Q. And did she share some photographs with you of what had
15 happened and the pictures that she had of her breasts?

16 A. She did.

17 Q. I am going to show you some of these pictures and see if
18 any of them are the ones that she might have showed you in
19 your therapy or not.

20 Do you recognize this picture, which is identified as
21 Plaintiff's 21?

22 A. I don't think so. I don't think that that -- I don't
23 think that was one of them.

24 Q. Okay. How about -- how about Plaintiff's Exhibit 14?

25 A. Yes. Yes, that was one of them.

1 Q. How about Plaintiff's 15?

2 A. I don't think I saw that one. I don't ---

3 Q. Okay. I'm just trying to determine which ones she shared
4 with you.

5 Plaintiff's 16?

6 A. I think she -- I think maybe. Well, I saw something very
7 similar to that.

8 Q. Plaintiff's 18?

9 A. I don't think I saw that one.

10 Q. Plaintiff's 19?

11 A. I don't think I saw that one, either.

12 Q. Plaintiff's 20?

13 A. I did not see that one.

14 Q. Okay.

15 A. But I felt like I saw -- I felt like there was another
16 one that I saw. But I definitely saw the one.

17 Q. Let me show you this -- it could be this one.

18 Plaintiff's ---

19 MR. SMYTH: Your Honor, can we establish that the witness
20 is familiar with them before we publish them again?

21 THE COURT: Come up here real quick.

22 [Whereupon, an off-the-record bench conference is held]

23 Q. Have you seen this one?

24 A. Yes.

25 Q. Okay. I thought that that might ---

1 A. Yes. I saw ---

2 Q. --- be it.

3 A. Yes. I saw that one for sure.

4 Q. That was Plaintiff's Exhibit 22.

5 A. Yes.

6 Q. Okay. And when she showed you those pictures, which
7 we've now identified which ones she did show you in therapy,
8 what did you -- what was your reaction?

9 A. I mean, I -- she described it. But seeing it was pretty
10 shocking. And I think that she, in part, had struggled with
11 feeling validated through the whole process, that I think may
12 have been looking for some validation. Like is this -- is
13 this me, is there something wrong with me, or is this a
14 problem.

15 Because -- and I've got it quoted in that note, that's
16 when she came in and she felt like Frankenstein, felt very --
17 she felt incredibly defective and ruined, and she showed me
18 those pictures, so to kind of back that up.

19 Q. And when you say validation, meaning she was -- she was
20 seeking to get some input from you that ---

21 A. Was she -- was this an overreact -- was she overreacting,
22 was it an appropriate response to be upset. Because she was
23 very, very distressed by it.

24 Q. Do you believe it was an appropriate reaction, as a
25 psychiatrist, to -- for her to have had the reaction she had?

1 A. Yes. It makes very good sense to me, yes.

2 Q. Do you believe, as a psychiatrist, that her reactions are
3 reactions that any woman would have that didn't have any
4 psychological conditions?

5 A. Yes.

6 Q. As a medical doctor, do you believe that those
7 photographs indicate normal healing?

8 A. I do not.

9 Q. Did she describe to you how her chest was separating and
10 how she called Dr. Schimpf's office for help?

11 A. Yes. Yes, she did. She has many times. Yes.

12 Q. And did you find those accounts that she gave you to be
13 reliable and credible?

14 A. They were the exact same every time. Phones records.
15 Yes, I did. The consistency and the detail in which they were
16 given.

17 Q. Talk about some of the de- -- could you remember, as we
18 sit here today, some of the details that she would impart to
19 you in those sessions that were consistent with what you are
20 talking about?

21 A. Do you mean from the beginning what happened?

22 Q. Anything you recall her telling you.

23 A. So what she had told me is she went in initially because
24 it was suggested by a GI doctor. I believe it was Dr. Domm.
25 There had been an issue, a pain issue, and had suggested that

1 there was maybe -- it was maybe something that a plastic
2 surgeon should look at.

3 And so she went to an office that was right next door.
4 She knew I believe the office manager or the nurse or someone
5 who worked there, and had gone in and they had discussed what
6 might help with that.

7 And I believe while she was there, there was talk about
8 some other things that could be done while she was -- while
9 she was under, that might be beneficial.

10 And she said that she went through the surgery; and it
11 was not too long after the surgery - I don't remember the
12 exact date - but the sutures started to separate. Outside of
13 her eyes and her breasts, all the sutures started to come
14 apart, and she called the office and was reassured that this
15 was just normal healing, that there wasn't anything to worry
16 about; and it continued to progress.

17 Eventually, she did -- she was seen in the office and
18 was given some sutures and sent back home. But then those
19 sutures -- then those did not last and she opened up again and
20 was calling repeatedly over and over, and nobody was calling
21 back.

22 And she finally at one point she did get a call and they
23 said to come in, and so she went in thinking she was going to
24 get seen and they handed her two prescriptions at the window.
25 I think an antibiotic and a pain medication, I believe.

1 And so she took those and kept taking them. And at some
2 point started to have some pain and felt like it was pain that
3 was related to the surgery and was really concerned about that
4 and continued to call and wasn't getting any response.

5 I think at some point went to the hospital just to make
6 sure it was not something cardiac because it was a new -- it
7 was a different kind of pain than she had experienced
8 associated with anxiety.

9 So she went in and I think was observed. I don't think
10 that they found anything problematic of her heart. And the
11 same thing happened I think we were in -- I think it was
12 July -- when -- do you know when she first saw Dr. Kalus? I
13 can't remember the ---

14 Q. Well, I can't ---

15 A. Oh. You can't tell me.

16 Q. I can't tell you.

17 A. So -- essentially, she kept getting the same feedback,
18 this is normal, we'll deal with it later. And nobody was
19 actually seeing her. I think she had seen him the one time.
20 And so he had laid eyes on her one time, and then there were
21 some prescriptions out the window; and she was not comfortable
22 being reassured when no one was actually seeing her.

23 And eventually I think she was feeling completely
24 dismissed and ignored and she felt like she wasn't being cared
25 for, understandably. And so she sought out a second opinion.

1 So she went online and found another surgeon, Dr. Kalus.
2 She went in and saw Dr. Kalus, and apparently he had some
3 concerns about the -- what was going on. He had some
4 significant concerns, so he went and called Dr. Schimpf, who
5 then was willing to get her in the next day.

6 And what she described, the next day -- and she's
7 described it many times. She replays it in her head. She
8 visualizes it and gives me the details at certain times.

9 She went into the office and went into the examining
10 room, and she says that he came in and from the very beginning
11 seemed very angry and annoyed. And her interpretation was
12 that another doctor had called him out and had seen her and
13 apparently she wasn't looking good and so he -- she thought
14 that he was feeling called out and felt that he was angry, so
15 that he seemed really angry with her at the time and sort of
16 abruptly put in I think two sutures without anesthetic; and it
17 hurt, and she said something about it. She said, that hurts.
18 And he said it's just fat and you shouldn't be able to feel
19 that as he kind of did the sutures. She says -- maintains
20 that she did.

21 And she said he took his equipment and sort of threw it
22 in the sink, indictment of angrily threw it in the sink and
23 just walking out of the room just said get out of here, and
24 left.

25 And there was no plan for follow up. There were no

1 instructions. That was the entire interaction. And so she
2 was left sitting there stunned. And she left the office.

3 And I believe it was just a few days later she's in the
4 shower.

5 Q. Let me just stop you right there.

6 A. Oh. Okay.

7 Q. And I just -- those are all things that Jeane has told
8 you, ---

9 A. Okay. Yes.

10 Q. --- correct?

11 A. Oh, yes. That's all ---

12 Q. Right.

13 A. Yes. Yes.

14 Q. And you don't know -- I mean, you weren't present for ---

15 A. I wasn't present. I just heard the story.

16 Q. Okay. I just want to make that clear for everybody.

17 A. I do not know -- I was not there. No, I do not know what
18 actually took place from -- all I know is what she told me.

19 Q. All you know is what she told you. That's correct.

20 A. Yeah.

21 Q. And what I'm trying to find out is in her relaying all of
22 those events, did you find those to be accurate and credible?

23 A. I did. Because I've heard them multiple times and
24 there's been no deviation. Everything's been the exact same.

25 Q. And assuming what Jeane told you is of those accounts is

1 accurate, is that a way for a doctor to treat their patients?

2 A. No, it's not. I would say what's appropriate is if a
3 patient calls, you return the phone call. And, you know,
4 complications do happen. Not everything works out as planned.
5 And you schedule follow-up appointments and you check in with
6 them. You have them come in every few days or every week and
7 you make sure that you see it through and you take care of the
8 problem.

9 And I think her struggle was that she was having to chase
10 the office down and wasn't getting a response and felt very
11 much on her own and her breast looked like that. So it was --
12 yeah, it was very traumatic and disturbing for her.

13 Q. Did she tell you, after when you met with her, that a
14 priest had administered last rites to her?

15 A. She did.

16 Q. Did you find that to be accurate and credible?

17 A. Yes.

18 Q. Did you think she was exaggerating and making that up?

19 A. No.

20 Q. Has she told you how it made her feel when the
21 defendants' lawyers and their experts have insinuated or
22 stated that that never happened?

23 MR. SMYTH: Objection, Your Honor. May we approach?

24 [Whereupon, an off-the-record bench conference is held]

25 Q. At some point in time did Jeane tell you, after the

1 surgery, that Dr. Schimpf had performed an operation on her
2 neck without her permission?

3 A. Yes, she did.

4 Q. Did you find that to be reliable and credible?

5 A. It seemed to me to be, yes.

6 Q. Would you, as a physician, undertake a procedure on a
7 patient without their informed consent ---

8 A. No.

9 Q. --- or their permission?

10 A. No.

11 Q. Is that a deviation of the standard of care as a
12 physician?

13 A. It is.

14 Q. Would that be reckless as a physician?

15 A. It would be.

16 Q. Did Jeane tell you, in your sessions with her, that Dr.
17 Schimpf had no medical records of her office visits as well as
18 photographs of her taken preoperatively?

19 A. Yes. Yes, that is what she said, that there are no
20 records, there's records of the surgery but there was no other
21 records.

22 Q. Did you find her telling you that to be accurate and
23 credible?

24 A. I didn't have a reason not to believe her, so it
25 seemed -- it seemed to be the case. I haven't heard anything

1 to the contrary.

2 Q. When Jeane comes to you for each visit, do you make a
3 medical record and document what you saw and what you
4 observed?

5 A. Yes, I do.

6 Q. Is it below the standard of care for a physician not to
7 keep medical records or report interactions with a patient?

8 A. It is.

9 Q. Do you believe that it is reckless?

10 A. It is.

11 Q. Were you taught in medical school to keep and maintain
12 medical records of your interactions, as a physician, with a
13 patient?

14 A. Yes.

15 Q. Did they teach you that here at MUSC?

16 A. They did.

17 Q. Does Jeane re-experience these events that we're talking
18 about that have been the whole -- where we got to at that
19 point in time, does she go over those with you?

20 A. Yes.

21 Q. And what does that tell you that she keeps -- clinically,
22 as a -- in your professional opinion, what does that tell you,
23 that she keeps reliving and re-experiencing these events?

24 A. Well, it's one of the symptoms of post-traumatic stress
25 disorder, and so it supports -- it's one of the things that

1 supports that diagnosis and just speaks to the level of
2 stress.

3 Q. Did you ever diagnose her with PTSD before the June 6th,
4 2014 surgery?

5 A. I did not.

6 Q. And what exactly is post-traumatic stress disorder, for
7 the jury?

8 A. So it's a condition that has the five -- there's five
9 main criteria. The first one is trauma. You have to have had
10 a significant trauma. Usually that's either experiencing or
11 witnessing serious harm or threat of serious harm, which we
12 certainly have here.

13 At one point she did -- actually, towards the end
14 actually she did think that her life was at stake, thought
15 that she might die when she was being read her last rites. So
16 there's definitely the trauma.

17 And then there's re-experiencing, and that's very --
18 typically -- and there's different ways one -- that can
19 manifest. But typically, and in Jeane's case, it's intrusive
20 recurrent thoughts, much like the trauma is playing over and
21 over and over in your brain like a movie, like a -- and you
22 just can't escape it. And so details of the event replay
23 constantly. And another symptom is physiological distress
24 when thinking about it. And another is psychological
25 distress, which definitely -- definitely has had that. So

1 that's re-experiencing.

2 And there is the avoidance. And so -- and that can
3 manifest in different ways. Sometimes it's obvious, avoidance
4 of reminders. But it's also avoidance of talking about it,
5 thinking about it, anything that's going to kind of bring it
6 up for her. And so I've certainly seen that.

7 As I said before, I didn't even know she was getting the
8 surgery. I don't think that there was ever any avoidance of
9 any kind of medical procedures. It just didn't' really come
10 up. And when she had to go back and see Dr. Kalus, we -- she
11 did not want to go. She knew she needed to address what she
12 needed to address, but was terrified, terrified. So trying
13 her best to avoid it. And has really avoided talking about
14 it. She's had to work a lot around talking to another
15 psychiatrist and, you know, bringing these things back up. So
16 there's definitely been the avoidance. That's three.

17 The fourth is change in cognition or change in mood
18 state. And so cognition is just a different way of viewing
19 the world or just viewing things.

20 So for example, trust, now feeling that she can't really
21 trust the medical field as well. And, before, that had never
22 come up. You know, an example would be feeling that like I'm
23 totally ruined, my body is ruined. And she has said that
24 specifically.

25 But also moods, such as anger, guilt, shame. And another

1 symptom would be more withdrawal, avoidance of people. And we
2 have had that. And not participating in activities as much as
3 one used to. And she has tried, but she -- it's definitely
4 been a struggle.

5 And the final symptom or the final criterion is
6 hyper-arousal. That would be elevated anxiety. That would be
7 more problems with sleep. That would be fits of rage or even
8 aggression. So more jumpy or hyper-vigilant. And she has
9 displayed that as well.

10 Now, there were some symptoms before that. I am not
11 saying that there weren't any of those symptoms. But the
12 re-experiencing certainly not. And definitely didn't meet
13 criteria. I didn't even have that as a rule-out. Like that
14 wasn't in my differential diagnosis in my previous notes.
15 Even though she had experienced a lot of traumatic reactions,
16 she just didn't have that post-traumatic stress disorder
17 picture that she did after the surgery.

18 Q. And that reminded me of a question that came to mind, is
19 before the surgery I think you mentioned at that point in time
20 you had seen her. Did you ever consider her to not be a
21 candidate for undergoing that procedure from -- that she
22 undertook with Dr. Schimpf, based on her psychological state
23 at the time?

24 A. I would not, no. I would -- no, I would not have. She
25 had had a procedure, a liposuction procedure. I'd have to

1 look to see how much earlier. But she had had that in the
2 past, and actually she did really well. She healed really
3 well. I mean was -- that was actually a positive session.
4 Psychologically, it had a really favorable impact. And so,
5 no, I would not say that.

6 Q. So hypothetically, in say the beginning of 2014, if Dr.
7 Schimpf had called you and said, you know, I'm considering
8 doing some surgery on -- liposuction and doing some procedure
9 on Mrs. Whitfield's breasts to address her pain, is there
10 anything that I should know about that would -- maybe I
11 shouldn't do this procedure or maybe she's really not a good
12 candidate for me to undertake this procedure from a
13 psychological point of view?

14 A. I would not have said that she's a poor candidate. I
15 would have -- no, I would not have suggested against it. I
16 wouldn't have thought that it would have been a problem.

17 Q. And just for the record -- you might have said this, and
18 I apologize if you have. But when did you diagnose Mrs.
19 Whitfield with the PTSD?

20 A. So I think I first -- I didn't. Initially, I did not.
21 It was in November of 2014, so it was about five months later
22 that I actually officially gave her the diagnosis.

23 Q. And what kind of therapy can you provide, or is it really
24 something that -- is there something that she would need
25 differently or does it change the way you treat her in terms

1 of where she was before versus where she is now?

2 A. Yes. Yes. I have wanted her to see someone who has
3 expertise in that area into therapy. So who does trauma
4 focused, cognitive behavioral therapy, and something called
5 EMDR, some areas that I don't -- I don't claim to me an expert
6 in EMDR, but wanted her to see a therapist who is specifically
7 trained in EMDR and trauma-focused therapy. So trauma
8 support.

9 Q. And you referred her to a specialist?

10 A. I did.

11 Q. And who was that?

12 A. Kristen Shealy.

13 Q. And is she a medical doctor?

14 A. She's not.

15 Q. And has she been to see Ms. Shealy?

16 A. I know that they have met I think a few times. But she
17 has been very hesitant to see her more recently.

18 Q. And why is that?

19 A. So she -- as time has gone on she has felt like ---

20 MR. SMYTH: Your Honor, may we approach again?

21 [Whereupon, an off-the-record bench conference is held]

22 Q. I think in our previous testimony you indicated that
23 after the June 6th surgery she was apprehensive about going --
24 doing future corrective work with Dr. Kalus?

25 A. Yes.

1 Q. Do you believe that that was a normal reaction to the
2 events as she described to you?

3 A. Given what she had been through with the previous
4 surgery, I wasn't surprised.

5 Q. Has Jeane's anxiety and mood disorder gotten worse after
6 the surgery, as compared to how her baseline was for the seven
7 years before the surgery?

8 A. It has been.

9 Q. Does Jeane feel that she's been violated by Dr. Schimpf?

10 A. She does.

11 Q. Did it bring back other memories of her being violated?

12 A. It did.

13 Q. Did it reawaken thoughts that she had maybe put in a box
14 and had dormant?

15 A. It did. It did. She had -- there were some other things
16 that had happened with the stalking situation. I will say
17 that that had brought up -- has brought up some of that, she
18 had mentioned the month before. But this really -- yes, this
19 definitely brought that up.

20 Q. And could you explain to the jury what the stalking
21 events were?

22 A. Yes. So her husband's ex-wife was seen driving by the
23 house repeatedly and there were -- sometimes someone would
24 call the house and there would be no -- there would -- there
25 would be a hang-up or kind of silence on the other line.

1 But the main thing is that she kept driving by, and it
2 was not a named thoroughfare. There would be no reason for
3 her to drive by. And neighbors would comment on it. And it
4 felt frightening to Jeane.

5 Q. Did you ever get the sense or impression that Mrs.
6 Whitfield was making this story up about the stalking?

7 A. No, I didn't.

8 Q. Did you find her accounts of that to be reliable and
9 credible?

10 A. They were.

11 Q. Did Jeane ever tell you before the surgery that she was
12 dissatisfied -- or I'm sorry, that she was -- was she
13 dissatisfied or not satisfied with her physical appearance;
14 did she ever bring that up to you before the surgery?

15 A. No.

16 Q. After the surgery, was she upset about the whole incident
17 with -- well, strike that. Did she -- did she tell you she
18 had complaints about how this has all affected her sexual
19 life?

20 A. Yes, she has talked about that.

21 Q. Has she told you in any details about how ---

22 A. Well, she doesn't want to take her shirt off. She
23 doesn't even want anyone to see her chest. It's -- she feels
24 very ashamed of that and so doesn't want to take off her
25 clothes, thereby barring opportunities for intimacy. No,

1 she -- that's definitely been a major area that she's been
2 affected.

3 Q. Since the events happened, has she told you what -- how
4 she perceived herself before in terms of her breasts?

5 A. I don't remember talking about how she perceived them
6 before. It doesn't mean we didn't talk about it. But I don't
7 remember offhand. I just know how she's felt subsequent to
8 surgery, which is defective, broken, ruined, Frankenstein.

9 Q. And that impact -- those descriptions impacts her view of
10 herself; correct?

11 A. Absolutely.

12 Q. Has she ever told you about how her negative-self
13 perception now has impacted how she carries herself throughout
14 life?

15 A. Yes. I know that she has at many points avoided being
16 out in public, being around other people. She's very self-
17 conscious. I think at one point she was trying to wear things
18 that would sort of give it more of a balanced appearance, but
19 always felt like people could tell. And so she's very self-
20 conscious about it.

21 Q. Did she -- did she -- did you ever -- did she ever tell
22 you that she was self-conscious about her appearance before
23 these events?

24 A. No.

25 Q. What did -- do you remember anything in particular she

1 has told you about Dr. Kalus?

2 A. She feels that he has been very caring and has listened
3 to her and has worked with her. She felt like he saved her
4 life and is really -- she's thought very highly of him.

5 Q. Has it been difficult for her to pursue this lawsuit?

6 A. Yes. Very.

7 Q. Have you counseled her not to pursue it?

8 A. No. It's not my place to tell her what to do in that
9 regard. But it has been very hard on her, yes.

10 Q. Does she worry about this happening to other women being
11 treated the same way?

12 A. Yes.

13 MR. SMYTH: Objection, Your Honor.

14 THE COURT: I'll sustain it. Move to the next question,
15 please.

16 MR. HALVERSEN: I just said does she every worry.

17 THE COURT: I understand.

18 You're instructed not to answer that question, please,
19 ma'am.

20 THE WITNESS: Okay.

21 Q. Do you have an opinion as to whether Jeane's -- I think
22 you might have testified to this -- but whether her previous
23 mental issues have been exacerbated or made worse by the 2014
24 surgery by Dr. Schimpf?

25 A. They have been, yes.

1 Q. And in terms of the frequency with which she would come
2 to see you after the surgery, since 2007 to the present -- I'm
3 sorry, since 2014 to the present, has she come to see you more
4 frequently than she used to come to you between 2007 and 2014?

5 A. She has.

6 Q. Do you attribute that to the surgery of Dr. Schimpf?

7 A. Yes.

8 Q. Do you think she could benefit from future medical
9 treatment with the trauma therapist, Ms. Shealy?

10 A. Yes.

11 Q. For how long?

12 A. That's very difficult to say. I would not be able to put
13 out a timeframe on that. But I -- I would not want to put a
14 limit on that.

15 Q. For the foreseeable future?

16 A. Foreseeable -- for the foreseeable future, yes.

17 Q. Is that fair?

18 A. That's fair.

19 Q. Would you -- do you agree that anyone that had a mood
20 disorder or panic disorder or that went through the experience
21 she describes would be at a very high risk of developing PTSD?

22 A. Yes.

23 Q. Assuming Jeane's interactions with you are accurate and
24 truthful, do you believe that that could give a person that
25 had no mental health issues symptoms of anxiety or depression?

1 A. It could, yes.

2 Q. Or PTSD?

3 A. Yes.

4 Q. Were you present for when the defense psychology expert,
5 Dr. Ballenger, performed his examination of Mrs. Whitfield?

6 A. Yes, I was.

7 Q. And what was -- what was Jeane's -- and just explain to
8 the jury what that -- what entailed that examination and how
9 it happened and your role in it.

10 A. Basically, there was an evaluation by a psychiatrist on
11 the defense's side and -- to come in and meet with her and to
12 I guess render an opinion whether there had been any psych- --
13 there's been psychological impact of the surgery.

14 And so he came to my office. She was only comfortable --
15 well, she wasn't comfortable with it at all; but really did
16 not want to do it. But very strongly that she did not want to
17 do it. But agreed to do it if it could be in my office and if
18 I could be present.

19 So I sat -- so he sat in my usual chair. And she sat in
20 her usual chair. And I was on the couch sort of kind of
21 behind her, not in her line of sight. But I was there.

22 And I didn't really have much of a role. I think there
23 were two times that he was asking her questions -- I think
24 there were twice, and I could tell that they weren't -- the
25 lines were getting crossed and sort of -- I guess sort of

1 interpreted -- I think it was two different times. I can tell
2 you those examples.

3 And so he asked her about the surgery, what had happened.
4 And asked her some about other symptoms. And wanted her to
5 talk about past traumas that she was -- did not want to
6 discuss.

7 And that was -- that was -- I think she -- maybe -- maybe
8 three hours long, two to three hours long, something like
9 that. And she was definitely anxious.

10 She was not -- I didn't feel like it -- I didn't really
11 feel like it accurately represented -- I didn't feel like she
12 accurately represented herself, because I think she was very
13 nervous.

14 Q. Would you agree with me that as part of the physician-
15 patient relationship, and specifically as it applies to
16 psychiatrists, it's important to have a baseline of trust with
17 your patient?

18 A. Right. Before you talk about really personal I think --
19 or just in -- I mean in general, yes.

20 Q. Yes.

21 A. But especially when you're talking about sensitive
22 topics.

23 Q. And would it -- would it be hard for a patient to open up
24 and have a meaningful discussion with someone that they don't
25 perceive that they have trust with?

1 A. Well, yes. I think in this case she felt like she was on
2 trial. She's felt like ---

3 MR. SMYTH: Objection, Your Honor. May we approach?

4 [Whereupon, an off-the-record bench conference is held]

5 Q. I think when we left off we were talking about the
6 examination process; and you indicated you do believe that
7 it's important to have a baseline of trust as a psychiatrist
8 with your patient, correct?

9 A. It is.

10 Q. And if you don't have that baseline of trust, is it going
11 to be hard to do an accurate evaluation of your patient?

12 A. It is.

13 Q. And in the circumstance that Jeane was in and you were
14 in, do you believe that the results of that examination are
15 not reliable under those circumstances?

16 A. I didn't think so, in part because there were questions
17 that were being asked and her responses weren't -- I felt like
18 they were kind of -- she wasn't giving all the information.
19 And I can only assume that it was anxiety for -- and or maybe
20 the way it was being asked.

21 But I knew what he was asking. And I felt like there
22 were -- I feel like -- I felt like they just -- like she
23 wasn't necessarily understanding his question at times, and
24 sometimes I didn't feel like he understood her response.
25 So --

1 Q. Is it a fair characterization that communication was
2 difficult?

3 A. Communication at times was difficult. Yes, at times.

4 Q. Okay. But was Jeane cooperating with the process?

5 A. Yes, she did cooperate. There were certain topics that
6 she didn't want to discuss. And he said, you don't have to;
7 I'm going to have to document that; you don't have to discuss
8 it, but I will document that you didn't. And she said, well,
9 okay, then I choose not to bring that up -- or discuss that.

10 Q. Do you believe from a psychological point of view, based
11 on Jeane recounting that she had had a procedure done on her
12 neck without permission, do you believe that that would be an
13 issue for Jeane not to trust Dr. Schimpf and to seek out a
14 second opinion?

15 A. Yes.

16 Q. Do you believe in that circumstance that a patient that
17 had no psychological history or mental health issues, that
18 went back to Dr. Schimpf under those same circumstances as
19 described to you, would you consider that person actually
20 might have some psychiatric problems?

21 A. I would question their judgment.

22 Q. Doctor, have the events that Jeane has described to you
23 and we talked to you this afternoon about of the surgery and
24 the -- and with the defendants, do you believe that more
25 probably than not that they have caused Jeane some

1 psychological damage?

2 A. Yes.

3 Q. And all the opinions today, and that opinion you
4 expressed today, are they most probably within a reasonable
5 degree of psychiatric certainty?

6 A. Yes.

7 MR. HALVERSEN: Thank you, Dr. Marcino. Mr. Smyth will
8 probably have some questions for you.

9 THE WITNESS: Okay.

10 THE COURT: All right, ladies and gentlemen, we've worked
11 hard today so we're going to go ahead and adjourn for today.
12 And we're going to start back at a normal time tomorrow, 9:30.
13 And I promise you I am going to try to get you out right at
14 9:30. So, again, if you will just be here a little bit sooner
15 we'll begin and resume the trial then.

16 Thank y'all so very much, and I hope y'all have a
17 wonderful evening.

18 MR. SMYTH: Judge, can we ---

19 THE COURT: Hold on.

20 [Whereupon, the jury exits the courtroom 8/28/19, 5:04
21 p.m.]

22 [Whereupon, bench conference regarding scheduling]

23 THE COURT: Keep the jury in the jury room for a moment,
24 please.

25 THE COURT: Ms. Marcino, they've gone over today by a

1 lot. So this jury has been here since about 8:45 this
2 morning. That is not your problem; that's mine. So what is
3 your abilities to be present tomorrow morning for about an
4 hour, hour and a half?

5 THE WITNESS: Well, I have patients scheduled starting at
6 8:30, straight through. I mean, Friday -- is Friday an
7 option? Because I have -- I could do ---

8 THE COURT: No, because they have to close their case;
9 and they can't close their case without you. So there's an
10 issue.

11 How long do you think you'll be? I don't suspect you're
12 going to be less than an hour. That's my concern.

13 MR. SMYTH: I think you're right, Your Honor.

14 THE COURT: The only thing I could do is -- I mean, she's
15 your last witness. So, I mean, that's it; so you can't rest
16 without her. I was going to say we could do somebody else and
17 bring her back at lunch. But that's it.

18 How bad does it bang you up if we start at like nine
19 o'clock in the morning and just go to like 10:00?

20 THE WITNESS: 9:00 to 10:00?

21 THE COURT: I mean, I know that kind of knocks an hour
22 out of your life, hour and a half.

23 THE WITNESS: Well, just -- yeah. Just re- -- I -- so
24 you think I could be -- you think I could be back at the
25 office by like 10:30?

1 THE COURT: I can guarantee it.

2 THE WITNESS: Okay.

3 THE COURT: I can actually have a sheriff's deputy drive
4 you there and have you there by 10:30.

5 THE WITNESS: Okay. So I have to cancel like the first
6 couple of hours. Let me figure out. Yeah. Yeah.

7 THE COURT: I can get you there.

8 THE WITNESS: Okay.

9 THE COURT: Trust me.

10 THE WITNESS: Okay. Okay.

11 THE COURT: All right. Just let the jury -- just tell
12 the jury, if you don't mind -- I can't start at 9:30 then.

13 THE WITNESS: Shoot. And we can't do any of it today, I
14 guess? That's fine. All right. So -- and I can be here
15 whenever in the morning.

16 THE COURT: Yeah. I am just trying to accommodate you as
17 much as possible.

18 THE WITNESS: Thank you.

19 THE COURT: Just because, you know, like I say, I mean,
20 we have them here until 5:00 -- they're not going to be home
21 until 5:45 now, and ask them to be back here at 8:45, that's
22 just pushing them too hard.

23 So if you could, just ask the jury -- just ask them to
24 try be here just a little bit early, 9:15. We can hopefully
25 just, you know, take an hour to 10:15 and then I can get you

1 there by 10:30.

2 THE WITNESS: Okay. Okay.

3 THE COURT: Just ask them if we can try to begin at 9:15.

4 All right. Thank you.

5 THE WITNESS: Okay. Then I guess I'll be ---

6 THE COURT: Just if you're sitting in that chair -- if

7 you're sitting in that chair at 9:14, I'm going to bring them

8 out at 9:15.

9 THE WITNESS: Okay. Okay.

10 THE COURT: And you're still under oath, so don't discuss

11 any of your testimony with anybody or any of the attorneys or

12 anybody involved, or anything pertaining to the case, until

13 tomorrow. And we'll get you in and out. All right? I

14 apologize for that,

15 THE WITNESS: Okay.

16 THE COURT: --- but I can't just keep them here for ---

17 THE WITNESS: I know. I get it.

18 THE COURT: -- for another hour so.

19 THE WITNESS: Okay.

20 THE COURT: I appreciate your understanding.

21 All right, we are going -- when I say we are going to

22 start at 9:15, that doesn't mean that people are out in the

23 hall, people are looking at documents, we've got something for

24 the Court, we want to bring something up. We're going to

25 start at 9:15 and go. All right.

1 [Whereupon, jury trial adjourns 8/28/19, 5:08 p.m.]

2 [Whereupon, jury enters the courtroom, 8/29/19, 9:25
3 a.m.]

4 THE BAILIFF: Your Honor, the jury is all present.

5 THE COURT: All right. Thank y'all so very much. I
6 appreciate y'all being here early and on time. And as I
7 indicated, we would try to get started a little early this
8 morning. So I appreciate that. Thank you very much.

9 Mr. Smyth?

10 MR. SMYTH: Thank you, Your Honor. May it please the
11 Court?

12 THE COURT: Yes, sir.

13 SARA MARCINO, M.D., Having Been Previously Sworn, was Examined
14 and Testified as Follows:

15 **CROSS-EXAMINATION BY MR. SMYTH OF DR. SARA MARCINO:**

16 Q. Good morning, Doctor.

17 A. Good morning.

18 Q. You're still treating Ms. Whitfield on a regular basis;
19 correct?

20 A. Correct.

21 Q. And as such, you have an ethical obligation to be her
22 advocate, don't you?

23 A. I do.

24 Q. And you would agree that you've been treating Ms.
25 Whitfield for anxiety, panic disorder, and depression, and

1 some symptoms of bipolar, since at least 2007; correct?

2 A. Correct.

3 Q. And throughout that twelve-year course of your treatment,
4 Ms. Whitfield has referred to herself in some colorful terms
5 such as being a basket case; correct?

6 A. Yes.

7 Q. And coming unglued?

8 A. Yes.

9 Q. And losing it, and certifiable?

10 A. Yes.

11 Q. And long before the surgery that she had with Schimpf --
12 with Dr. Schimpf, she also had been reporting nightmares and
13 night terrors?

14 A. There have been some nightmares and night terrors in the
15 past, yes.

16 Q. She had a -- she had a history of significant nightmares,
17 didn't she ---

18 A. She ---

19 Q. --- about different traumas in her life?

20 A. She did have some nightmares.

21 Q. She reported wild animals chasing her, fear of being
22 shot; those kinds of things?

23 A. After the incident with the pit bull, there were some
24 dreams about that. And, otherwise, they were typically more
25 non-specific dreams.

1 Q. And you also agree that she's got this anxiety disorder
2 or panic disorder?

3 A. She does.

4 Q. And in terms of quantifying it, you would agree that her
5 case is severe?

6 A. I would say that it is.

7 Q. I want to turn our attention now to some of the notes
8 leading up to the surgery at issue in this case. And I'm
9 going to show you what's been pre-marked and admitted as
10 Defendant's Exhibit 26 and ask you if you recognize that
11 document.

12 A. Yes.

13 Q. Can you tell us what that is, please?

14 THE COURT REPORTER: And if I could just first clarify.

15 MR. SMYTH: Certainly.

16 THE COURT REPORTER: That was marked for identification
17 but not admitted.

18 MR. SMYTH: Oh, that's not been admitted? Okay. I'm
19 sorry.

20 THE COURT REPORTER: Thank you.

21 MR. SMYTH: I'll lay the foundation.

22 Q. Is that a medical record from your chart, Doctor?

23 A. It is.

24 Q. Okay.

25 A. Yes.

1 Q. On Ms. Whitfield?

2 A. Yes. You're talking about the note from April 2nd?

3 Q. No. The top one.

4 A. The top one? Okay. From December. So there was
5 December 9th, 2013; and then the next note after that was
6 April 2nd, ---

7 Q. Right.

8 A. --- two thousand and ---

9 Q. We'll actually get through both.

10 A. Okay.

11 MR. SMYTH: But, Your Honor, at this time I would move to
12 have this document admitted into evidence.

13 THE COURT: All right. Any objection?

14 MR. HALVERSEN: Can we see it?

15 MR. SMYTH: Oh, sure.

16 [Whereupon, Mr. Smyth proffers documents to the plaintiff
17 counselors]

18 THE COURT: Any objection?

19 MR. HALVERSEN: No, Your Honor.

20 THE COURT: All right. Without objection.

21 [Whereupon, Defendant's Exhibit Number 26, Marcino
22 record, marked for identification]

23 [Whereupon, Defendant's Exhibit Number 26 is admitted
24 into evidence by the Court]

25 Q. Doctor, in looking at your note of December 9th, 2013,

1 does it -- does your note indicate that Ms. Whitfield is under
2 a tremendous amount of stress?

3 A. Yes.

4 Q. And were you aware that that was the time that she first
5 started filling out online applications to have cosmetic
6 surgery with Dr. Schimpf?

7 A. No, I did not know about that.

8 Q. All right. And at the bottom of the page is a second
9 note from your visit of April 14th; so about four months
10 later, five months later?

11 A. Yes.

12 Q. And does your note indicate there that she's trying to go
13 off of her medications?

14 A. Yes.

15 Q. And does your note also indicate that she was -- had been
16 doing better in January and February but in March began
17 heavily drinking again?

18 A. Yes. It says in January and in February she was doing
19 better, she was trying to be off of Ambien and medications in
20 general. She was taking -- had been taking Klonopin and
21 Ambien and that small dose of Risperdal. And she did not want
22 to be taking Ambien and Klonopin and Risperdal.

23 And Risperdal does have a -- the unfortunate side effect
24 of weight gain being significant, and so people do -- and
25 there's other side effects as well. So people struggle with

1 that.

2 And so she was trying to be healthy. She hadn't been
3 drinking, she's exercising, she had lost weight being off of
4 it.

5 And then in March, the -- her husband's son and ex-wife
6 had been coming around again. I think the son had knocked on
7 the door and had been on their property. And she did start
8 drinking more heavily at that time. And she was having some
9 nightmares. And it made her very anxious about her safety.

10 I think a neighbor had seen -- had seen them on the
11 property. And so she reported it, but the police didn't do
12 anything to help with that. And it was causing stress in her
13 marriage. And she was very worried about the son, T.J., and
14 feared that he could potentially even shoot her.

15 Q. And just to clarify, T.J. is Mr. Whitfield's son from
16 another marriage?

17 A. Yes.

18 Q. And so she was afraid that he was going to come to the
19 house and shoot her; in this visit of April 2nd, that's what
20 she reported?

21 A. Yes.

22 Q. And she was having nightmares about that?

23 A. I don't know that she was having nightmares about that.
24 She was just having generic nightmares.

25 Q. Okay. And your recommendation for her, under the

1 assessment and plan there, you said, must quit drinking
2 with ---

3 A. Yes.

4 Q. --- two exclamation points ---

5 A. Yes.

6 Q. --- and that she needed to be back on her medications;
7 correct?

8 A. Yes.

9 Q. I'm going to show you what's been pre-marked for
10 identification as Exhibit 27 and ask you if you recognize that
11 document.

12 A. Yes.

13 Q. Is that a medical record from your chart?

14 A. It is.

15 Q. On Ms. Whitfield - I should have added.

16 A. Yes.

17 MR. SMYTH: At this time, Your Honor, we would offer
18 Exhibit 27 into evidence.

19 THE COURT: All right. Any objection?

20 MR. HALVERSEN: No objection.

21 THE COURT: All right. Without objection.

22 [Whereupon, Defendant's Exhibit Number 27, Marcino 0027,
23 marked for identification]

24 [Whereupon, Defendant's Exhibit Number 27 is admitted
25 into evidence by the Court]

1 Q. Looking at your note, this -- is this dated April 17th
2 of ---

3 A. It is.

4 Q. --- 2014?

5 A. Yes.

6 Q. So approximately two months before the surgery at issue
7 in this case?

8 A. Yes.

9 Q. All right. And does your note on this visit indicate
10 that Ms. Whitfield was again having more problems with her
11 husband's ex-wife?

12 A. Yes. I think she was now suing her husband and her.

13 Q. And she was also having nightmares about people breaking
14 into her house?

15 A. Yes.

16 Q. And she reported feeling trapped, afraid, and on edge?

17 A. Yes.

18 Q. And she was still drinking but your note indicates less;
19 correct?

20 A. Yes.

21 Q. All right.

22 A. She had not -- well, she hadn't had anything to drink.
23 So I'd seen her before on the 2nd of April. And this was
24 about two weeks later on the 17th.

25 She hadn't had -- the few days leading up to the

1 appointment she had not had anything to drink. But before
2 that she had curbed her drinking, but I wanted her to not -- I
3 didn't want her to be drinking at all. And so she was still
4 drinking some.

5 Q. And your assessment there was that her acute anxiety
6 persists in the context of her (sic) ex-wife's harassment?

7 A. Yes.

8 Q. And you recommended that she continue taking her
9 medications?

10 A. Yes.

11 Q. All right. The next visit, on the bottom of that page,
12 it looks like it's about two weeks later on April 28th of
13 2014?

14 A. Yes.

15 Q. And in that note, did you record that she again had
16 ongoing stress related to her husband's ex-wife?

17 A. Yes. There continued to be developments. So at this
18 point in -- the ex-wife had said that he had not paid her any
19 alimony. And she was able to get no-trespass orders against
20 the ex-wife and son at that point. But it was just an ongoing
21 process, yes. So it was -- it was very stressful, yes.

22 Q. All right. And you actually increased her Risperdal on
23 this visit; correct?

24 A. Yes.

25 Q. And Risperdal is what kind of medication, for the jury's

1 edification, please?

2 A. It is -- it's called an atypical antipsychotic. It's
3 used for a lot of different things. She was not psychotic.
4 It was not for that. At that dose it's more -- has some mood-
5 stabilizing benefits.

6 Q. Okay.

7 [Whereupon, Mr. Smyth proffers documents to Mr.
8 Halversen]

9 MR. SMYTH: Any objection?

10 MR. HALVERSEN: No.

11 Q. I am going to show you what's been marked for
12 identification as Defendant's Exhibit 28 and ask you if you
13 recognize that document.

14 A. Yes.

15 Q. Can you tell us what it is, please?

16 A. Yes. It's the next note in my chart. So the first
17 one -- now we're in May, so this is May 5th, 2014.

18 MR. SMYTH: At this time, Your Honor, we would offer this
19 document into evidence. I understand there's no objection.

20 THE COURT: All right. Without objection.

21 MR. SMYTH: Thank you.

22 [Whereupon, Defendant's Exhibit Number 28, Marcino 0026,
23 marked for identification]

24 [Whereupon, Defendant's Exhibit Number 28 is admitted
25 into evidence by the Court]

1 Q. All right. Let's go through this note. This is the last
2 visit that you had with Ms. Whitfield before her surgery with
3 Dr. Schimpf, isn't it?

4 A. Yes. It's about a month before, yes.

5 Q. I don't know if the jury can read that or not (display on
6 ELMO). And so this is a month before the surgery, May 5th.
7 And can you take us through this note under your history and
8 physical; what does it say about her level of anxiety?

9 A. So anxiety was very high.

10 Q. Does it say extremely elevated?

11 A. Yes, it says anxiety -- oh, do you want me to read it?

12 Q. Yes, ma'am. Please.

13 A. Okay. Anxiety was extremely elevated this weekend. She
14 feels violated, has felt traumatized, which brought back
15 increase of an upsetting memories about a rape from thirty
16 years ago. She's been irritable, snapping, and had developed
17 a rash.

18 She did -- she stopped Zyprexa. A somatic symptoms,
19 which is that means it was a physical symptom, which is a
20 rash. So she stopped Zyprexa.

21 She talked about her rape in a nightclub parking lot, and
22 also talking about -- also talked about losing a son in
23 infancy, and then talked about physical abuse by an ex-
24 boyfriend. So that was the first time that we'd really talked
25 about some of the traumas that she's experienced in the past.

1 Q. Okay. And this is a month before she decides to go have
2 surgery with Dr. Schimpf?

3 A. Yes.

4 Q. And it's your last visit with her before she had the
5 surgery?

6 A. Yes.

7 Q. There's a reference in there to a sexual assault, and we
8 certainly want to be sensitive to that; but the indication was
9 that that occurred at a nightclub parking lot?

10 A. Yes.

11 Q. Earlier in the week, Ms. Whitfield testified that there
12 was one that occurred I believe at a college. Did she report
13 that to you as well?

14 A. I don't recall. She -- maybe. I don't remember.

15 Q. Okay. So in any event, these are the circumstances that
16 she was in a month before the surgery; correct?

17 A. Yes.

18 Q. And she didn't tell you that she was going to have
19 surgery on this occasion, did she?

20 A. No.

21 Q. And I believe your testimony was that even if she had
22 told you that she was going to have the surgery, you would not
23 have recommended ---

24 MR. SLOTCHIVER: Judge, we have got a matter of law we'd
25 like to bring up.

1 THE COURT: All righty.

2 [Whereupon, an off-the-record bench conference is held]

3 THE COURT: Ladies and gentlemen of the jury, if you'll
4 just take a quick break, I'll bring you right back in.

5 [Whereupon, the jury exits the courtroom 8/29/19, 9:38
6 a.m.]

7 THE COURT: All right. What is your objection?

8 MR. HALVERSEN: Your Honor, we have an objection to the
9 fact that it's misleading the jury as to what actually
10 happened. And I don't think there's any issue, debate, that
11 there was only one rape. And what your comments were
12 insinuated, there was more than one.

13 MR. SMYTH: No, I was referring to the fact that there
14 were two different accounts that have been given as to the
15 location of where it happened.

16 THE COURT: All right. Well, I took it as the same
17 thing, that there was a separate incident. And I was thinking
18 to myself, wow, this lady really has had some unfortunate
19 events in her life. So I took it as the same thing. So the
20 question begs what do y'all want me to do about it.

21 MR. SMYTH: I mean I am happy to clarify that with the
22 witness when they come back in.

23 THE COURT: That's fine. That -- I think that is
24 probably the best way of doing it. The only issue that I am
25 having is is that when y'all approach every time -- and I

1 appreciate it. I understand it kind of fast-tracks some of
2 this process. But none of this stuff is on the record. And
3 so for y'all to keep and maintain a clean record, understand
4 that every time you have one of these issue from here on out,
5 I'm sending the jury out. So we are just going to have a
6 parade of juries. If they've got some Step-Finders today,
7 they're going to get their steps today. All right?

8 Bring me the jury, Mr. Robinson.

9 [Whereupon, the jury enters the courtroom 8/29/19, 9:40
10 a.m.]

11 THE BAILIFF: Your Honor, the jury is complete.

12 THE COURT: All right. Thank you very much. You may
13 resume your examination.

14 MR. SMYTH: Thank you, Your Honor.

15 Q. Dr. Marcino, before we took a break, there may have been
16 some confusion in terms of the assaults that have been
17 reported. There's only been one assault reported; correct?

18 A. Correct.

19 Q. Okay. It's just a different location, giving two
20 versions of it?

21 A. She was college-aged. So I don't know if it was --
22 that's what was meant during college. I just know that she
23 was around nineteen or twenty and it was in a parking lot.

24 Q. Okay. Thank you.

25 Now, in the face of the symptoms, the extremely --

1 extremely elevated anxiety levels, the intrusive memories, the
2 feeling violated, feeling traumatized, it's your testimony
3 that even if Ms. Whitfield had told you she was considering
4 cosmetic surgery, you would not have counseled her against
5 that; correct?

6 A. Probably not. Because -- well, my understanding was when
7 she first went in it was because there was some sort of a pain
8 issue and her G.I. doctor referred her and they had thought
9 that there was I think an encapsulation -- there was some sort
10 of issue that could be resolved through that plastic surgery.

11 So I didn't think that it was just cosmetic. I know
12 there were some things that were done cosmetically in the
13 process, but she had -- I know one occasion in the past she
14 had had some liposuction and actually did very well with that
15 and had been quite anxious before.

16 So I don't -- I don't think so. I don't really see the
17 two as particularly relevant.

18 Q. But you do agree that she should have reported her
19 psychiatric history honestly to her doctor before the surgery;
20 correct?

21 A. Yes.

22 Q. And she didn't have any other visits or interactions with
23 you again until July the 29th, about a month and a half after
24 the surgery; correct?

25 A. Correct.

1 Q. All right. And I think that visit note is recorded on
2 the bottom of the page?

3 A. It is. And I think that that -- when she was in the
4 hospital, I think had the surgery the 10th of July. And this
5 was the 29th of July.

6 Q. Okay. And the very first thing that she reported to you
7 on that visit was that her mother had been over-medicated, had
8 multiple falls ---

9 A. Yes.

10 Q. --- and injuries, had broken her hip?

11 A. Yes.

12 Q. Had a negative experience at the rehab facility?

13 A. Yes.

14 Q. And then ultimately died of a pulmonary embolism;
15 correct?

16 A. Correct.

17 Q. She did report to you that she had had surgery as well?

18 A. Yes.

19 Q. And that she had a -- I'm sorry, I can't read the note
20 myself. She claimed -- complained to you that her breast
21 surgery went wrong and that her eye surgery went wrong;
22 correct?

23 A. Yes.

24 Q. But she didn't mention anything to you about liposuction
25 on her chin at this visit, did she?

1 A. I think she did, actually. It was that visit or maybe
2 the next one. But I didn't write anything.

3 Q. So it's not documented in her record that she mentioned
4 anything, is it?

5 A. No, but it definitely was discussed.

6 Q. Was that important information?

7 A. That she had that done to her ---

8 Q. Her chin surgery.

9 A. --- chin? I think it is important that there was
10 something else that was done that she didn't know what going
11 to -- that wasn't intended to be done. So she did describe it
12 to me. And I remember her words, because it has come up
13 multiple times.

14 Q. Right. But not important enough to include in your note?

15 A. I don't write everything down, necessarily. I mean, I
16 remember it, so ---

17 Q. And that wasn't the only thing that she reported to you
18 in this visit, either, was it; she also reported to you that
19 her sisters were pressuring her to settle her mother's estate
20 so that they could get some money?

21 A. Yes. So she had -- I think she was talking about how
22 everything had happened at one. So she went into the hospital
23 and her mother died the next -- like right at that same time.
24 And she was dealing with the consequences of that.

25 And then, meanwhile, she has family members pushing her

1 to settle the estate. And she was saying she's hardly even
2 able to function at this point and was really struggling and
3 that was just adding to everything.

4 Q. And on top of that, she wasn't taking her medications
5 anymore, either; was she?

6 A. She was not taking the medication at that point.

7 Q. And you would agree that she hadn't been taking her
8 medications probably for a while before that?

9 A. She was taking ---

10 Q. I think you testified earlier that she may have stopped
11 her medications around the surgery because of interactions
12 with pain medications

13 A. Yes, she -- last -- she was taking them in May and did
14 not take -- was not taking them at this point because -- I
15 think because of pain medications and did not want to mix
16 Klonopin and opioids. And Ambien and opioids don't mix well,
17 and I think she was very anxious about that. Because at that
18 time she was taking Oxycodone and worried about interactions.

19 Q. And you would agree with all of this going on in her life
20 it would be more difficult to handle if she's not on her
21 medications?

22 A. It would be.

23 Q. And so you re-started her on her medications; correct?

24 A. We did at that point, yes.

25 Q. I am going to show you what's been marked as Defendant's

1 Exhibit 29 and ask you if you recognize that document.

2 A. Yes, I do.

3 Q. Is that your next note from August the 1st of 2014?

4 A. Yes.

5 Q. Okay.

6 MR. SMYTH: Your Honor, we'd to offer that document into
7 evidence, please.

8 THE COURT: All right. Any objection?

9 MR. HALVERSEN: No objection.

10 THE COURT: All right. Without objection.

11 [Whereupon, Defendant's Exhibit Number 29, Marcino 0025,
12 marked for identification]

13 [Whereupon, Defendant's Exhibit Number 29 is admitted
14 into evidence by the Court]

15 Q. And isn't it true that the only complaint that she
16 made -- or that you have documented in your note is that her
17 sisters were angry with her over money and greed?

18 A. The -- that's the only thing that I wrote. I'm sure we
19 talked about a lot more. Because it looks like that was an
20 hour-long appointment. But, yes, she was dealing with her
21 family being angry with her.

22 Q. And it looks like she was sleeping better and calmer,
23 back on her medications; correct?

24 A. Correct.

25 Q. All right. And then she had surgery with Dr. Kalus I

1 believe in March of 2015?

2 A. I ---

3 Q. You don't recall that?

4 A. --- don't have the exact dates.

5 Q. Okay. Do you recall her having suicidal thoughts after
6 she saw herself following Dr. Kalus' second surgery with him?

7 A. She had -- you said it was March of?

8 Q. 2015. March 11th.

9 A. 2015 -- she was having suicidal thoughts in August of
10 2014; and that continued to be a problem, yes.

11 Q. After Dr. Kalus' surgery?

12 A. Yes. There were suicidal thoughts before and I believe
13 after. I'd have to look and see; but, yeah, I would say yes.

14 Q. Did she ever tell you that she felt like Dr. Kalus had
15 left her deformed?

16 A. She did not feel that Dr. Kalus had left her deformed.
17 She felt like he did the best he could with what he had to
18 work with.

19 Q. All right. I want to turn your attention now to what
20 we'll mark as Defendant's Exhibit 33 [sic - Exhibit 30], ask
21 you if you recognize that document.

22 [Whereupon, Defendant's Exhibit Number 30, Marcino,
23 00053, was pre-marked for identification]

24 A. Yes.

25 Q. Okay.

1 A. These are notes from this summer.

2 Q. Okay. And the bottom right there is dated July 22nd,
3 2019?

4 A. Yes.

5 Q. All right. And that's a record that is a part of your
6 chart for Ms. Whitfield?

7 A. Yes.

8 MR. SMYTH: Your Honor, we'd offer this document into
9 evidence, please.

10 THE COURT: Any objection?

11 MR. HALVERSEN: No objection.

12 THE COURT: All right. Without objection.

13 [Whereupon, Defendant's Exhibit Number 33 - later
14 corrected to Number 30 - is admitted into evidence by the
15 Court]

16 Q. And isn't it true that on this last visit of July 22nd,
17 that you were prescribing six different medications to Ms.
18 Whitfield at this time?

19 A. I was prescribing -- yes. I was prescribing a low does
20 of Lithium to augment the Lexapro. So it was Lexapro for
21 depression, anxiety; Latuda, which is good for fluctuating
22 depressions and also bipolar disorder; Lithium, which is
23 effective for depression and for bipolar disorder in a very
24 low does; and then Ambien to help sleep.

25 So she was supposed to take those four regularly and if

1 she were to have acute panic or if there was something coming
2 up like -- like a deposition or some sort of situation like
3 that, there was available to her Propranolol and also Xanax.

4 Q. You would agree with me that over the twelve or so years
5 that you've been taking care of Ms. Whitfield she's had issues
6 with compliance and taking her medications as prescribed?

7 A. Yes.

8 Q. And you would agree that she does better when she is
9 compliant and takes the medications?

10 A. Yes.

11 Q. And, conversely, she struggles more when she gets to use
12 alcohol or not take her medications?

13 A. Yes.

14 Q. And that's all been true since you began seeing her?

15 A. Yes, it is. Of course, it's complicated because she also
16 has more problems with side effects when she is taking the
17 medication. So that's a battle that a lot of people struggle
18 with. They may function better but have to contend with
19 weight gain and other side effects.

20 Q. And I think earlier yesterday afternoon you told the jury
21 that you felt like the incident with this surgery has caused
22 you to diagnose Ms. Whitfield with post-traumatic stress
23 disorder; is that correct?

24 A. Yes.

25 Q. And that's PTSD?

1 A. Yes.

2 Q. All right. But isn't it true that she's had a number of
3 other traumas in her life, to include the assault that we've
4 talked about, being shot, being punched in the face by an ex-
5 boyfriend, finding the charred remains of a boyfriend after a
6 chemical explosion, miscarriages, the death of multiple family
7 members, multiple issues with a pit bull and nightmares with
8 that, being divorced, being stalked by her husband's ex-wife;
9 aren't all of those -- any one of those traumatic events
10 things that could trigger a post-traumatic stress disorder, in
11 and of itself?

12 A. Yes, they could; and also make her much more vulnerable
13 to developing. Yes.

14 Q. And you would agree -- well, I guess one of the parts of
15 your testimony was that this incident with the surgery somehow
16 reawaked some of these past nightmares; correct?

17 A. Yes.

18 Q. But she had those, as we looked at your note, in May of
19 2013 -- or, excuse me, May of 2014 ---

20 A. Yes.

21 Q. --- well before the surgery?

22 A. It did. It just perpetuated it.

23 Q. Right.

24 A. So even after things resolved with the ex-wife, which
25 they did, those continued to be problems.

Examination of Dr. Sara Marcino - Redirect by Mr. Halversen

1 Q. All right. There were multiple things that she
2 complained of causing nightmares and intrusive thoughts in May
3 of 2014; correct?

4 A. Yes.

5 Q. And that was the last visit that you had with her before
6 she had the surgery?

7 A. Yes. But that doesn't mean if you've had some sort of
8 trauma that a subsequent trauma somehow doesn't count or it
9 doesn't have any effects because they've already experienced
10 other things.

11 Q. Right. But ---

12 A. But, yes. But, yes.

13 Q. They were happening?

14 A. There were -- there were symptoms before that definitely
15 -- but this exacerbated it, the symptoms.

16 MR. SMYTH: Thank you, Doctor. I don't have any further
17 questions.

18 MR. HALVERSEN: Dr. Marcino, I just have a quick follow-
19 up.

20 **REDIRECT EXAMINATION BY MR. HALVERSEN OF DR. SARA MARCINO:**

21 Q. What I believe the defendants marked as Exhibit 28, which
22 was your first consult after the June 6th, 2014 surgery, do
23 you have that in front of you?

24 A. I do.

25 Q. And what was the -- what was your assessment -- which I

1 don't believe Mr. Smyth asked you. But what was your
2 assessment of Mrs. Whitfield after that visit?

3 A. This is the July 29th ---

4 Q. Yes.

5 A. --- visit? That it had been a horribly traumatic
6 experience for her.

7 Q. And you actually noted that on your chart, did you not?

8 A. Yes. Said horrible trauma. Yes.

9 MR. HALVERSEN: Thank you for keeping such good notes.
10 It helps us know what happened.

11 Thank you, Your Honor. No more questions.

12 THE COURT: All right. Ms. Marcino, thank you so much
13 for accommodating us and coming back today.

14 THE WITNESS: Sure.

15 THE COURT: I know that takes you away from your
16 practice. And as I promised, we have a very fast ride back to
17 your practice. All right?

18 THE WITNESS: Thank you. I appreciate it.

19 THE COURT: Hold on. She needs to get ---

20 THE COURT REPORTER: I need those exhibits. You
21 can't ---

22 THE WITNESS: Oh. Sorry.

23 THE COURT: The ones that have been marked.

24 THE WITNESS: I'm sorry.

25 [Whereupon, exhibits retrieved from witness]

1 [Whereupon, the witness exits the witness stand]

2 THE COURT: All righty. Call your next witness.

3 MR. SLOTCHIVER: At this point, the plaintiff rests its
4 case.

5 THE COURT: All right. Ladies and gentlemen of the jury,
6 there's a matter of law that I need to take up. If you'll
7 just give us a quick couple of minutes, I'll bring you right
8 back in.

9 [Whereupon, the jury exits the courtroom 8/29/19, 9:55
10 a.m.]

11 THE COURT: All righty. Yes, sir? Any motions before we
12 begin the defendant's case?

13 MR. SMYTH: Yes, Your Honor.

14 THE COURT: All right.

15 MOTION FOR A DIRECTED VERDICT

16 MR. SMYTH: At this point, Your Honor, the defense would
17 move for directed verdicts on a number of grounds. And so we
18 will -- we can go through those one by one, if you like.

19 Obviously, the Court is familiar with the standard that
20 is applicable to Rule 58. Our first grounds is that we
21 believe that we are entitled to a directed verdict with regard
22 to any damages pertaining to the patient's left breast.

23 The Court will recall that we had plaintiff's experts'
24 testimony yesterday, Dr. Rosenberg and Dr. Kalus, and that
25 both of them have conceded that there was no breach in the

1 standard of care with regard to the treatment of the left
2 breast. And so to the extent plaintiff is seeking damages
3 related to that, we believe that we're entitled to a directed
4 verdict on that issue and would so move.

5 If you would like to hear additional argument, I can make
6 it. But I think that covers it, in general.

7 THE COURT: All right.

8 MR. SMYTH: Do you want to treat them one by one, or do
9 you want me put them all out?

10 THE COURT: Put them all out.

11 MR. SMYTH: Okay. With regard to our next claim, we
12 would move for a directed verdict on the issue of punitive
13 damages. Obviously this is a clear and convincing standard.
14 We don't believe there's been any evidence in the plaintiff's
15 case that would support a finding of punitive damages in this
16 case, and so we would move to have that stricken from the case
17 at this point.

18 THE COURT: All righty.

19 MR. SMYTH: And then plaintiffs have made some claims
20 that sound in negligence per se in two respects. One is
21 dealing with duties owed from a statute. There were -- there
22 were two that have been discussed, one which was a licensing
23 regulation for an ambulatory surgery facility. There's been
24 no testimony that that regulation was applicable to the
25 defendants.

1 In fact, the evidence is to the contrary; because the
2 surgery was performed at another plastic surgeon's ambulatory
3 surgery center not owned by either defendant.

4 So Dr. Schimpf was sharing space with Dr. O'Neill and
5 using his surgery center, so clearly that regulation would not
6 apply because Dr. Schimpf nor Sweetgrass are the licensee of
7 that facility. And so we believe that that claim should be
8 dismissed.

9 And then -- and with regard to -- it was referenced, I
10 believe, to the medical board regulation, which again is a
11 licensing regulation that only the medical board has
12 jurisdiction over, not the kind of regulation that is intended
13 to be relied on in a negligence per se type claim.

14 When you look at the essential purpose of it, it is for
15 internal discipline within the profession and in this has no
16 applicability to a medical malpractice case; and so we would
17 move to have any claims of negligence per se stricken from the
18 case as well.

19 The other thing, Your Honor, with regard to both of those
20 assertions, is the lack of causation. Both the experts have
21 admitted in this case that there was no damage that flowed
22 from the lack of medical records and that the plaintiff was
23 not injured from the lack of medical records.

24 In fact, the evidence is to the contrary because it shows
25 that -- Dr. Kalus actually admitted that he was able to talk

1 to Dr. Schimpf, could have called him for any information he
2 needed and didn't. And so there's no indication that her
3 treatment was postponed, withheld, or somehow negatively
4 affected, by a lack of records. And so I think there's a very
5 strong argument, Your Honor, that there's been no proof of
6 proximate cause with regard to those claims.

7 THE COURT: Okay. All righty. Who would like to
8 respond?

9 MR. SLOTCHIVER: I will be happy to, Judge.

10 THE COURT: All right. We'll start with the first one,
11 damages of the left breast.

12 MR. SLOTCHIVER: Judge, everything was connected; and
13 that's what the testimony has been -- has come out. In fact,
14 the doctors have testified that it was perfectly normal and
15 reasonable that when you have a problem with the right breast
16 and it has to be removed, to take out the left breast. So
17 that's something for the jury to consider.

18 To leave it in, that it was -- it was talked about being
19 misshaped. We had testimony about the fact that the seam was
20 coming apart. But more significantly was the testimony that
21 when you have -- as Dr. Rosenberg said, when you have a female
22 with one breast that's in and one breast that's out, some will
23 take it out and some leave it in. Dr. Kalus said the same
24 thing.

25 Because but for the problem to the left breast, there

1 would not have been this distortion, this asymmetry, that was
2 caused directly as a result for the accident.

3 So there was damage. And it was necessitated. And it
4 was -- it was reasonably necessitated and reasonably done.
5 And that's what the doctors have testified, within the
6 standard of care it's reasonable to take it out in light of
7 the other breast having already been taken out.

8 So I believe that responds to the first one. Be happy to
9 go to the second one, if that's okay.

10 THE COURT: Okay.

11 MR. SLOTCHIVER: On the second argument, as to punitive
12 damages, Judge, rules are there for a reason. And I believe
13 you've heard about all the rules. And I've got a partial list
14 of them. But there are rules to maintain records, there are
15 rules to have photographs.

16 You know, a good example was just a few moments ago we
17 had the doctor testifying and she was cross-examined on her
18 notes. The notes were created as part of a rule. The doctors
19 have all -- Dr. Rosenberg testified keeping rules is a
20 requirement. We presented argument through the rules that we
21 presented, the state rules. And he may distinguish as to what
22 governs them, but those state rules require you to keep notes
23 and to keep photographs.

24 And the rules are kept for many reasons. Not just for
25 the doctor's office that's treating you, but also they're used

1 in the surgery and the medical records are used again down the
2 road.

3 Not keeping records, not keeping rules, not following
4 procedures, not using proper equipment, these are all things
5 that lead to recklessness.

6 And we've had a lot of testimony by the experts that the
7 conduct that was performed was reckless. Abandoning her, if
8 you believe the version that was presented by the plaintiff,
9 she was abandoned by the doctor. They would not call her
10 back. They wouldn't see her. And she tried and she tried and
11 she tried.

12 There is -- by their own -- if we believe their story -
13 and I know that the Court is looking at it in the favor most
14 likely to the plaintiff - they misdocumented their records.

15 Their story is we have pre-op and post-op but we were
16 given permission to do your liposuction but we didn't give you
17 a post-op instruction on your neck.

18 They haven't followed the rules. They haven't followed
19 the regulations. These are all evidence of recklessness.

20 They have records kept in places they should not have
21 been kept. Mrs. Tolbert testified that she found a record in
22 her filing cabinet in her office and the record should have
23 been kept in her -- in the patient's file.

24 She testified as to a photograph that she found in her
25 phone, at her house, an old phone, that should have been kept

1 in the office.

2 Once again, these are all signs of recklessness. There's
3 significant testimony about poor judgment. There's
4 significant testimony about reckless conduct. And I believe
5 it's up for the jury to determine as to whether or not it goes
6 to punitive damages.

7 THE COURT: All right. What about the two negligence per
8 se claims as to the licensing regulations and statute that was
9 brought in, and to the reference to the medical board
10 regulations?

11 MR. SLOTCHIVER: Those set forth standards, state
12 standards, that were not followed.

13 THE COURT: I -- I agree with you on that part of it.
14 Move to the portion that he makes the argument concerning
15 whether -- what are the damages.

16 MR. SLOTCHIVER: The damages from -- I'm sorry. From?

17 THE COURT: From not maintaining the medical records
18 and -- well, that's essentially the most important one that's
19 been brought up at trial.

20 MR. SLOTCHIVER: Yes, sir. The doctors have testified
21 that the records are kept for many reasons. The mere fact
22 that Kalus was able to do surgery without them, Kales was
23 faced with an urgent situation where he would have needed to
24 do surgery no matter what, is what he has testified, it needed
25 to be done when he first saw her.

1 But without the records we can't look and see how she
2 looked before. The doctors can't see what took place. The
3 complaints that she raised can't be documented.

4 The -- and that's significant, Judge, because we have
5 testimony from the plaintiff that she went there because of a
6 pain under her chest and she was told by the doctor that he
7 could fix it, that he could fix that problem.

8 Now the argument is perhaps that's not what I told you.
9 But if he couldn't fix it, then he misdiagnosed her and the
10 entire proceeding, everything she's undergone -- not only the
11 surgery with Dr. Kalus but -- not only the three surgeries
12 with Dr. Kalus, but the original surgery with Dr. Schimpf and
13 all the hospitalization would not have been necessary.

14 And that's what those records help us show. And it does
15 also help her when it comes to future people, future doctors.
16 Dr. Rosenberg testified that the lack of the medical records
17 caused her damages. And he went into detail about his
18 testimony as to why.

19 So there's evidence before the jury to hear as to the
20 recklessness and as to the damages caused by the lack of the
21 medical records.

22 THE COURT: All right. All right. As to the -- first,
23 the motion for directed verdict as to the damages of the left
24 breast, I agree that testimony has come out that, in fact,
25 that there was -- Dr. Rosenberg testified that - and I believe

1 that Kalus testified - that there was sutures that were
2 opening however that did ultimately resolve and heal itself;
3 however, but for the fact that the right one was so damaged it
4 had to be removed, the left one would not have to have been
5 removed. And therefore I find that that's an issue as to
6 damages for the jury to consider.

7 As to the punitive damages, Dr. Rosenberg testified on
8 several occasions that the acts of the -- of Dr. Schimpf were
9 reckless in nature.

10 And punitive damages -- to award punitive damages, it
11 says puni- -- may be awarded when conduct of the defendant has
12 been something more than mere negligence and the evidence must
13 establish the defendant -- the defendant's acts were reckless,
14 willful, and wanton.

15 And I believe that there has been enough sufficient
16 testimony as to the reckless behavior and, therefore, the jury
17 can consider punitive damages.

18 As to the negligence per se concerning the licensing
19 regulations and medical board regulations, I agree with the
20 defense to the extent that it's going to be a hard sell for
21 damages. But I think there's enough for them to consider it
22 and so I am going to deny the motions.

23 All right. We're going to start your case in about two
24 seconds.

25 Yeah, anything you want to put on the record, go ahead.

1 MR. SMYTH: Yes, sir, Your Honor. Sorry.

2 I think my argument on the left breast may have gotten
3 lost. The argument is that Dr. Rosenberg, yesterday on the
4 stand, admitted that there was no deviation from the standard
5 of care. Dr. Kalus' testimony said the same thing with regard
6 to the left breast.

7 So we've jumped over that hurdle that the plaintiff's
8 have to carry a burden on and jumped right to the damages
9 claim.

10 THE COURT: But I think they get ---

11 MR. SMYTH: So they can't get to the damages without
12 showing there was a breach of the standard of care.

13 THE COURT: What's your argument as to that?

14 MR. SLOTCHIVER: Your Honor, it's the same thing that you
15 just addressed a moment ago. But for having to take out the
16 other breast, she would not have had to take out this one. So
17 all the monies, all of the injuries, all of the future
18 surgeries, necessitated by it, were necessitated by this exact
19 action.

20 And if you go a step farther and consider the testimony
21 that's been presented by both Dr. Kalus and Dr. Rosenberg,
22 there's a lot of reconstruction that needs to be done now and
23 in the future, whether it's the proposal by Dr. Kalus or the
24 proposal by Dr. Rosenberg, both of them indicated a smaller
25 breast would likely be part of it.

1 The problem is on the other breast, the one that they
2 don't want to talk about, it's a large breast; so either
3 you're going to recreate it and have even more asymmetry --
4 but in order to put her back, in order to make her as whole as
5 she can be made whole, you have to take out that other breast
6 and you have to take out the implant.

7 THE COURT: Well, I agree but for the damage to the
8 right, nothing would have been -- nothing would have needed to
9 have happened to the breast on the left and therefore we
10 wouldn't be in the position that we're in.

11 And it's -- I don't think that they have to prove
12 anything about the left breast as to the standard of care of
13 that one. I think it's only for consideration of damages. I
14 mean, that's what they're asking for and that's what they're
15 basing it off of.

16 I don't believe that they're going to make any reference
17 that they deviated from the standard of care on the left
18 breast. It's just for the purposes of damages that that's the
19 -- to the extent that they had to take the left one out
20 because the right one had to come out and now a left one has
21 got to be put back in.

22 MR. SMYTH: I understand the Court's ruling, Your Honor.

23 THE COURT: All right.

24 MR. SMYTH: That's my argument.

25 But I do have -- I know you want to get going. But ahead

1 of this next witness -- our first witness is going to be Dr.
2 Schimpf. And I've got two motions in limine.

3 THE COURT: All right.

4 MR. SMYTH: Do you want to take those up now?

5 THE COURT: Absolutely.

6 MR. SMYTH: Okay.

7 MOTIONS IN LIMINE

8 MR. SMYTH: Your Honor, the first motion in limine has to
9 do with Dr. Schimpf's dismissal from MUSC or resignation from
10 MUSC. The reason that we would move in limine to keep the
11 plaintiff from making any reference to that has already
12 been -- it's tied into the other motions that we have made
13 this week in terms of his extramarital relationship, and so we
14 don't believe plaintiffs are entitled to get into that.

15 I just want an instruction so -- I can't unring the
16 bell ---

17 THE COURT: Is that the basis for -- is that the basis
18 for why he left?

19 MR. SMYTH: There was a -- well, there were multiple
20 reasons why he left. He actually resigned from that. And
21 there was -- yeah, I mean, the plaintiffs are making the
22 argument that that's why he left. But there were other
23 reasons, monetarily, and disagreements with administration.
24 And so, I mean, I think it may be permissible to say that he
25 left or resigned.

1 But I don't plan to go into any of his relationship at
2 MUSC to make it an issue. But I don't want them to try to
3 back-door in around the Court's ruling on the other prior
4 issue related to that. So I wanted to bring that to the
5 Court's attention.

6 THE COURT: All right.

7 MR. SLOTCHIVER: If I may be heard? Judge, that is
8 directly -- in fact, his testimony in deposition -- and I can
9 pull that up and show it to you if you would like. But what
10 he said -- I said, Doctor, isn't it true that the reason you
11 had to leave MUSC - and I'm paraphrasing - is because you were
12 told either leave or you're going to be fired because we
13 believe you're having an affair with somebody on staff.

14 THE COURT: What's that got to do with medical
15 malpractice?

16 MR. SLOTCHIVER: It -- well, it has to do -- it only
17 comes up if he testifies that he left because he wanted to go
18 venture out on new things.

19 THE COURT: All right.

20 MR. SLOTCHIVER: He didn't leave for that reason.

21 THE COURT: If he opens that ---

22 MR. SLOTCHIVER: And the other thing ---

23 THE COURT: If he opens that door, we'll address it at
24 that time.

25 MR. SLOTCHIVER: The other factor to it, Judge, which I

1 think is significant -- because we have members here that work
2 with MUSC. He was also -- and I do want to be able to go into
3 it about the fact that when he left MUSC he was told he could
4 never come back.

5 THE COURT: What's that got to do with medical
6 malpractice?

7 MR. SLOTCHIVER: It all depends on what he says in his
8 direct testimony.

9 THE COURT: Wait and see what he says.

10 MR. SLOTCHIVER: Okay.

11 THE COURT: Make the objection at that time.

12 MR. SLOTCHIVER: Thank you.

13 THE COURT: When we come back, we're all going to look at
14 the clock ---

15 MR. SMYTH: Sorry. One more.

16 THE COURT: All right. Go ahead.

17 MR. SMYTH: Your Honor, there has also been reference in
18 Dr. Schimpf's deposition -- he was asked about medical-board
19 complaints. There are -- there's a pending medical-board
20 complaint. However, that proceeding is treated strictly
21 confidential. And I would point you to Code Section 40-47-
22 190, which protects the confidentiality of all those
23 proceedings. It hasn't been decided. There's been no
24 findings from it. And so we don't want any reference ---

25 MR. SLOTCHIVER: We're not asking him about that.

1 THE COURT: Yeah. As long -- I mean, he's not going to
2 open the door and say ---
3 MR. SMYTH: No, sir.
4 THE COURT: --- anything -- so, yeah, they're not going
5 to ---
6 MR. SMYTH: No, sir, I just wanted to kind of preempt
7 that.
8 THE COURT: All right. And when we get back we're all
9 going to look at the clock and we're all going to agree on
10 what time it is so we can say we all agreed on one thing
11 throughout this trial. All right?
12 I'll be back in two minutes. We're all going to agree.
13 [Whereupon, a recess is taken 8/29/19, 10:13 a.m. to
14 10:18 a.m.]
15 THE COURT: All right. Thank you very much.
16 MR. SLOTCHIVER: Judge, if we can briefly this up so it
17 will move smoothly?
18 THE COURT: Okay.
19 MR. SLOTCHIVER: Two issues that I think we have.
20 THE COURT: Hold on if we have to put it on the record.
21 MR. SLOTCHIVER: I don't know if we do but.
22 THE COURT: Okay.
23 MR. SLOTCHIVER: I think it is more administrative.
24 THE COURT: Okay. Go ahead.
25 MR. SLOTCHIVER: One is with the photographs that -- the

1 exhibits that they want to put in. My concern is I have
2 already put in a lot of the exhibits. They want to put in the
3 same exhibits that I put in, under a defense label, and then
4 we have the jury with twice as many exhibits and it's
5 confusing. I don't mind for demonstrative purposes; but I
6 think that if it's already in, they should not put it in
7 twice.

8 THE COURT: Okay. What's the argument for putting it in
9 twice?

10 MR. SMYTH: It's not putting it in twice, Your Honor.
11 The version they put in doesn't contain the dates of the
12 photos. And that is a very important fact in the case.

13 THE COURT: Okay.

14 MR. SLOTCHIVER: Well, we -- the problem, Judge ---

15 MR. SMYTH: We are happy to use ours instead of theirs
16 though ---

17 MR. SLOTCHIVER: For example, ----

18 MR. SMYTH: --- so it is clear.

19 MR. SLOTCHIVER: --- this has a date that they put in.
20 Not a date ---

21 MR. SMYTH: It's a chart.

22 MR. SLOTCHIVER: They are putting in the dates. They
23 are -- no, it's not a chart. They're putting in dates --
24 we -- there's a disagreement. Let's do it like this. There's
25 a disagreement between counsel as to the dates that things

1 took place.

2 They're putting dates on their documents as if that's
3 when it took place. And the only date we have on a document
4 is when it came directly from Kalus' chart with the date on
5 it.

6 I don't believe putting a date on a document and showing
7 it to the jury as a representation that it is a factually
8 correct is proper. It's actually altering a medical -- a
9 record in order to put in information you like. And you can't
10 do that.

11 They can argue the dates, they can talk about the dates;
12 but to put in a date and to add it to a document would not be
13 proper because ---

14 MR. SMYTH: Your Honor, I apologize, but that is one-
15 hundred percent false. These are the dates that came on the
16 document, from the doctor's office, with our subpoena.

17 They took the dates off when they made their blow-ups.
18 This is how it appears in the doctor's chart. We've got the
19 Bates stamp number on it ---

20 MR. HALVERSEN: And some of those dates aren't accurate.

21 MR. SMYTH: --- to prove that.

22 THE COURT: Well, why ---

23 MR. SMYTH: That's your argument. But that's how they
24 came in the doctor's chart. This doesn't change ---

25 MR. HALVERSEN: It's true ---

1 MR. SMYTH: --- the medical record.

2 MR. SMYTH: It's true, some of those aren't accurate.

3 MR. SMYTH: Well, we have a disagreement about that.

4 THE COURT: All right. Put it in.

5 MR. SMYTH: Thank you.

6 THE COURT: All right. Are y'all ready to go?

7 MR. SLOTCHIVER: Oh. The only other one, Judge, is -- he
8 used this demonstratively. But they want to put in this
9 document that they've created with the phone record as an
10 exhibit.

11 I don't mind this one here (pointing), but actually I am
12 going to object. And we can save time. When they use --
13 introduce it as an exhibit for the jury, I'm going to object
14 to a document they created using a timeline that they set
15 forth. I don't believe ---

16 MR. HALVERSEN: We just saw this for the first time right
17 now.

18 MR. SLOTCHIVER: So demonstratively fine, but I -- they
19 have a smaller one they want to put in. I don't believe that
20 should be evidence. It's not from a medical record. It's
21 something that the law firm created on its own.

22 THE COURT: Well, is it factually inaccurate?

23 MR. SLOTCHIVER: I don't know.

24 MR. HALVERSEN: We don't know. I mean, there's -- it
25 doesn't contain 32 -- the 3242556 numbers on here, does it?

1 MR. SMYTH: It's a summary based off of her phone bills,
2 Your Honor ---
3 MR. HALVERSEN: But she ---
4 MR. SMYTH: --- that they have put ---
5 MR. HALVERSEN: --- also used the 324256 ---
6 MR. SMYTH: I'm sorry ---
7 MR. HALVERSEN: --- to make complaints to your office.
8 And those aren't on there.
9 MR. SLOTCHIVER: So it's not ---
10 MR. HALVERSEN: It's misleading.
11 MR. SMYTH: No -- no, no. These are the phone records
12 you produced to us in discovery. We went through them and
13 pulled every time that your -- that are in evidence.
14 MR. HALVERSEN: Well ---
15 MR. SMYTH: Every time your client called one of our
16 phone numbers we made a summary of it.
17 MR. HALVERSEN: Well ---
18 THE COURT: Are those -- are those phone records in
19 evidence?
20 MR. SMYTH: They are.
21 THE COURT: All right.
22 MR. HALVERSEN: If we had known this was an issue, we
23 could have brought the other cell phone records to say what
24 other calls were made.
25 MR. SMYTH: And we would have loved to have seen other

1 relevant records. But we've used what have been produced, you
2 know.

3 MR. HALVERSEN: Well, you never requested the 2556
4 number.

5 THE COURT: All right. We've resolved that issue, it
6 seems like.

7 Bring me the jury, Mr. Robinson.

8 THE COURT REPORTER: I've got one other issue to resolve.
9 We didn't ---

10 THE COURT: Hold on. Hold on.

11 THE COURT REPORTER: The exhibits that the
12 psychiatrist -- the one that was referred to as [Defendant's]
13 Exhibit Number 30 that you admitted, the actual label on it
14 was 33. So if we could adjust that to label 30 instead of
15 33?

16 MR. SMYTH: Yes, ma'am. That was my mistake. You can
17 adjust that.

18 THE COURT REPORTER. Okay. Is that fine with the Court?

19 THE COURT: Yes, ma'am.

20 THE COURT REPORTER: Thank you.

21 [Whereupon, what was originally referred to Defendant's
22 Exhibit Number 33 is changed to Defendant's Exhibit Number 30,
23 to correspond with that of which the witness was provided and
24 referred to during testimony]

25 THE COURT: Grab them, Mr. Robinson.

1 [Off the record momentarily, awaiting jury]

2 MR. SMYTH: Your Honor, I've shown them my exhibits ahead
3 of time, and I don't think there are any other objections.
4 Can we agree that those are in evidence now, the ones that I
5 have just shown you?

6 MR. SLOTCHIVER: Based on the Court's ruling, yes.
7 Absolutely.

8 THE COURT: Okay.

9 THE COURT REPORTER: I have no idea what exhibit numbers
10 you're talking about.

11 MR. SMYTH: Let me show you.

12 THE COURT REPORTER: What are they labeled, what exhibit
13 numbers?

14 MR. SMYTH: Thirty-four.

15 MR. SLOTCHIVER: Todd, the only -- the phone records, if
16 you could lay a foundation for the phone records.

17 MR. SMYTH: Okay.

18 MR. SLOTCHIVER: Okay. But the other ones, yes.

19 THE COURT REPORTER: Thirty-four?

20 MR. SMYTH: Yes, ma'am.

21 THE COURT REPORTER: We're saying these are admitted?

22 MR. SMYTH: Yes.

23 THE COURT REPORTER: Thirty-Four.

24 MR. SMYTH: Thirty-five.

25 THE COURT REPORTER: Okay.

1 MR. SMYTH: Thirty-six, thirty-eight, thirty-nine, forty.
2 [Whereupon, jury enters 8/29/19, 10:24 a.m.]
3 THE BAILIFF: Your Honor, the jury is complete.
4 THE COURT: All right. Thank you so very much.
5 We are taking up just one housekeeping matter, so give us
6 a couple of seconds.
7 THE COURT REPORTER: Okay. Your Honor, I have
8 Defendant's 34, 35, 36, 38, 39 and 40 admitted into the
9 record.
10 THE COURT: All righty. Thank you so very much.
11 [Whereupon, Defendant's Exhibit Number 34, Number 35 and
12 Number 36, marked and admitted into evidence by the Court]
13 [Whereupon, Defendant's Exhibit Numbers 38 through 40,
14 marked and admitted into evidence by the Court]
15 THE COURT: All right. Ladies and gentlemen, the
16 plaintiffs have rested.
17 Mr. Smyth?
18 MR. SMYTH: Thank you, Your Honor. May it please the
19 Court?
20 THE COURT: Absolutely.
21 MR. SMYTH: The defense calls Dr. Schimpf to the stand,
22 please.
23 [Whereupon, Dr. Schimpf is duly sworn by the clerk of
24 court]
25 THE CLERK OF COURT: You may be seated.

1 [Whereupon, the witness takes the witness stand]

2 THE CLERK OF COURT: And for the record, please state
3 your full name, spelling your last.

4 THE WITNESS: Sure. It's Dennis Schimpf. S-C-H-I, M as
5 in Mary, P as in Peter, F as in Frank.

6 THE COURT: All right. Thank you very much.
7 DENNIS SCHIMPF, M.D., Having Been First Duly Sworn, was
8 Examined and Testified as Follows:

9 **DIRECT EXAMINATION BY MR. SMYTH OF DR. DENNIS SCHIMPF:**

10 Q. Good morning, Doctor.

11 A. Good morning.

12 Q. Is this your first time testifying in a courtroom?

13 A. Yes, sir.

14 Q. You've been here all week and people have been talking
15 about you and the medical care that you've given. Would you
16 like a chance to tell your side of the story?

17 A. Yes, sir, I would. Thank you.

18 Q. Would you please introduce yourself to the jury and tell
19 them a little bit about yourself?

20 A. Sure. My name is Dennis. I have seven children. My
21 wife and I have been married for nineteen years, some good
22 years and some difficult. I've been here in Charleston now
23 about thirteen years. I grew up in Western New York, Buffalo.
24 Did general surgery training up there.

25 I actually went to medical school at Ross University,

1 which is an offshore school. The first two years are done
2 actually in the Caribbean, or the British West Indies.

3 And the main reason for that is I went to college on a
4 athletic scholarship. I played basketball, believe it or not.
5 I joked that I was a lot taller back then but -- and but
6 originally wanted, believe it or not, to be a lawyer; so I
7 went through humanities and philosophy.

8 Unfortunately, my mother became very sick and ended up
9 dying of a brain tumor. And I started volunteering in an
10 emergency room. And really loved that, my last year of
11 college. And I had to do a certain amount of volunteer work
12 to graduate. Of course, as the year gets shorter and is about
13 to graduate the only place I could do it was a hospital. So
14 it forced me to do it there because it was open twenty-four
15 hours a day. And it really made me interested in medicine.

16 And unfortunately up until that point I was a decent
17 student, but not great; and I hadn't taken any science
18 courses. So I had to go back and spend two years of doing all
19 the pre-medical stuff. And I got basically straight As at
20 that point. And I really loved it. I took, you know,
21 difficult courses that I wish I had been exposed to sooner.

22 So at that point my family doctor had taught at Ross
23 University on faculty, part time; and he had told me there was
24 a school that was nontraditional and but had about 4,000
25 people practicing in the United States. And so that was the

1 route that I went.

2 I spent two years at that school there. And then all of
3 my clinical training was done either in Europe or England,
4 actually the first nine months. And then the last year-and-a-
5 half was done throughout the United States in New York, Miami;
6 pretty much those two places.

7 At the conclusion of that I was able to get into general
8 surgery, which at the time was one of the toughest residencies
9 to get into. I ended up becoming the administrative chief
10 resident of that program. We had fifty-four residents.

11 At the conclusion of that I then ended up in Charleston
12 to continue training in plastic surgery and stayed on here in
13 Charleston working in an academic center for the first five
14 years and then transitioning into private practice.

15 Q. And your private practice is called what?

16 A. Sweetgrass Plastic Surgery.

17 Q. Right. So how many years training did you have before
18 you became a plastic surgeon?

19 A. Before you could go out and practice, I had four years of
20 college, two extra years of the postgraduate, four years of
21 medical school. I did a full five-year general surgery
22 residence and became board certified in general surgery. And
23 then two years of plastic surgery, board certification in
24 plastic surgery.

25 Q. And you mentioned the general surgery residency. Were

1 you elected the chief resident of your class?

2 A. Yes. That was the administrative position for the
3 program.

4 Q. And you're licensed to practice medicine in South
5 Carolina?

6 A. Yes, sir.

7 Q. Board certified in plastic surgery?

8 A. Yes. I'm no longer board certified in general surgery.
9 That's a ten-year run. And I didn't recertify because I don't
10 practice general surgery.

11 Q. Okay. And are you a member of any professional
12 organizations?

13 A. I am. The American Society of Plastic Surgery and the
14 American Society of Static Plastic Surgery. That's an
15 organization as the two other -- or as the two experts
16 mentioned, reviews cosmetic procedures and takes people in who
17 basically do cosmetic surgery. And then I'm a fellow of the
18 American College of Surgeons.

19 Q. And you have hospital privileges here in town?

20 A. I do.

21 Q. And where is that?

22 A. East Cooper, Roper, Summerville, Trident. I believe
23 that's it.

24 Q. All right. And do you perform a lot of surgeries in any
25 given year?

1 A. I do. I also have a credential to perform surgery now in
2 my own surgery center which is accredited by the Triple A
3 Agency, which is the accrediting body for those ambulatory-
4 based sort of private practices.

5 I do -- in terms of sort of reconstructive surgery, in
6 the first part of my career I performed about 4,000 breast
7 procedures. I ran a referral center for tertiary breast care
8 that people were sent to from other places for breast care.

9 Since I've been in private practice, I do about 800
10 surgeries a year now. It's almost exclusively cosmetic at
11 this point. I don't -- I don't do really anything other than
12 that. I have two junior partners who tend to do that other
13 stuff ---

14 Q. Okay.

15 A. --- that's not cosmetic.

16 Q. And have you written any publications or textbooks in
17 your field?

18 A. Yes. I wrote, you know, multiple sort of articles. I
19 don't have my CV in front of me. Probably the most sort of
20 one I'm proud of is I wrote the chapter for the John Cameron
21 Textbook for Surgery.

22 Cameron is the textbook that's used worldwide to train
23 surgery residents. It's a black textbook that every general
24 surgery resident throughout the world actually uses. And John
25 Cameron is now the emeritus chairman of Johns Hopkins. And he

1 actually called my office and nobody knew who he was and they
2 sort of dismissed him like he was a salesman, but he had asked
3 if I'd help write that. And I was a senior author in that.

4 Q. Okay. And have you written any non-medical works?

5 A. I did. Last -- I guess it's been a year now. Well, last
6 September I finished a book called Finding Beauty. It was a
7 combination of sort of education for plastic surgery patients
8 and a couple of things. One, trying to help people understand
9 that these surgeries are intended to help them feel better and
10 emotionally be better but the surgery alone will not do that.

11 And I also had a lot of sort of pre-op and post-op
12 references as to how to prepare for surgery. A lot in there
13 about how it affects families, the stress that it can put on
14 patients.

15 I tell patients everyone hates me the first week of
16 surgery, and they hate everyone around them because of the
17 choice that they made and what they are going through but that
18 it will get better.

19 Q. And with regard to the procedures at issue in this case,
20 have you previously performed mastopexies with implant
21 exchanges like Ms. Whitfield had?

22 A. Yes, I have. A large number both in the reconstructive
23 world doing surgery for symmetry when a patient has had a
24 mastectomy and then a reconstruction and altering both that
25 side as well as the contra-lateral side.

1 We tried to look at sort of my case log. I think I've
2 done about 600 of those with some combination of implant and
3 lift, and about 400 straight reduction.

4 Q. Okay. And when did you form Sweetgrass Plastic Surgery?

5 A. It was either -- I was surprised that the name was still
6 available, so when I filed for an outgoing -- when the CPA and
7 that filed for an LLC for it I believe it was in May of 2013.
8 And sort of started really functioning in July of 2013.

9 Q. And you're the sole owner of that practice?

10 A. I am.

11 Q. You were in the courtroom earlier this week when the
12 plaintiffs called a CPA to discuss the tax returns of
13 Sweetgrass. Does that have anything to do at all with Ms.
14 Whitfield's care in this case?

15 A. No, sir.

16 Q. Have you ever been told by the IRS, or any auditing body,
17 that your tax returns were somehow deficient in any way?

18 A. No, sir. I've used, since I -- well, personally and
19 since I've been in business, a CPA and a full professional
20 bookkeeper. I don't do any of the -- any of that bookkeeping
21 personally.

22 Q. In talking to you, I found out that you're involved with
23 a charity. Can you tell the jury a little bit about that?

24 A. Sure. You know, with seven children -- my youngest
25 daughter we refer to as the peanut. She's about nine now. My

1 other daughter and I were in Wal-Mart years ago, around the
2 same time, 2013. And when thinking about the impact bikes
3 have on children and kids -- and we bought my youngest
4 daughter a brand-new bike, and she got that for Christmas.
5 And we all were amazed at how happy she was. She'd only had
6 hand-me-down bikes up until that point. And it was her first
7 really shiny thing. And it really made her, I think, proud of
8 herself and felt good.

9 And so I went out and started the idea of buying brand-
10 new bikes and helmets for disadvantaged children. And,
11 really, distributing the bikes was a challenge. And so the
12 first few years we worked with teachers. So we would ask
13 teachers, you know, give us how many people in your class
14 asking -- who has a bike and what their bike's like. And so
15 we started that way and eventually gave them through North
16 Charleston Recreation Department.

17 And some social issues happened here in Charleston around
18 that time with the police department, and so we started giving
19 the bikes to the police and they would go out and distribute
20 them so the first interaction a child had with a police
21 officer was a positive one as opposed to a negative.

22 And we had several events through the years. We
23 partnered with Boeing, and we've partnered with now currently
24 the Charleston City Police. And we've given away 1,500 brand-
25 new bikes and helmets to children.

1 Q. All right. And the name of that charity is?

2 A. Pedals for Peanuts.

3 Q. All right. Let's talk about your treatment of Ms.
4 Whitfield. Do you recall Ms. Whitfield as a patient?

5 A. I do.

6 Q. And what do -- what's your first recollection of her?

7 A. Well, that she did come in through Dr. Domm, that she had
8 been a patient of his. I remember seeing, you know, her and
9 her husband in the office. And then, unfortunately, towards
10 the end when she -- you know talking with Dr. Kalus and him
11 taking over her care, I remember that.

12 I believe, you know, most of her care, the first four or
13 five weeks, was somewhat normal for postoperative care. Maybe
14 the first four weeks, three to four weeks.

15 I think that the first week of July or that sort of
16 second week of July, I guess it was, before -- those six or
17 seven days were the days where, you know, she had problems and
18 was unhappy.

19 Q. It's been suggested I think during this trial that she
20 came to you for one surgery and ended up leaving with several
21 other surgeries. Did you do anything to coerce Ms. Whitfield
22 into having more surgery than what she came to you for?

23 A. No. And that's not uncommon that people come in and
24 change or add on to things. And I think, you know, my job is
25 to sort of evaluate and figure out if what the patient

1 wants -- and this is sort of what I wrote in the book. Our
2 job is to match patient expectations with, hopefully, what a
3 surgery will deliver. Otherwise, the patient is going to be
4 unhappy. And, you know, ultimately, the last thing that we
5 want is unhappy patients.

6 So but it's very common for folks to come in -- we even
7 have folks who on the intake form will say something, and come
8 in and it's completely different because they don't -- they
9 don't necessarily want to share that with the front desk or
10 they don't want their family to know or they -- but usually
11 when it happens, it's usually because somebody comes in and,
12 you know, we talk about stuff or they ask questions.

13 There's a huge amount of misperception in the public eye
14 about plastic surgery and what can be done and what the costs
15 are and what's achievable. And so I think our job to really
16 inform patients about that.

17 You know, equally -- an old phrase from general
18 surgery -- I had a Viet Nam sort of old trauma surgeon that I
19 trained under that said, you know -- he had a lot of great
20 sayings. But he said it's easy to know who to operate on,
21 it's who not to operate on.

22 And so in the process of talking about procedures -- not
23 with Ms. Whitfield, necessarily or specifically, but in any
24 patient scenario, we are very careful because once obviously
25 they have surgery, the repercussions can be long-lasting and

1 difficult.

2 Q. Do you talk more people into surgery or out of surgery?

3 A. We talk more out, I would say. Because mainly people's
4 perception of what they can achieve with what they come in --
5 you know, Cool Sculpting is a great example. Everybody knows
6 what it is now. It's on TV. Patients come in that are, you
7 know, honestly overweight. They're not patients for it and
8 they want to -- they come in and they say, I want that
9 freezing thing, I want to freeze fat out. And, you know,
10 that's not what they need. They don't -- they don't -- they
11 need diet or they need lifetime -- or lifestyle changes.

12 So finding and meeting that perfect sort of in theory
13 perfect idea of what a patient wants, with what we can
14 deliver, is crucial.

15 Q. Okay. And is it important for patients to give you a
16 accurate history of their medical condition?

17 A. It is. Yes, sir.

18 Q. Tell the jury why that's important.

19 A. Well, I think there's differing levels of that.
20 Obviously, the first thing we want to do is not cause harm to
21 somebody under anesthesia, especially if they're being put to
22 sleep.

23 You know, anesthesia itself, before you even start the
24 surgery, has intrinsic risks with it. So understanding
25 cardiac-pulmonary risk factors is important. And then going

1 down the line from that; obviously knowing sort of what other
2 issues a patient has had, other surgeries they've had, are all
3 very important. And, you know, understanding what their other
4 experiences are if they want to have surgery. And certainly,
5 you know, understanding from the psychiatric standpoint where
6 they've -- where they've been.

7 And, you know, I feel for Ms. Whitfield having to sit
8 here and watch the discussions we've had about her psychiatric
9 history. And I don't -- my need or understanding of that is
10 not to judge somebody, but we need to know their ability to
11 deal with the surgery and the stress of the surgery.

12 And I write that in the book. Because it's important. I
13 think people who have a higher level of anxiety events -- it's
14 not a judgmental thing. But when something begins to go wrong
15 or doesn't seem exactly how they perceive it to be, it's much
16 more difficult to convince them, so to speak, or to get them
17 to understand that this is going to be okay.

18 And I understand that it's a patient who it's their body,
19 they don't understand surgery, they don't understand what goes
20 on. They equally don't understand what we've seen in the
21 surgeries that we've done. And we've seen the whole process.

22 And so I think knowing that -- where somebody is from a
23 psychological standpoint helps us to gauge their response to
24 the healing process.

25 Q. And this has been previously admitted as Defendant's

1 Exhibit 2. I'm going to ask you if you recognize that.

2 A. Yes, sir.

3 Q. And what it is, please?

4 A. This is an online form that's filled out by the patient
5 to be done at the -- as they come into the office, so we have
6 information about their background.

7 Q. And do you ask the questions -- ask the questions at the
8 bottom of of a page about whether the patient has had any
9 issues with emotional or psychological problems?

10 A. Yes, sir.

11 Q. And what did Ms. Whitfield tell you in that regard?

12 A. No.

13 Q. And does this form also cover the medications that a
14 patient's taking? On the second page.

15 A. Yes.

16 Q. And did she report any medications that would lead you to
17 believe she had any issues psychologically?

18 A. No. Ambien is a very commonly-used sleep medicine. Five
19 to ten milligrams is generally a reasonable dose for most
20 people.

21 Q. And you were in the courtroom when Dr. Marcino just
22 testified about Ms. Whitfield's last visit with her prior to
23 coming to you.

24 A. Yes.

25 Q. Were you aware of any of the circumstances that were

1 going on in Ms. Whitfield's life prior to the surgery?

2 A. I was not.

3 Q. Would that have been important information for you to
4 know?

5 A. Yes, sir.

6 Q. What do you think -- had you been told that information,
7 how would that have changed things?

8 A. Well, it gives a picture to, again, not in a judgmental
9 way, but a way of what's going on in their life. And the
10 perfect example, that is weight-loss surgery. If you want to
11 have bariatric weight-loss surgery you have to undergo
12 psychological screening, family-support screening, that kind
13 of stuff, to have the surgery, basically. And that's a
14 different type of surgery, obviously, and a little bit more
15 invasive; but it involves the same concept.

16 And I think it's important for me to know, also, from my
17 side, to understand how things might be perceived by her and
18 her family and what else is going on in their life, to
19 understand the struggles that they are having, as everybody,
20 you know, has their own challenges.

21 I would have liked to have had input from her
22 psychiatrist at that point. We often do -- even maybe --
23 well, for both the psychiatric sort of quick diagnosis and
24 recommendations, but also just from -- that medication list
25 is, you know, worrisome with anesthesia and other medicines

1 that we may give her, the medicines that we don't prescribe.
2 So the interactions. I don't know all of the interactions,
3 like Dr. Marcino, about psychiatric medicines. So we would
4 want -- we would want people off those medicines, obviously,
5 if possible. And if they can't, then they shouldn't have
6 surgery, most certainly.

7 And sometimes people are just at a bad point; and I think
8 the surgery becomes an oasis, like if I do the surgery all of
9 this other stuff will get better.

10 And that's a lot of some of the stuff in the book is that
11 that surgery alone is not going to do that. And people will
12 say, it's okay, do the surgery, nothing will happen to me.
13 And I'm amazed at people's perception of self-preservation.

14 You know, we can tell -- when I did trauma surgery, I
15 vividly remember in general surgery telling a patient who had
16 a ruptured triple A, a ruptured aneurism, who came into the
17 emergency room and the family -- we said, you know, he has
18 about a fifty percent chance of surviving when we took him to
19 surgery. And they said, oh, so he'll be okay.

20 And it's -- it's just -- I think it's how we get out of
21 bed in the morning, how you get onto I-26 is to think I won't
22 get in an accident.

23 And, unfortunately, surgery is like that; folks say, I
24 had surgery before, it went great. Or I'm going to have
25 surgery, I've never been sick, everything I've ever had heals.

1 You know, I like to say it's like having children. You
2 know, it doesn't matter whether the last one's a boy or a
3 girl. It has no impact on the next one and the next one and
4 the next one. And it's a -- it's a new event each time.

5 And, equally, if people have had problems they'll say,
6 well, I had a problem last time, does that mean I will this
7 time. No. You know, the body doesn't itself have a memory of
8 what happened last time it was operated on. So it's a new
9 event each time.

10 Q. And when was it that you first learned about some of the
11 history that Ms. Whitfield has unfortunately undergone?

12 A. I couldn't tell you the exact timing. I think it was
13 probably in relation to the lawsuit, because I didn't -- I
14 didn't see her, obviously, once Dr. Kalus took over her care;
15 so I would not have been interacting with her.

16 Q. And in your experience with patients with the level of
17 anxiety and some of the other problems that we've discussed,
18 would they have a more difficult time dealing with a
19 complication than somebody who doesn't have those?

20 A. Well, I think that they're, number one, less trusting of
21 me; and they assume that there's a problem at the first time
22 that we either don't match up with what they perceive is going
23 on or what they want to hear about what's going on.

24 And so -- and I know it's hard and, you know, seeing your
25 own body and having things. But they're less likely to accept

1 what I'm saying.

2 And so -- excuse me -- when we have somebody who doesn't
3 have that issue and they have a complication, or they just
4 have a normal healing issue, when we say -- they'll come in
5 and say, I just came in to make sure everything's okay, is
6 everything okay. And we'll say either yes or no. And if we
7 say yes, then they accept it and we continue.

8 Q. Let's talk a little bit about some of the issues that
9 we've heard this week. You've -- there have been a lot of
10 questions about some of the records that were -- were missing
11 in your chart for Ms. Whitfield. Given what you know about
12 the claims in this case, would any of those missing records
13 have changed anything about her clinical course?

14 A. No, they wouldn't -- wouldn't have changed anything.

15 MR. SLOTCHIVER: Objection. Speculation.

16 THE COURT: Overruled. You can answer.

17 THE WITNESS: Thank you.

18 A. No, they would not have changed anything in how she was
19 managed. I -- we should have done a better job of it. And I
20 can tell you I've worked in multiple places and worked with
21 multiple physicians; and surgeons especially were generally
22 not good at keeping records.

23 Hospitals, you know, will make you get caught up at some
24 point or you can't schedule cases anymore, or they won't let
25 you admit patients. You know, I've seen charts from other

1 doctors, people I work with, who are incomplete.

2 You know, we really have to try to be better at that and
3 we have to try to make it complete. And so a lot of those
4 hospitals, like I said, will make you go back whether it's a
5 year old, two years, three years. It has to be entered.

6 And I think the electronic -- the transition to
7 electronic medical records has been a challenge for doctors,
8 and especially surgeons, because of kind of our schedule of
9 being half in operating rooms, half in clinics.

10 We did not do a good job with it at all. When I realized
11 that there were missing documents I went from the best of my
12 memory to at least knowing what the transactions had been with
13 her, or interactions, in a very honest way. I didn't, you
14 know, obviously try to deceive anybody with that.

15 But, you know, these things unfortunately happen because
16 of human errors, whether it's been dictated or I didn't
17 dictate it or I forgot to do it. You know, we would get
18 reminders in some places about when they weren't there or
19 weren't complete. But it's something that, you know, now I
20 have ascribing of P.A.s and nurse practitioners. And the
21 medical records have advanced in the last five years to be
22 much easier to use.

23 And so I think, you know, unfortunately, at this point in
24 time we did not do as adequate a job as we should have.

25 But I will say, you know, in those instances, no hospital

1 has ever reported a physician for having an incomplete record,
2 that I'm aware of. They want them fixed and updated. There's
3 been no sort of penalty or punishment towards a person when --
4 I think, you know, we have a duty, as we'll talk about I'm
5 sure, that -- to do the best that we can with that and when it
6 is incomplete we need to fix it. And in an honest and
7 straightforward way.

8 But, unfortunately, I can honestly say to my knowledge
9 I've never seen a perfect medical chart, either mine or anyone
10 else's.

11 And I don't -- I don't -- I know that there was no point
12 that I was uncertain of what was going on. I took care of Ms.
13 Whitfield for a short period of time, and the majority of that
14 was that week where she had issues and she was interactive and
15 we were talking. And obviously I talked with Dr. Kalus. And
16 then she was eventually in the hospital.

17 So there was no question about what going on with her
18 care that a piece of paper would have fixed. Obviously, our
19 focus is on treating patients, and not charts.

20 Q. There's been some discussion about preoperative photos.
21 Are you the person that takes preoperative photos?

22 A. I'm not. At that point in time when Ms. Whitfield was
23 there, we were office-sharing with another plastic surgeon and
24 we were using -- kind of co-sharing the staff. I mean that
25 was sort of the idea.

1 But in some places we would take pictures ahead of time.
2 If it was not possible, especially if it was going to be a
3 surgery in a hospital where it was a public place and you
4 didn't want people disrobing in a kind of transient area.

5 But in the world of cosmetic surgery, we take the
6 pictures the morning of, mainly for a couple of reasons. I
7 don't -- we don't take the pictures until the patient is there
8 and going to have surgery.

9 If we took pictures of every patient that came in that
10 was considering surgery it would be cumbersome and I think it
11 would also be unfair to the patient. We shouldn't have
12 perhaps or possibly naked photos of people who aren't actually
13 having surgery. So it's done the morning of, before the
14 patient goes to the operating room.

15 Q. And you referenced the fact that when you were operating
16 on Ms. Whitfield, that you were using the facilities of
17 another plastic surgeon. Was that O'Neill Plastic Surgery?

18 A. Yes, sir.

19 Q. And was he the owner and the licensee for that surgery
20 center?

21 A. Yes. It was Clyde ASF accredited, and it was in his
22 name, yes.

23 Q. You weren't the owner of it?

24 A. I was not. I basically just office-shared. We tried to
25 share. And it only lasted a year, the year of 2013 to 2014

1 from July '13.

2 Q. Did he have an employee who was responsible for taking
3 those photos for your patients as well as his?

4 A. Yes. The nurse -- we had two or three different nurses
5 that would rotate through the facility based on availability.
6 But, yes, the nurse that was on that day would take the
7 photographs.

8 Most of our patients are female, and us taking pictures
9 of them I've never been fully comfortable with.

10 Q. Even there -- though there are some notes that are
11 missing from your chart, and these preoperative pictures,
12 would it be correct to say that you did not keep a medical
13 record of Ms. Whitfield?

14 A. I don't believe that's correct. I think we did not -- we
15 do not have every document. I think that is.

16 Q. And you've reviewed your chart in this case?

17 A. I have, yes.

18 Q. Okay. Did you have a history from Ms. Whitfield, ---

19 A. Yes.

20 Q. --- this what we already looked at?

21 A. Yes. Uh-huh.

22 Q. Okay. Did you have patient registration forms?

23 A. Yes.

24 Q. All right. Did you have a copy of Ms. Whitfield's
25 driver's license and a contact information?

1 A. Yes.

2 Q. Did you have consents for photography and patient
3 appointment logs?

4 A. Yes.

5 Q. All right. Did you have a privacy policy on file?

6 A. Yes.

7 Q. Did you have financial policies in the file?

8 A. I believe I've seen that, yes.

9 Q. And a financial history as well?

10 A. Yes.

11 Q. And this a document I wanted to show you that we've
12 pulled out. And we've agreed it's been admitted into evidence
13 as Defendant's Exhibit 34.

14 [Whereupon, Mr. Smyth proffers documents to the witness]

15 A. Thank you.

16 Q. Do you recognize that document?

17 A. Yes, sir.

18 Q. And what is it? Please tell the jury.

19 A. Financial policy regarding revisions and complications.

20 Q. Okay. And just so we can zoom out here a little bit.

21 That's a document that Ms. Whitfield signed on the May 27th?

22 A. Yes.

23 Q. Of 2014?

24 A. Yes.

25 Q. Okay. And how is this document used?

1 A. Well, I think it's -- again, you know, we tell folks, we
2 try to convey to them that there are no guarantees and that we
3 want them to be happy. And we tried to figure out a way to
4 prepare or plan going forward if they -- if they're not
5 completely satisfied. And so it talks, you know, a little bit
6 about there are no guarantees in results, it is not a perfect
7 science, so to speak, and that if stuff needs to be done in
8 the future there could be a cost associated with it.

9 Q. What's your policy, though, in terms of taking care of
10 your patients who may experience a complication?

11 A. Since I've been in practice now by myself, we virtually
12 charge no one for the revisions. I think that is -- that has
13 been traditionally a sticky point in the world of plastic
14 surgery. But I think now is becoming more well-accepted. I
15 think within a reasonable timeframe and for reasonable things,
16 which have to be deemed reasonable by the patient and
17 obviously the doctor.

18 If it comes down -- if a patient spends money and they're
19 unhappy about a scar or they're unhappy about some small
20 symmetry or they're unhappy about something that I believe is
21 easy and reasonable -- or just reasonable, really, we'll fix
22 it and we won't charge them. At most, we might charge them a
23 small facility fee for, you know, basically the products that
24 are needed, if necessary.

25 But it's much more advantageous to do that and have

1 somebody walk out the door and be happy with their experience
2 than to go out and say, you know -- for a couple hundred
3 dollars after they spent thousands of dollars, to say, you
4 know, we're nickel-and-diming them and doing things that we
5 shouldn't -- you know, not making them feel happy, so to
6 speak.

7 Q. So in this case if Ms. Whitfield had needed additional
8 care and chosen to stay with you, would you have charged her
9 anything?

10 A. No, I would not have.

11 Q. Going back to your medical record in this case, does it
12 contain surgical cost proposals?

13 A. Yes.

14 Q. All right. Do you have preoperative instructions for the
15 patient?

16 A. Yes.

17 Q. Do you have documents about what to expect from
18 anesthesia?

19 A. Yes.

20 Q. Do you have copies of information telling the patients
21 about what medications they should take or not take prior to
22 surgery?

23 A. Yes.

24 Q. Do you have informed consent forms for several procedures
25 that were done?

1 A. Yes.

2 Q. Would that include liposuction?

3 A. Yes.

4 Q. All right. Do you have a consent form for the patient to
5 sign agreeing to accept anesthesia?

6 A. Yes.

7 Q. Do you have an operative record that the nurse prepares
8 during the procedure?

9 A. Yes.

10 Q. Do you have anesthesia history and physical?

11 A. Yes.

12 Q. Is there a record by the anesthesiologist of her care in
13 the procedure?

14 A. Yes.

15 Q. Do you have an operative note from the surgery?

16 A. Yes.

17 Q. Do you have post-anesthesia recovery records?

18 A. Yes.

19 Q. Do you have discharge notes?

20 A. Yes.

21 Q. Do you have information about the breast implants that
22 were put into Ms. Whitfield?

23 A. Yes.

24 Q. And that's the identification card?

25 A. Yes, it's stickers for that card or -- are placed in a --

1 the chart. Yes.

2 Q. And did you provide postoperative instructions?

3 A. Yes.

4 Q. And do you have information about prescriptions you had
5 written?

6 A. Yes.

7 Q. In reviewing the record is there over 120 pages worth of
8 documents in your file?

9 A. That sounds right, yes.

10 Q. But you agree you could have done a better job on a
11 couple of those?

12 A. We could have, absolutely. And, you know, it's
13 unfortunate. And I certainly wish that had not happened.

14 Q. Is there anything that you believe you could have written
15 in those postoperative notes that would have changed her
16 condition?

17 A. No. I'm certain of that. Because, again, she was in
18 front of me and we were dealing with her. And -- there was
19 nothing that in that time period I needed to know, because I
20 directly took care of her.

21 Q. There's been some discussion about how and why these
22 notes weren't generated. There was talk about Dictaphones and
23 tapes and ---

24 A. Right.

25 Q. Do you have a specific recollection or any understanding

1 as to why the records aren't there?

2 A. I don't know the absolute reason for it. There have
3 been -- obviously, we had malfunctioning tape players. The
4 reason that I went to that program or that way of doing it was
5 that when I was in another plastic surgery office doing
6 training here locally, towards the end of my fellowship, they
7 were using the exact same Dictaphones and using the same
8 transcriptionist. And I'm not great with, you know, sort of
9 technological stuff. And it didn't really interest me to get
10 into EMR stuff that was high tech, so I copied what they had
11 been doing.

12 And they -- one of those gentlemen had been in practice
13 over twenty-five years or twenty-three years, and was doing
14 that. And the other one had been in practice for about
15 fifteen. So I just followed what I had seen being done.

16 I was -- again, as most surgeons, we were not great on
17 doing notes as great as we should have been or generally
18 should be. So I don't know the exact reason, but I do
19 obviously wish we did have them. It would make this much
20 easier.

21 Q. All right. And previously I think you referenced what's
22 been marked and admitted as Plaintiff's Exhibit 31.

23 A. Yes.

24 Q. Is that the summary that you dictated?

25 A. It is. So the plastic surgeon that I trained under, John

1 Robinson, was a great guy. He worked as a plastic surgeon for
2 about forty years.

3 And in training, you know, he had said -- you know, kind
4 of tell you things about caveats and how to treat things. And
5 one of them was when a patient's sort of leaving or unhappy
6 and stuff, or if there's not adequate stuff in the chart that
7 you believe they may need going forward when they go to
8 somebody else, that he would recommend writing a summation
9 letter, so to speak, or a summary letter. Knowing and dating,
10 obviously, that it's -- that it's not from real-time but that
11 it's a document that hopefully lays a story or an outline of
12 what happened and also gives anybody in the future somebody to
13 contact if they'd like to discuss further what had happened.

14 Q. All right. And so when did you prepare that document?

15 A. July 21st, 2015.

16 Q. So roughly a year after this incident?

17 A. Yes, sir.

18 Q. All right. And did you do it from recollection?

19 A. I did. And there are some inaccuracies in dates. And I
20 think I was confused by the calendar that I was looking at at
21 the time.

22 But the -- again, the focus of what I would say, in my
23 opinion of my interaction with Ms. Whitfield, is that that
24 week of July, sort of the 6th, 7th through the 13th; and that
25 is the one that I was most focused on in this because I think

1 that's what lends itself to her course.

2 THE COURT REPORTER: Excuse me. If I could interrupt
3 you. If you could repeat the exhibit number? You said
4 Exhibit Number 31?

5 MR. SMYTH: I believe it's 21 ---

6 THE WITNESS: Thirty-one.

7 MR. SMYTH: Thirty-one. Sorry.

8 THE COURT REPORTER: Okay. Thirty-one, and you said
9 previously admitted. I have marked that ---

10 MR. SMYTH: That's plaintiff's.

11 THE COURT REPORTER: Oh, plaintiff's. Okay.

12 MR. SMYTH: Sorry.

13 THE COURT REPORTER: That was my fault. Thank you.

14 MR. SMYTH: Got to yellow sticker.

15 THE COURT REPORTER: Thank you.

16 THE WITNESS: Do I just keep these up here?

17 THE COURT REPORTER: For now, but don't leave with them.

18 Q. To your knowledge, did these lack of records that we've
19 been talking about, did that prevent Ms. Whitfield from
20 getting any care in this case?

21 A. Not to my knowledge. She obviously, as we've heard,
22 subsequently went to Dr. Kalus, who I am familiar with and
23 know. He did call me when she was I believe still at his
24 office that day, and then he called me one subsequent time as
25 he took over her care.

1 Q. Did he ever ask you for any records or anything you were
2 unable to provide him?

3 A. In the phone calls? No. Huh-uh.

4 Q. Was there any information that you withheld about Ms.
5 Whitfield's care from him when called?

6 A. No.

7 Q. And I believe he did later request a copy of your
8 operative note?

9 A. He did, yes. That was some months later, I believe, when
10 maybe going into one of the subsequent surgeries. The phone
11 call that I had with him on the -- when he told me he was
12 taking over her care, he didn't ask anything really clinical.
13 He just said that she couldn't take care of the wound at home
14 anymore and that the family wanted her admitted under him and
15 him to take over her care.

16 I said, obviously okay, and if there's anything I can do
17 to help, let me know. But that was the last I spoke with him.

18 Q. And when he did request your operative note, did you
19 provide it?

20 A. I did, yes.

21 Q. Let's change topics here a little bit and talk about the
22 issue of informed consent. Can you please tell the jury what
23 informed consent is and how you ---

24 A. Sure.

25 Q. --- maintain that with your practice?

1 A. Yes. It's a -- it's obviously one that is well-talked
2 about in the legal world and also in the medical world. So
3 to -- for a patient to undergo a procedure, we have to
4 obviously explain to them in a way that they comprehend.
5 Which obviously can be difficult when speaking to people of
6 all varying levels of education, you know, sort of fluency in
7 English. But I mean but it's something that we have to tell
8 folks.

9 Most people say anything over one-percent risk needs to
10 be specifically discussed with a patient.

11 And so when a patient is considering surgery, an informed
12 consent I don't -- I don't view as a one-stop instance when it
13 happens. It's an evolution of progress.

14 And by that I mean when a patient comes in the first
15 time, has questions about a surgery, we talk about risks,
16 benefits and likely outcome. So we don't -- we don't show
17 them a picture of a supermodel in Cosmo and say, you know,
18 this is our -- this is our happy-day outcome. We talk about
19 what the likely outcome will be.

20 And the patient gets information. They may or may not
21 get a quote about the price. And they go -- they leave. They
22 are not -- most -- almost always are not committed to surgery,
23 and they go out and think about it.

24 I would consider that the beginning of informed consent.
25 Because we're talking about that. If they choose to have

1 surgery we have a pre-op visit of some sort. Which we again
2 try to meet with the patient. Now a patient -- some patients,
3 depending on their experience with surgery and their
4 comfortableness with the process, may meet directly with me.
5 They may meet with one of like say P.A.s, nurse practitioners,
6 extenders or mid-level providers, and go over further
7 paperwork and actually may at that time decide to have the
8 surgery.

9 And so we will then -- I will then, or a surgeon I think
10 it is pretty standard, will then meet again with the patient
11 the morning of. And in all three of these, again, I will
12 say -- and I actually ask the mail what they find sometimes to
13 be scary questions, which what are we doing for you today.
14 And the main reason that I ask them that is I want them to
15 tell me what they're having done. And I'll say, I know what
16 we're doing but I want to make sure that you understand what
17 you're having. And -- and at that -- and at that point,
18 obviously they have surgery.

19 So they -- obviously, people can read papers and say they
20 don't understand them or they can -- but I think our important
21 things in informed consent is to have a dialog about it, to
22 give them opportunity to look at the documents and prior to
23 being put to sleep to have surgery a chance to ask any
24 questions that they don't understand or that they've heard
25 something about. You know, obviously today everybody goes on

1 Goggle and come back in and say, I Googled this and I don't --
2 you know, does this -- can this happen or is this going to
3 happen to me. And so it's -- I don't think it's a one-stop
4 process. It's actually an evolution.

5 Q. And with regard to Ms. Whitfield, is that the way her
6 informed-consent process was handled?

7 A. Yes.

8 Q. Okay. And I believe the records we've looked at so far
9 indicate that she made her first inquiry about surgery in
10 December of 2013 and then had surgery in June. Would there
11 have been multiple times when she would have ---

12 A. Yes.

13 Q. --- come to the office?

14 A. Yeah. She was. And I -- and I can't, you know, say that
15 I remember sitting with her at each of those instances or in
16 that process. I know she picked up her paperwork on a
17 different day.

18 And I -- and I don't necessarily -- and I'm not meaning
19 to represent that I met with her every time. But certainly
20 before somebody is put to sleep, we do meet and talk about,
21 one final time, surgery. And I do know that happened.

22 Q. Okay. And you've had a chance to look at the forms that
23 she signed with regard to the mastopexy surgery?

24 A. I do.

25 Q. Okay. Let me show you what's been previously marked as

1 Defendant's Exhibit 16.

2 MR. SMYTH: I apologize, Your Honor. I thought these
3 were in order.

4 [Whereupon, Mr. Smyth proffers documents to the witness]

5 A. Thank you.

6 Q. And that the informed consent form that you had Ms.
7 Whitfield sign in this case?

8 A. Yes, sir.

9 Q. Okay. And let's look at some of the risks that are
10 contained in that document. Looking at this one, which is
11 Number 67 on the bottom right -- does it have that sticker on
12 it ---

13 A. Yes.

14 Q. --- 39 of 52?

15 A. Okay, 39. Yes, sir.

16 Q. Okay. And at the top of that page there is some
17 information about breast augmentation and simultaneous
18 mastopexy. Tell the jury a little bit about how you would
19 discuss that particular risk with Ms. Whitfield.

20 A. Sure. And it's a general discussion. We talk about this
21 is a surgery that has two real processes going on. One is
22 obviously placement of an implant, and the second is movement
23 of breast tissue.

24 And so we talk about the risks that are inherent to that.
25 And obviously the biggest thing and I think the number one

1 thing with this surgery is scarring. Patients really have to
2 accept the fact that they will have a scar after the surgery.

3 And the perfect patient's response is usually I just want
4 to look better in clothing and a bathing suit. They're
5 married or they're at a point in their life where they're not
6 worried about the scars. And so that's a very good patient
7 for the surgery. There are ---

8 Q. May I stop you there for a second? What does -- what
9 does the scar look like? What do you tell them to expect?

10 A. We basically -- I'll show them. It's a circle and what
11 we call an anchor scar in most folks. So a circle around the
12 area. It goes down about seven centimeters and then
13 underneath the breast.

14 Q. Okay.

15 A. When we talk about the underneath part, the breast
16 usually covers. But there will be a scar when you look at
17 your breasts straight-on, or anyone else looks at it. And
18 it's -- people will often say, does the scar go away. And it
19 will fade and get better for up to a year, but it never goes
20 away. It's a permanent scar.

21 We talk a lot in this surgery about asymmetry; because
22 you're moving four things, in reality. You're moving breast
23 tissue on both side, and you're placing two implants. So we
24 have four variables.

25 There was a lot of debate for a long time about whether

1 or not to do the surgery as one or separate, and it's been in
2 the past several years accepted as a one-stage procedure
3 because we can get people, in about eighty-five percent of the
4 time, not to have to have a second surgery. So there's a
5 fifteen-percent revision rate and a twenty percent --
6 actually, twenty-percent complication rate with the surgery.
7 So we talk about it being higher than a lot of surgeries.

8 But breast augmentation alone in the United States has a
9 twenty-five percent re-operation rate in two years. And
10 that's for -- all encumbers that have breast implants placed.
11 That's because of breast implant positioning. Infection is
12 fairly low; but scar tissue, things that occur with that.
13 So -- and we go through the things that are just inherent.
14 Anesthesia, like I said, I mean that's an important one, just
15 being put to sleep. And then infection, bleeding, those
16 things that pertain.

17 This surgery has a risk of altering or changing nipple
18 sensation. And it does have a significant or a real -- I
19 won't say -- not necessarily significant, but a real risk of
20 having tissue injured because of the movement that's being
21 done.

22 And I tell people, especially with breast reductions,
23 that one-hundred percent of the time part of their wound will
24 open. No -- and there's a couple of reasons for that that
25 people don't fully appreciate. When we suture skin together

1 we're pulling sutures as tight as we can at that time, and you
2 have inherent swelling or trauma due to the actual surgical
3 procedure.

4 And what happens over the next four to seven days, two to
5 seven days, whatever it may be, that swelling begins to go
6 down. And so that suture that was really, really tight
7 initially has now had the tissue contract and it's loose; and
8 so the skin will gape a bit, it will have areas that are not
9 perfectly abutted. But skin heals at a millimeter a day, in
10 general; and so very small openings, you know, heal quickly.

11 And but it's -- and it's as -- I mean, two things I would
12 mention. Am I allowed to respond to the other experts here or
13 no?

14 Q. Well, we can talk about that in just a moment.

15 A. Oh.

16 Q. In terms of the delayed healing on this page, what do you
17 tell people about the risk of delayed healing?

18 A. It can be short or long. You know, I think they have to
19 understand that and that surgery, in general, to fix this, is
20 not the best option early on.

21 And the reason is because it starts a long course of
22 problems. And so I tell folks, like with an abdominoplasty,
23 tummy tuck, breast augmentation, anywhere where tissue is
24 being brought together, it may open and if it does you have to
25 be patient. Wound care, second -- what's called secondary

1 healing.

2 So when we make an incision and suture something closed,
3 it's called primary healing. It's just tissue is put
4 together. If it opens then you do something called secondary
5 healing or treatment. And that's doing wound care, dressing
6 care. You know, it can be -- there's a bunch of different
7 enzymatic things that are tried today and different creams.

8 But, again, because the body -- it will heal amazingly
9 well and will heal extremely, extremely large areas. And
10 that's something I saw in all the years I did cancer
11 reconstruction.

12 Q. Let's look at Page 43 of that form, if you have it. Do
13 you have that page?

14 A. Yes, sir.

15 Q. Okay. Down at the bottom there, there's a paragraph
16 about kind of mental health disorders and elective surgery.
17 Tell the jury what that's there for and what you're
18 explaining.

19 A. Well, it paraphrases basically what we -- what we talked
20 about. You know, I think there is a large, obviously, amount
21 of mental health issues in society in general. And I think
22 everybody obviously has some challenges that they face. And
23 it's -- again, it's not our job to judge that or to -- but,
24 again, they have to understand that early discussion, that and
25 when things do not heal necessarily linear and in a perfect

1 way that it's not a problem and that things will heal, and
2 that sometimes doing something or being aggressive, despite
3 your best efforts, can cause a more complex problem in the
4 long term.

5 And so understanding -- and again, I'm not a
6 psychiatrist. But if somebody is having issues and kind of
7 just existing, then we need to kind of try to understand how
8 to deal with that.

9 Q. Did you in this form convey to Ms. Whitfield that there
10 was a risk that she might have some wound-healing issues?

11 A. Yes.

12 Q. Okay. And does this risk address any of the
13 complications she may have experienced in this case?

14 A. I'm sorry?

15 Q. Does this form address ---

16 A. Yes.

17 Q. --- the risks that she experienced in this complica-
18 tion ---

19 A. Uh-huh.

20 Q. Okay.

21 A. Yes, sir. I'm sorry, yes.

22 Q. Do you tell the patients that there's a risk they might
23 need more surgery if they do experience one of these
24 complications?

25 A. Yes. And it was in that form that we -- I mean

1 especially where we're removing tissue, scarring is often an
2 issue of these procedures.

3 And we tell folks that -- the other -- the other
4 frustrating thing I think, especially for folks who may be
5 facing other challenges in their life or psychologically, is
6 scars don't get better in a day or a week or even a month. It
7 takes a year for the average person to have their scar fully
8 mature. And that's a lot of time of me telling them it's
9 going to get better, it's going to get better.

10 And, in fact, it generally gets worse before it gets
11 better. So in the first one to three months you may have a
12 thinner line and it may be healing fine; but the wound can
13 become hypertrophic, red, swollen, big. And they're disturbed
14 by that. It bothers them and they get upset by it.

15 And, you know, I think that that's obviously hard to hold
16 on for a year. But I do tell them that we'll fix it, there
17 are things that we can do, there's things that we can do to
18 make it better. It's just hard to buy into that long process.

19 Q. And did you ask Ms. Whitfield to sign informed consent
20 forms for the procedures she had in this case?

21 A. We did.

22 Q. And two of those forms are for liposuction?

23 A. Yes.

24 Q. Okay. Tell the jury about your liposuction consent form.
25 Does it relate to a specific body part?

1 A. It doesn't. Even -- even today they will change the top
2 part of that. I don't remember what company makes these. But
3 there's a couple of different companies that make consents,
4 the doctors' companies. One of them, the ASPS, the American
5 Society of Plastic Surgery.

6 And they have generalized language, and then at the top
7 it can be changed for a specific surgery and then if there
8 happens to be -- or a specific area, and then if there happens
9 to be something anywhere else that needs to change, it is.
10 But they are a template of the same.

11 Q. So there's been some discussion about whether Ms.
12 Whitfield consented to have liposuction on her chin.

13 A. There has.

14 Q. If she had signed an additional form would it be any
15 different from the liposuction forms that we have already?

16 A. It would not.

17 Q. Let's talk a little bit more about the chin. Did you --
18 did you get consent from Ms. Whitfield to do that surgery?

19 A. It is my belief based on, you know, my practice of
20 several years, that we would have talked about it in that it
21 happens a lot. We have patients -- especially she was
22 spending a good amount of money and having multiple procedures
23 done. We were opening a kit, or basically equipment, to do
24 liposuction. It is Smart Lipo or what's called, you know,
25 heat-based lipo. And so often people will say can I do

1 something here or can I do it there; and I will say, yes, and
2 say, you know, it's similar to what you're having done
3 elsewhere. And at that time, you know, we would have the
4 staff get them another consent for it.

5 I -- I can honestly say that probably happens once a
6 month and we don't -- now, if somebody's asking obviously for
7 something extravagant, we charge them. But in some -- in the
8 circumstance like that, it's a few extra minutes of time, the
9 machine, and the equipment to open; and so we would do it.

10 I can -- one thing that I know I can say a hundred
11 percent, I have never done surgery on somebody that didn't
12 know that they were having it. There's no benefit to that for
13 me, and there's nothing but risk.

14 Whether she had her chin done or not that day, I had no
15 vested interest in it. And I was trying to make the patient
16 happy.

17 Q. You don't remember a specific conversation from five
18 years ago ---

19 A. I can't say that I do, no, sir.

20 Q. But in terms of your custom and habit ---

21 A. Yes.

22 Q. --- would you ever do a procedure on a patient without
23 getting their consent first?

24 A. I can say I never have, nor would I.

25 Q. Okay. There's been some talk where yesterday -- I guess

1 when we had Dr. Rosenberg was here we looked at Defendant's
2 Exhibit 9.

3 A. Yes, sir.

4 Q. Which is part of the operative record from your chart.
5 Can you talk to us a little bit about this document, how it --
6 first of all, who creates it?

7 A. This is a chart that's on the computer in the operating
8 room.

9 Q. Right.

10 A. It's part of Nextech's system that O'Neill had in his
11 operating room.

12 Q. All right. Let's go through it. I don't know if we can
13 get this zoomed in big enough to where it's legible.

14 A. And this is filled out by the nursing staff and
15 circulator.

16 Q. Okay. What is a circulator, for those of us that don't
17 work in an O.R.?

18 A. So an operating room is an interesting place. It has --
19 obviously once everyone's in there it has the patient, it has
20 an anesthesia provider if anesthesia is being given, it has
21 obviously a surgeon or a doctor. And then it has a scrub tech
22 and a circulating who -- or circulator, who's normally a nurse
23 of some sort.

24 And so obviously all those folks have different
25 responsibilities. The scrub tech sets up the equipment and

1 gets the room ready. The nurse is a higher level of training
2 and has a registered nursing degree or some form of a nursing
3 degree. They're responsible for a lot of the paperwork,
4 because obviously they have more I guess education and
5 responsibility.

6 And so once the room's set up, they'll begin doing the
7 paperwork and things like this or once the surgery starts. So
8 these are things that in order to meet sort of the
9 accreditation to apply to ASF, which was what was governing
10 that facility, this has to be completed and done.

11 Q. Okay. So let's talk about some of the information that's
12 contained on here. There's a list of items, and a box in the
13 next column that has checkmarks in it, and then a time. Can
14 you tell me what this section is telling us?

15 A. They have to go through a checklist and basically say --
16 it's similar to like what's done in an airplane. That's the
17 best comparison -- or flying that you make is that it's a
18 structured way of going through stuff to ensure -- or to best
19 ensure that there's not an issue.

20 Hospitals do this, ambulatory surgery centers do this;
21 anywhere that -- anywhere that really operates on a patient in
22 any way. If you go to get a colonoscopy or if you -- they
23 have to do this checklist and it has to be filled out.

24 Q. And this particular checklist was done by the circulating
25 nurse that day?

1 A. Yes.

2 Q. And who was that?

3 A. Dawn Trussel.

4 Q. And who did she work for?

5 A. Dr. O'Neill.

6 Q. Okay.

7 A. And she -- well, she worked with both of us in a capacity
8 that she helped both of us.

9 Q. All right. And has she since passed away?

10 A. Unfortunately she died of ovarian cancer.

11 Q. Okay. So going through this document with those dates
12 and times, the first item on there is the patient is
13 identified. In your experience in the O.R., when does that
14 typically happen?

15 A. This is -- the patient is brought in the room and placed
16 on the operating table and verified as the correct person.

17 Q. Okay.

18 A. We have -- it varies on where you go. Obviously big
19 hospitals have the bands that you have to have on that make
20 sure that -- and they -- and now they even have to scan them
21 to actually I think in some places verify. But -- and so they
22 are verified in the operating room.

23 Q. All right. And then the next item there is procedure and
24 discussed?

25 A. Yes.

1 Q. So what does that entail?

2 A. That's the beginning of our sort of idea of a timeout,
3 which is the word above that, above this set. It's ---

4 Q. Right.

5 A. --- up there. So timeout came into effect in medicine
6 similar to what was being done in the military. I think it's
7 a carryover from the military.

8 Basically, that nobody in the room is sort of below
9 anybody else and that everyone has to verify what is being
10 done and then it is their job to ensure that what goes on
11 during that process, it's everyone's job, that that is the
12 correct. And if at any point someone is uncomfortable with it
13 or doesn't believe that's being followed, they have a sort
14 of responsibility to say something and to -- and to --
15 especially -- it's a big thing with nurses, because it is
16 their license that's on the line if there becomes a problem.

17 Q. Okay. So this whole process that we're looking at is
18 what the timeout consists of?

19 A. Yes. So like the surgeon concerns discussed, nursing
20 concerns, anesthesia. A big thing has become making sure
21 that -- and again a lot of this is carried over to hospitals.
22 I mean this is one-operating-room outpatient, you know, clinic
23 or office. But making sure everybody knows who they are, each
24 other is and verifi- -- and then surgery site verified.

25 They have to go through and discuss, you know, what has

1 been marked and what is going to be done; and then what is
2 discussed and marked is what can be done.

3 The only settings where that's not the case, again, when
4 I did trauma surgery, you would have things that obviously are
5 added as needed for the circumstance but.

6 Q. In case there's any members of the jury that haven't had
7 surgery, what are you referring to when you say marking?

8 A. I'm sorry. Well, and it's the thing I guess you see on
9 TV all the time with plastic surgery is that people when they
10 come in the areas that they're going to have surgery on, we
11 mark.

12 Not only for the site, but also because a lot of what
13 we're doing is contouring. The tissue is much different when
14 you -- when you lay down. So we want to mark people upright.
15 A lot of times women will stand and say like this the area I
16 want to get rid of, and it -- and when you lay down it's not
17 the same. So it's marked ahead of time to ensure that we're
18 removing the right spots.

19 Q. Okay. Now further down on this page, the operative
20 record begins. But just above that there is a list of
21 procedures. Are those the procedures that are being referred
22 to in the preceding section?

23 A. Yes.

24 Q. Okay. And under number four, that talks about
25 liposuction. Does it mention specific areas that are to be

1 performed?

2 A. Yes.

3 Q. And what does it say?

4 A. Abdomen, medial thigh axial, and neck.

5 Q. So and then moving on down the page a little bit, there's
6 -- is that the team that was in the operating room that day?

7 A. Yes, sir.

8 Q. So that's you, Dr. Bradham who is the anesthesiologist,
9 and there is a ---

10 A. CST is a Certified Scrub Tech.

11 Q. Okay. And then the circulator there that you mentioned,
12 Ms. Trueslow?

13 A. Yes. Yes.

14 Q. All right. And then looking down a little bit farther on
15 the page. Let me get this. There is a list of times. And
16 can you tell the jury what those times mean?

17 A. Yes. So anesthesia start is not when the patient is put
18 to sleep. It's actually when the anesthesia provider begins
19 billing. So it is when they first evaluate the patient or may
20 first meet them or start an IV or do something like that.

21 And there's often -- well, there's always lead time
22 because they have to begin the process. They assess them.
23 Before a person will put somebody to sleep they will go and
24 talk with the patient about their history. They take a pre-
25 anesthesia history, which is the one that's used for them that

1 they use to put the patient to sleep.

2 They'll talk about what they're there for. There are --
3 the big thing is they want to talk about their experiences or
4 past surgery.

5 MR. SLOTCHIVER: Your Honor, may we approach?

6 THE COURT: Sure.

7 [Whereupon, an off-the-record bench conference is held]

8 THE COURT: Ladies and gentlemen, let's take about a
9 five-minute break, a real quick bathroom break, and we'll come
10 right back in.

11 [Whereupon, the jury exits the courtroom 8/29/19, a.m.]

12 THE COURT: All right. Yes, sir? Go ahead and state
13 your objection for the record.

14 MR. SLOTCHIVER: Thank you, Judge.

15 My concern was -- I'm trying not to object to leading
16 questions, and I'm trying to let the information flow. But my
17 concern was that the doctor is testifying as to an area of
18 anesthesiology and how it works with anesthesiologists.

19 I have no problem with him saying in my experience this
20 is what I've seen and this is what generally happens. But
21 unless he has specific recollection of this procedure or
22 unless he has the qualifications of an anesthesiologist as to
23 what they do and when they do it, I don't believe it would be
24 proper.

25 THE COURT: All right. Mr. Smyth?

1 MR. SMYTH: Your Honor, I think the doctor is operating
2 in an ambulatory surgery center where all this information --
3 or all these activities are happening in his presence. He can
4 certainly testify as to what he's seen and observed. And if
5 he wants to cross-examine him on whether he's an
6 anesthesiologist or filled out any of the anesthesia forms,
7 that's certainly fair game. But I don't think it's an
8 improper question, given the doctor's ability to talk about
9 what happens in his operating room.

10 THE COURT: I agree. I think he's probably seen this
11 procedure a thousand times, as he's testified to; so I'll
12 overrule it.

13 Let's take a quick five-minute bathroom break.

14 If you [witness] need to a break, you're more than
15 welcome to. Just remind you -- just remember, you're still
16 under oath.

17 [Whereupon, a recess is taken 8/29/19, 11:28 a.m. to
18 11:37 a.m.]

19 [Whereupon, the jury enters the courtroom at 11:39 a.m.]

20 THE BAILIFF: The jury is all seated.

21 THE COURT: All righty. Thank you so very much. Hope
22 you had a good break.

23 Mr. Smyth?

24 MR. SMYTH: Thank you, Your Honor.

25 THE COURT: All righty.

1 Q. Doctor, when we left off we were looking at this form
2 that we were talking about from the operative record. And I
3 think you were talking about the times that were -- the page
4 here on the bottom. What is your understanding of the
5 significance of those times?

6 A. So the first time is the time that an anesthesia provider
7 would start providing his service. So that would be basically
8 when they start billing for their time and their service.

9 And I know this because actually in my facility I pay our
10 anesthesia folks. And so there's always an anesthesia time
11 and an operative or there is O.R. time for the actual surgery.

12 So that's usually somewhat sooner. It can be, you know
13 anywhere from fifteen minutes to an hour, depending on how
14 fast we're going and different times of the surgery.

15 And then 8:30 is when the patient actually entered the
16 room. So they started anesthesia when they brought the
17 patient in the room. So sometimes they get the patient --
18 start the IV in the holding area. Sometimes they start in the
19 operating room.

20 And then that twenty-minute period is sort of where
21 they're doing their things; hooking them up to monitors,
22 starting IVs, doing all that kind of stuff, getting into
23 position. The big thing is cushioning and padding so that the
24 patient's not laying on a hard surface that's going to cause a
25 pressure issue.

1 And then the surgery starts at 8:50. That's the surgeon
2 initiation of the procedure and usually coincides with the
3 actually timeout because we can't start the actual surgery.

4 And then 12:08, we finish the operation. Obviously,
5 they're still getting anesthesia.

6 And 12:27 is when they've been woken up, the IVs have
7 been removed, the patient is now in packing or recovery. The
8 patient's being basically recovered by the nursing staff or
9 the -- or somebody, a medical assistant, and being basically,
10 you know, turned over to the family and going through
11 discharge stuff.

12 Q. Thank you. So if the procedure started at 8:50, and I
13 think you said the timeout had to happen before that, do you
14 have any understanding as to why the times in the timeout
15 would be 9:45?

16 A. This is done at a computer, so this is -- a lot of the
17 nurses will write stuff on a like a piece of paper or a piece
18 of cardboard and all the information. And then those first
19 thirty minutes sort of, again, like an airplane, are the
20 important sort of getting started, getting a patient
21 equipment, everything going of the actual surgery. And so
22 they don't really have time to enter data at that point. And
23 then as we get into the surgery and are moving along, then
24 they do that stuff. And so this I am assuming the time that
25 those checks were entered.

1 Q. Okay. Thank you, Doctor.

2 A. Sure.

3 Q. And have you looked at the anesthesia and pre-anesthesia
4 forms in this case as well?

5 A. Yes.

6 Q. And do they contain reference to liposuction being done
7 on Ms. Whitfield's chin?

8 A. Yes.

9 Q. Okay. And you said the pre-anesthesia form, which is
10 something you mentioned earlier, when is that done?

11 A. Before the -- they're administered anesthesia.

12 Q. So the patient is awake?

13 A. Yes.

14 Q. And do you have any understanding as to what type of
15 anesthetic agents are used in this procedure?

16 A. Propofol is the main agent, which is the most widely used
17 IV sedation. And I think that is what's used in all
18 colonoscopies and EGBs and stuff. And then a combination of a
19 benzodiazepine will often be used, like Versaid. And a pain
20 medicine, to some degree, Fentanyl, Dilaudid, Morphine,
21 something like that can often be used.

22 Q. Have you had any occasions where patients will come back
23 to you after having this type of anesthesia and tell you they
24 don't remember what there're -- what happened at surgery?

25 A. Yes.

1 Q. How frequently does that happen?

2 A. I don't ask them that question. But I've definitely had
3 folks say I don't remember, you know, or I remember getting
4 there that morning and then I remember being on my couch, or I
5 remember different varying experiences of anesthesia.

6 I assume, you know, anybody that's been put to sleep can
7 relate to that. Propofol is a good drug in the sense that
8 that period is usually a few hours. It's not like some
9 inhaled gas that they'll use in hospital settings.

10 Q. And do you remember how much material or fat you would
11 have removed from Ms. Whitfield's chin or jaw?

12 A. I don't remember off the top of my head, but I did read
13 it in something. I believe it was 100 cc's of fluid was put
14 in and 75 cc's was removed.

15 Q. Give the jury an idea of what that looks like.

16 A. In general 100 cc's or grams of tissues is equated to a
17 stick of butter, in general. Fluid is a little different, as
18 it condenses down. But the other way to look at it is a shot
19 glass is about 30 cc's, so it's two-and-a-half shot glasses
20 volume.

21 Q. Okay. And you heard the testimony earlier that Ms.
22 Whitfield said you took her father's jaw from her. Did you
23 operate on any of the facial structures of Ms. Whitfield
24 during this procedure?

25 A. No. This is a soft-tissue procedure. So the jaw

1 generally means the bone structure or the mandible. What we
2 are doing is basically what people grab and don't like over
3 time as you age, having that looseness or -- there are two
4 muscles that run here [motioning], and they descend with time
5 so you get that turkey neck or whatever you might want to
6 refer to. And liposuction is the easiest and sort of safest
7 way to address that, as opposed to a neck lift or a facelift.

8 Q. Do you recall Ms. Whitfield ever complaining to you about
9 any of the work that you did on her jaw or neck?

10 A. I don't.

11 Q. Let's talk about the breast surgery at issue in this
12 case.

13 MR. SMYTH: And maybe, Your Honor, with the Court's
14 permission, can I have the witness come down out of the stand?

15 THE COURT: Absolutely.

16 MR. SMYTH: All right.

17 [Whereupon, the witness stands in front of jury]

18 Q. So we've heard a lot about the mastopexy and the implant
19 exchange. Can you kind of take the jury through, using this
20 illustration, as to how that surgery is done and what you're
21 doing as a surgeon?

22 A. Sure. This is a sideways view. So the patient would be
23 standing like this [indicates]. The main reason for showing
24 sideways views, this is the chest wall or the ribs. This red
25 structure is -- obviously, you can see the peck minor, so the

1 first muscle structure. This is the peck major [indicating],
2 the muscle that you can squeeze. And then this [indicating]
3 is all breast tissue. The yellow is kind of the breast fat.
4 And this darker [indicating] is -- I'm sorry, parenchyma of
5 the breast, meaning a little bit more of the hard stuff in the
6 breast.

7 So in patients who've had a previous implant placed, this
8 pocket is already developed. And the reason for that is the
9 implant causes a foreign-body reaction. Which if you put a
10 pacemaker in somebody or a prosthetic joint, scar tissue forms
11 around that as a natural phenomenon of the body.

12 We don't really understand it very well. We don't know
13 why some folks get pain, why some gets harder. So if you see
14 somebody who you may know, one breast will get really high and
15 harder and kind of contracted. And we don't know why that
16 happens in this area.

17 And this is the actual implant. There are two
18 hypotheses. One is that there's a microfiber or a film
19 bacteria that gets on the implant and causes a reaction over
20 time; and the other one is that blood gets in there and causes
21 a chronic reaction eventually.

22 It's an interesting phenomenon. It happens on one side,
23 sometimes; sometimes it happens on both. Obviously, it
24 doesn't make sense on one. It's the same body, the same
25 structures.

1 But the important thing is that that capsule gives you an
2 extra layer of protection. It's a hard, firm substance. It's
3 like -- almost like a piece of leather. So unlike somebody
4 that's getting an implant for the first time, they only have
5 fat. And so that implant, it's just not protected. It
6 doesn't have a hard area that you can really suture.

7 In here we open the capsule and we take the implant out
8 for an exchange, put a new implant in, and we actually suture
9 that capsule back shut. So that has an extra layer of
10 protection. So, in general, it's more protective.

11 In terms of the lift, all of the work that we're doing
12 with the breast lift is out here, very superficial. We're
13 moving fat, basically. This is the areola, and this is the
14 nipple.

15 And two things to know. The average areola size is two
16 thumbs, 40 millimeters basically. Somewhere between, you
17 know, 38 and 40 millimeters. The average nipple size is
18 basically a pencil eraser.

19 So it's important to know that, because one of the things
20 in plastic surgery is that we are mandated, basically, as a
21 society -- if you want to submit pictures to a journal,
22 there's photo standards that have to be followed. So by that
23 I mean there's a certain amount of feet away from the patient
24 and there's certain angles that the patient has to be taken
25 at, and lighting. So if you look at a plastic surgery

1 journal, they're standardized.

2 The reason for that is because today with phones, you can
3 make something look dramatically different than it is. So you
4 can zoom into something and make it look huge and it looks
5 overwhelming; whereas in reality, it's not -- it may not be
6 that scenario. And so as phones became more -- or photographs
7 became electronic we, as an industry or a society, are having
8 to adjust. And that's become a big part of it.

9 So we can refer back to this at some point as we look at
10 pictures, but the -- I just want to point out that what you're
11 seeing in those photographs is fat. That is on the
12 superficial level of what you're seeing. And the nipple and
13 areola we'll talk a little bit about.

14 But the implant in this scenario, so you're -- your
15 tolerance for a wound in this scenario is higher than somebody
16 in their first-time augmentation. And we tell people with
17 first-time augmentation the biggest, baddest thing that can
18 happen to you is we have to take the implant out. So you have
19 to start over again. Another implant is usually three months
20 later. So it is in my opinion that we try to save an implant
21 at all cost because you don't want to go backwards and start
22 again.

23 And so the procedure that we did here involved cutting
24 around the areola and nipple and a little bit underneath, that
25 incision that I was showing you, and elevating the areola and

1 nipple, and the implant was exchanged. So this was suture
2 closed here. And then the fat and skin was closed in a
3 different level.

4 The other things is with implants, obviously you can go
5 bigger or smaller. This pocket is already stretched out from
6 the previous implant, so any woman or person who's seen
7 somebody with implants, when they lay down the implants fall
8 to the side in most people. That's because this pocket is no
9 longer tight. It kind of adapts and stretches.

10 So you could go in and put a bigger implant in that
11 scenario and not be putting new stress on this tissue. But,
12 obviously, putting a smaller one is even less stress on that
13 tissue. So downsizing implants for symptomatic relief of
14 having back pain or whatever, scar tissue or other problems
15 you may have, is very accepted and safer than the initial
16 actual onset of the surgery.

17 Q. Thank you.

18 [Whereupon, the witness re-takes the witness stand]

19 Q. There's been a lot of discussion about tension this week
20 and the amount of tension that was used to suture this wound
21 closed. Can you explain? And I don't know if you want to do
22 it using the illustration or if you just want to tell them
23 about it. But explain how you handled that issue.

24 A. Sure. I think that it is a very important part of this
25 surgery. The reason that, as I pointed out, we close things

1 in deeper layers is because you don't want all of the
2 attention focused on the skin.

3 Any -- almost all plastic surgery procedures have a
4 degree of tension because we're removing tissue. So a great
5 example is C-sections. Women will come in, they'll have had
6 pregnancies. They obviously have loose skin and tissue.
7 They'll come in and say, my scar was great with my C-section.

8 But if you look at that, the tissue basically lays
9 together. You've delivered a child. The skin is all
10 stretched out. It basically falls together, so it is going to
11 heal extremely well. The things that affect wound healing are
12 things like tension, for sure.

13 When we do things, we're -- the reason a person comes to
14 us is to move tissue or change the form of the tissue. And so
15 by that definition, we are moving structures.

16 And tension is, especially in breast surgery, something
17 that you have to be very aware of. Again, my experience with
18 breast surgeries is extremely large; but I think more
19 importantly than that, my experience with cancer
20 reconstruction is large also. And that's an area where you're
21 removing big deficits of tissue where cancerous tissue is
22 removed and we are rotating -- doing rotational flaps, meaning
23 we'll take tissue from the back, rotate it to the front,
24 rotate it from the front to the back. You're pulling tissue
25 under tension, for sure.

1 So I know what tension looks like. I respectfully and
2 strongly disagree with what has been said about that. And the
3 reason for that is I know what tension looks like. I wouldn't
4 have left it that way.

5 Number two, you know, if this thing -- the way the
6 surgery was done in seeing the pictures, which we'll see,
7 tension is something that affects tissue early on.

8 It's -- if you've pulled it too tight it will blanch,
9 like they've said. It will have indentations in the sutures.
10 It will -- if it's venous congested, meaning too tight,
11 squishing the veins or the venous blood, it gets very bluish
12 and, you know, ecchymatic. And ecchymatic means all bruise.

13 If it's a ischemic, meaning there's not enough blood flow
14 getting to it, it gets blanched and white and it's very, very
15 obvious.

16 The treatment for that is very simple. You cut the
17 sutures out until the tissue looks viable again.

18 So I have done breast surgeries where I've closed and
19 it's been under too much tension. And I had a lady that I had
20 to do that within the past year who had a big reduction and
21 movement and one side was purple and blue when it was closed;
22 so we cut the sutures out around the nipple, came back five
23 days later and closed it.

24 So I don't agree with that. In the actual technique the
25 way that I did this is called the tailor tacking. It's

1 basically where ---

2 Q. I'm going to show you -- this is an operative note.

3 MR. SMYTH: I think it's maybe previously been admitted,
4 but I'll mark it just for purposes of why we are talking about
5 it. This will be Defendant's Exhibit 41.

6 [Whereupon, Defendant's Exhibit Number 41 is marked for
7 identification by the court reporter]

8 [Whereupon, Mr. Smyth proffers documents to the witness]

9 A. Thank you.

10 Q. Is that -- tell the jury what that is, please.

11 A. It's the operative summary ---

12 Q. Okay.

13 A. --- of what was done.

14 Q. All right. And I think you were starting to tell them
15 the technique that you used to assist.

16 A. Yeah. So it's an inferior pedicle, a -- reduction, or
17 mastopexy technique. And basically it's that scar that we
18 discussed in the tissue. The nipple and areola are lifted.
19 And the way to close that in some folks and in this area is we
20 basically take a stapler, a skin stapler, and the scrub tech
21 will take ---

22 Q. (Displaying)

23 A. That's for the next thing, I think. But ---

24 Q. Did you bring one of the staplers?

25 A. Yeah. That is similar.

1 Q. Is that it?

2 A. Yeah, it is similar; yeah.

3 MR. SMYTH: Your Honor, may I have permission to have the
4 witness get down to show them?

5 THE COURT: Absolutely.

6 MR. SMYTH: Do you want to use this ---

7 THE WITNESS: Yeah, I can show them that too.

8 A. So for the skin closure on the outer side, we begin to
9 staple the skin and pull it together. So the scrub tech will
10 pull it together. I'll staple it. If it's too tight, take
11 the staple out and we do it again.

12 Once we get to where we're comfortable with the tension,
13 so to speak, or closure, take a marking pen, mark it, take all
14 the sutures out and cut the skin and close.

15 So I do disagree with what both of them said yesterday.
16 I don't know if neither of them had read this or maybe
17 forgotten that. But tailor tacking is the way to address
18 closure under tension so.

19 Q. Okay. So and your operative note reflects that you did
20 that?

21 A. Yes.

22 Q. All right. Do you recall running into any problems or
23 complications during Ms. Whitfield's surgery?

24 A. No, sir, I don't remember any.

25 Q. Okay. I'm going to show you what's been previously

1 marked as Defendant's Exhibit 15 and is in evidence. Do you
2 recognize that?

3 A. I do, yes.

4 Q. Can you tell the jury what this is, please?

5 A. This is a compression device. So when folks have
6 liposuction of various parts of the body, they have
7 compression placed. It can be as simple as an Ace wrap.
8 Sometimes we use foam and an Ace wrap.

9 There are garments and there are specific body parts
10 which a wrap can be applied. In general, we have them wear
11 that the first three to five days or so, twenty-four hours a
12 day, or as much as possible, and then transition to wearing
13 the compression over a six-week period for just nighttime and
14 when they're at home.

15 Q. Okay. And is this the wrap that your practice would have
16 used when Ms. Whitfield was having her surgery?

17 A. Yes, Marena is the type we've carried.

18 Q. Okay. And does it have any impact or use with regard to
19 eye surgery?

20 A. No. It's exclusively used in our practice. And I've
21 only seen it used for neck surgery.

22 Q. Okay.

23 A. And facelifts. So neck and face.

24 Q. All right. And is there -- are there any symptoms that a
25 patient might feel who's had liposuction?

1 A. Yes.

2 Q. What would those be?

3 A. Well, the first few hours or several hours, there's a
4 numbness associated with it. They generally have drainage out
5 of the hole.

6 We go back and forth on putting the suture in the hole
7 that we use to access the lipo site. But liposuction is done
8 by injecting fluid first. So it's blown up with fluid and
9 then suction is performed. There's medicine in the fluid.

10 And so they generally have soreness and tenderness for
11 anywhere from two to maybe seven days in most people. They
12 can have residual nerve pain, burning, irritation,
13 inflammation, over several weeks.

14 It remains swollen usually for anywhere in one to three
15 weeks, the initial swelling from the fluid. And full
16 resolution of liposuction is generally a six-month to
17 twelve-month process. So it'll get better over that time
18 period.

19 Q. Based on your experience is there any way a patient
20 wouldn't know they had undergone liposuction?

21 A. I have never had somebody say that before or since.

22 Q. All right. And Ms. Whitfield came back to you I believe
23 four days after the surgery?

24 A. Yes.

25 Q. And so that's June the 10th?

1 A. Yes.

2 Q. Do you have a specific recollection of what was said
3 during that visit?

4 A. I don't.

5 Q. Do you recall there being any issues or complications,
6 though?

7 A. No.

8 Q. There's been a lot of discussion about a phrase that Ms.
9 Whitfield I think attributed to you, that you said -- you said
10 gave her something-something. Is that a phrase that you've
11 ever used?

12 A. No.

13 Q. And do you remember what you would have done, or anything
14 else, about that first postoperative visit?

15 A. She had had eyelid surgery. Those sutures are called
16 subcuticular, running through the skin. We usually leave --
17 end out on each side. So it starts on the side of the upper
18 lid, goes through the middle. I often put tape over it. It
19 takes three to five days for that to kind of re-approximate.
20 Years ago they didn't actually even suture them closed. We do
21 now because patients don't tolerate that kind of wide-opening
22 area for very long.

23 So at that visit that suture would have been removed and
24 we would have, you know, asked about any problems, any
25 concerns, and checked over the surgical sites; and that would

1 have been it.

2 Q. Okay. There's been a lot of discussion about phone calls
3 and communication during the postoperative period. Have you
4 looked at the phone records that Ms. Whitfield provided from
5 her cell phone in this case?

6 A. I have.

7 Q. All right. And did you help us prepare a summary of
8 those calls that were received from her cell phone?

9 A. I saw it, yes.

10 Q. All right. I'm going to show you what we'll mark as the
11 defendant's next exhibit in line.

12 Number -- that would be Defendant's 42?

13 THE COURT REPORTER: Correct.

14 [Whereupon, Defendant's Exhibit Number 42 is marked for
15 identification by the court reporter]

16 [Whereupon, Mr. Smyth proffers documents to the witness]

17 A. Thank you.

18 Q. All right. Do you recognize that document?

19 A. Yes.

20 Q. And is that based on your review of the cell phone bills
21 from Ms. Whitfield?

22 A. Yes.

23 Q. All right. And did you check all the numbers that are
24 associated with you and your practice or calls ---

25 A. We did.

1 Q. --- made to it?

2 A. For O'Neill and for Sweetgrass, yes.

3 Q. And is that accurate to the best of your understanding?

4 A. Yes.

5 MR. SMYTH: Your Honor, at this time we would offer this
6 exhibit into evidence.

7 THE COURT: Okay. Any objection?

8 MR. SLOTCHIVER: None, Your Honor.

9 THE COURT: All righty. Without objection.

10 [Whereupon, Defendant's Exhibit Number 42 is admitted
11 into evidence by the Court]

12 MR. SMYTH: All right.

13 THE COURT REPORTER: And that's Exhibit Number 42.

14 MR. SMYTH: Forty-two, yes, ma'am.

15 Q. All right. Looking at this document, Doctor, when was
16 your first phone conversation with Ms. Whitfield?

17 A. June 8th ---

18 Q. So it was ---

19 A. --- 2014.

20 Q. --- two days after surgery?

21 A. Yes.

22 Q. This might be easier for the jury to see.

23 [Whereupon, adjust display]

24 Q. Okay. So first phone call she would have called in to
25 the telephone number for O'Neill Plastic Surgery?

1 A. Yes. The phones -- because we office shared we still had
2 two different numbers. But they were forwarded to the same
3 location so you could answer. They were electronic phones
4 which had multiple lines, so you could answer both at the same
5 location.

6 Q. Okay. And then underneath that was there another call on
7 the 8th?

8 A. Yes.

9 Q. And who was that call from?

10 A. It was my cell phone number to Mrs. Whitfield.

11 Q. Okay. And the call duration was three minutes?

12 A. Yes.

13 Q. All right. You called her back after she called
14 originally; is that what happened?

15 A. I believe so, yes.

16 Q. Okay. Do you remember the specifics of any of the
17 conversation?

18 A. I don't.

19 Q. Do you typically give your cell phone number to patients?

20 A. Everyone.

21 Q. Okay.

22 A. Especially who have had surgery, obviously. And I can
23 speak on that for a moment. I mean, when the pagers became
24 difficult and phone became easier, you know, what I found from
25 early years of practice is having patients the ability --

1 giving patients the ability to directly reach you circumvents
2 a lot of confusion and problems.

3 And, again, the same family doctor that I was friends
4 with, that I went to, told me that a long time ago that
5 patients will only use it when they need it but it's very
6 helpful for people to have.

7 And so I give it -- and I still do, to this day. It's on
8 every discharge form that we have.

9 Q. Okay. So at this point, two days after the operation,
10 Ms. Whitfield had your personal cell phone number?

11 A. Yes, sir.

12 Q. All right. The next call, can you walk us through that,
13 please?

14 A. On the 9th Ms. Whitfield called at 9:34 and 1:14. The
15 call went to O'Neill Plastic Surgery for seven minutes.

16 Q. When it says O'Neill Plastic Surgery, does that mean she
17 was speaking with somebody from that practice, or what does
18 that mean?

19 A. No, it depen- -- the -- again, they were at one central
20 phone. We had one office at that location in Daniel Island.
21 So, again, office sharing and staff sharing, they -- staff
22 would have answered the phone lines.

23 Q. Was there another call that day, as well?

24 A. Yes. At 1:14.

25 Q. Okay. And then the next call, when was that?

- 1 A. 6:11.
- 2 Q. Okay. What does that indicate?
- 3 A. She called the office and spoke to someone for three
- 4 minutes.
- 5 Q. Okay. And then the next call would have been when?
- 6 A. The 16th.
- 7 Q. And how long was that phone call?
- 8 A. Two minutes.
- 9 Q. Okay. The next call would have been on when?
- 10 A. 18th.
- 11 Q. All right. And does that ---
- 12 A. Six minutes.
- 13 Q. What happened during that call, if you know?
- 14 A. There was a -- was a six-minute call. And it appears
- 15 that the appointment was cancelled with that call.
- 16 Q. All right. When was the next interaction with Ms.
- 17 Whitfield?
- 18 A. On the 25th of June.
- 19 Q. Okay. So approximately a week later?
- 20 A. Yes.
- 21 Q. All right. And tell us about the calls that are there on
- 22 that summary.
- 23 A. There were two phone calls made, on the 25th at 12:37 and
- 24 12:38. The first one was only a minute. The second one was
- 25 two minutes. There was a text that was sent at 1:01. And

1 then there were two more phone calls from Ms. Whitfield, one
2 at 4:20 for a minute and one for -- or I'm sorry, one at 4:23
3 for three minutes. And then a phone call from Vicky Tolbert
4 to Ms. Whitfield for two minutes at 7:39.

5 Q. And have you -- let's keep going through this. So when
6 was the next phone call that was made?

7 A. June 30th.

8 Q. Okay. And that was to O'Neill Plastic Surgery?

9 A. Yes. That's right.

10 Q. And then when was the next time she would have called
11 back?

12 A. It looks like July 7th ---

13 Q. Okay.

14 A. --- for six minutes. And that was a Monday. I do
15 remember that part. And that begins the week that she had
16 issues.

17 Q. All right. So the first call, it looks like she called
18 that morning on the 7th. And then what happened after that?

19 A. She called at 7:15. And then I ended up calling at 7:32
20 and 8:37.

21 Q. Okay.

22 A. Calling her back.

23 Q. And do you have any recollection of what would have
24 happened in terms of patient interaction that day?

25 A. I don't. I know Dawn had actually called me. I remember

1 because I was at the Isle of -- I think it was called Isle of
2 Palms I guess for that weekend. Because it was a holiday
3 weekend. And she had called and said that Ms. Whitfield had
4 wanted me to call her. And I did call her.

5 Q. Okay. And then the next calls are when?

6 A. July 9th for a minute at 12:30 p.m. And then two minutes
7 at 12:31. Both from Ms. Whitfield to the office. And then
8 July 10th was the final call, for seven minutes at 2:43.

9 Q. Looking at this entire summary, are there any calls from
10 Ms. Whitfield to your cell phone?

11 A. No.

12 Q. What is your practice, Doctor, in terms of returning
13 patient phone calls?

14 A. It's definitely something that we really try to do. I
15 think I understand the frustration. And we know now,
16 especially as well as then -- I know it's frustrating for
17 patients. Now we have multiple offices and multiple staff.
18 And I think, you know, giving them a phone-line number
19 directly to you gives them a peace of mind and it circumvents,
20 like I said, a lot of problems. But we, you know, now
21 definitely focus on getting back to them through the
22 technology that we have.

23 Q. Okay. Have you had a chance to look at the photographs
24 that are available in this case?

25 A. Yes.

1 Q. All right. And do you believe those speak to the healing
2 process for Ms. Whitfield in this case?

3 A. You know, I think they do. You know, I understand that
4 they're offensive. I understand that they're scary to the
5 patient. I understand, you know, the worry that that could
6 create.

7 But I think the photographs that have been used have been
8 distorted in some ways. Not -- not intentionally or anything.
9 But just from the magnification and the angles and the way
10 that the photos have been taken, which is no fault of
11 anyone's. It's inherent with phones today and photography
12 electronically.

13 But I think -- you know, I still feel very strongly, even
14 more so looking through the pictures, that, you know, this
15 could have been a different scenario.

16 Q. Do you have a different understanding from the timeline
17 that's been presented thus far this week?

18 A. I do. I think it's only -- you know, there's been so
19 many pieces and moving parts. And I bear responsibility for
20 some of that as not laying out a clear paper trail as to how
21 that happened.

22 But I think the photographs when organized and really
23 looked at in chronological order and taken for representation
24 of size and what was going on, combined with the fact that,
25 you know, she was seen in hospital, she was seen by other

1 physicians, I think they do speak pretty clearly to the
2 process.

3 MR. SMYTH: Your Honor, may I have the witness come down
4 and explain?

5 Q. Could you walk us through what you believe these
6 photographs show in terms of the impression of her wound?

7 A. Sure.

8 [Whereupon, the witness exits the witness stand and
9 stands in front of jury]

10 Q. And I'll show you what's been previously marked as
11 Defendant's Exhibit 38 and ask you if that's one of the
12 documents that you reviewed?

13 A. Yes.

14 Q. All right. And can you tell the jury what that is,
15 please?

16 A. This is a progression of the pictures that were supplied
17 to Dr. Kalus, the physician who testified as an expert, and
18 with dates that came from his chart.

19 Q. Okay.

20 MR. SMYTH: We would move -- at this time we would move
21 this document into evidence, please.

22 THE COURT: All righty. Any objection?

23 MR. SLOTCHIVER: No objection as to the documents coming
24 in. We don't agree with the dates, necessarily; but no
25 objection to them coming in.

1 THE COURT: All righty. No objection.

2 THE COURT REPORTER: And the number again?

3 MR. SMYTH: Thirty-eight.

4 THE COURT REPORTER: Okay. And 38 was one that was
5 listed before that was entered.

6 MR. SMYTH: Okay. Thank you.

7 THE COURT REPORTER: Thank you.

8 Q. So what do you -- what would be easiest for you to walk
9 through? Where do you want to start?

10 A. Well, I think we can start with the one [indicating] ---

11 Q. This one?

12 A. Yes.

13 Q. Okay.

14 A. So in looking at this picture, there's a few things going
15 on. One, you know, I -- the tape that's on there is half-inch
16 steri-strips, commonly used in surgery. The reason that we do
17 that is that skin is open. It can be open for forty-eight
18 hours, to initially seal after a surgery. Obviously it can
19 open again later at a time.

20 What you're seeing here is Mastisol. It's a brownish
21 colored liquid that helps tape stick to the skin. And this is
22 just dried blood. So when it was put on, there was blood
23 there. This is the nipple, and this is the areola.

24 And so one of the things I wanted to show is that, again,
25 about photography, this is a nipple size. The top of this is

1 a nipple.

2 So when you imagine this being in proportion or sized to
3 what you're looking at, this is dramatically, dramatically,
4 you know, blown up. And so when you look at this, this is
5 something that with the naked eye -- saying that this is not
6 healing, or opened, is completely inaccurate.

7 The other reason that you don't see sutures here is
8 because this is an intracuticular suture. That means the
9 suture has been put under the skin and is a running suture so
10 they you don't get those what's called railroad marks or train
11 marks in the skin of the areola and nipple.

12 So this is an actually, again, piece of the steri-strip
13 [displaying]. So this piece is that. So you're seeing it at
14 a level of magnification that is just dramatically,
15 dramatically, enhanced.

16 There's nothing -- this is a pink, viable nipple and
17 areola. The areola, again, is about two thumb lengths -- or
18 widths in a normal person. This is completely normal.

19 And this -- there's disagreement. And I'm sure we'll
20 talk about the next section of this. But this was supplied by
21 Dr. Kalus' office. These are the dates that were on his
22 chart.

23 This is obviously the 25th of June. So her surgery at
24 this point is nineteen days old. If this had been a tension
25 issue, this skin would have been damaged, the skin would have

1 been injured.

2 Skin can only go about four to six hours before it starts
3 suffering some kind of injury, being ischemic or congested.
4 In fact, can only go about twenty-four before you have
5 irreversible damage.

6 So this tissue is not threatened. It's well-healed.
7 This is nineteen days after surgery. This is not something
8 that needs any attention, other than if anything remove the
9 rest of the tape because it begins to smell and it gets a
10 little moist underneath it. As you can see, one piece has
11 been taken off or fallen off. But, again, this piece is that.

12 Q. Okay. And then what was the next picture in line?

13 A. So that's on the 25th.

14 Q. Is this also a picture from that same ---

15 A. Yeah, that's from the same ---

16 Q. Okay.

17 A. So that's it same thing.

18 And then there's a picture that I wanted to show that Dr.
19 Kalus had in his chart. So this is the picture that Dr. Kalus
20 called me about. And I -- and I know that for a couple of
21 reasons. Not only the date, but I know from my experience
22 with him, because he didn't know what these were.

23 So -- and it's -- and if it's not I'm not meaning that in
24 a negative way. It was a new device. It was called an INSORB
25 stapler. It's a stapler that we fire under the skin.

1 Q. Is that the one you brought today?

2 A. Yeah, and it's actually the one we brought.

3 So that device goes under the skin and pulls the tissue
4 together. Again, a way to try to event -- or prevent the
5 outer skin from having scaring.

6 That devi- -- that -- what you're looking at there --
7 this is actually the INSORB stapler. And I can put it out
8 here if you'd like to see it. Hopefully it doesn't go
9 shooting. That's how big they are [displaying].

10 So, again, that's why we have standards in photography in
11 plastic surgery.

12 MR. SMYTH: Can we pass those around?

13 THE COURT: Sure.

14 A. Yeah, sure. They are so small. Maybe you can pass the
15 whole device if you would like.

16 So what you're looking at in that picture is an eraser-
17 size and an INSORB staple. These [pointing] are sutures that
18 have been in there. And this [pointing] is actually while
19 doing a vertical lift. These [pointing], he took out. And he
20 debrided this yellow-greenish stuff, which is just a little
21 exudant.

22 This wound is two centimeters, two thumbs, by one, in his
23 note. So, you know, for them to say in their testimony that
24 this is the worst wound they've ever seen and they didn't --
25 and they're were taken back by it, I don't understand that. I

1 don't know how that can be.

2 I think in this picture, to non-medical people, sure, it
3 looks disturbing. But this is what he called me about.
4 That's the picture.

5 Q. Okay. And then so that was on July the 10th that he saw
6 the patient. Are there other photos that help you illustrate
7 what's going on here?

8 A. Well, I think then if we go to -- that was actually on
9 the 9th, I believe.

10 Q. 9th, okay.

11 A. So then on the 11th and 13th -- well, the 13th was
12 probably the ones that they showed.

13 So this gets back into the pictures here that obviously
14 are very gruesome looking. So you see here the sutures broke.
15 This is still on that -- from June 25th to the 9th or 10th,
16 there you look; you have a change.

17 And so this still is still intact [pointing]. The
18 nipple, again, this is -- this is an eraser size. So this is
19 one eraser head and another eraser head size. For the rest of
20 the skin the tissue is intact.

21 And here [pointing] there's definitely bleeding. And I
22 don't know what happened to cause that. And there's
23 definitely a dehiscence of the tissue. I don't know what
24 caused that. But what I do know is that there's healthy red
25 bleeding. There's fat here [pointing].

1 This picture was after his office. The reason I know
2 that for sure is that I don't use silvadene and didn't use
3 silvadene at that time. He did use it. So he gave her that.
4 And told me that, that he did start her on silvadene.

5 And we have a little bit closer picture. This [pointing]
6 is actually in the operating room. So we know that meets
7 right, because there's the drapes for the operating room.

8 Q. And that page that you're showing the jury, that's the
9 same document that came -- that's Exhibit 38?

10 A. Yeah, this was provided by their expert.

11 Q. And those are the dates that came on the document from
12 Dr. Kalus' office?

13 A. Yes.

14 Q. All right.

15 A. And this coincides with the date that we asked for a text
16 from doctor -- from the patient at one point.

17 Q. One of the comments you made was that there was healthy
18 red bleeding?

19 A. Yes.

20 Q. Explain what that means.

21 A. So tissue doesn't bleed if it's necrotic. So when you
22 say something's necrotic, any -- to some degree there's some
23 degree of necrosis.

24 The reason that going in and debriding something like
25 this, is that you end up debriding way more tissue than is

1 necessary. The human body is extremely, extremely efficient
2 at demarking tissue. And so if somebody is not sick, meaning
3 high fever, high white count, septic, and they're -- this can
4 be tolerated very easily.

5 Again, looking at this [photo display board], it looks
6 very big. If you look at a tape measure, you know, by his
7 measurements after surgery, what he cut out was five
8 centimeters. So basically he cut out an area between there
9 and my thumb on her breast, emergent -- basically urgent, I
10 guess he said. Or emergently.

11 This is not -- and emergent -- and I'm not criticizing.
12 Obviously, he was treating the patient. But, you know, I
13 think if this is the worse wound he's ever seen, then he
14 shouldn't have been probably treating it because, you know, if
15 it's the worse you've seen, then you're going to do something
16 that's aggressive. And I think to some degree that may be
17 what happened.

18 The reason that this is not tensioned further -- we have
19 another picture of this lower one I can show. And the big
20 reason that it's not tensioned is, as I said, it's several --
21 several days old, and it -- or nineteen days old and it's
22 healing.

23 There's one blown up in the O.R.

24 Yeah, that one [photo provided].

25 So here's a picture that he provided on the day that he

1 did surgery. So this was before he did it. The patient
2 has been draped. These are the two sutures [pointing].

3 MR. SMYTH: Oop, does it go this way?

4 THE WITNESS: It can go either way I guess.

5 [Whereupon, photo adjusted]

6 A. Yeah. So that's -- and so here is the suture that you're
7 seeing in the picture. You can see inside here it's extremely
8 small. But that's what you're looking at, a basically a 40-
9 chromo suture.

10 Again, this is the size of an eraser head [pointing].
11 And this is the size of two thumb lengths [pointing]. This is
12 the running intracuticular suture [pointing]. It is called
13 Monocryl.

14 So something happened that this suture from, you know, as
15 recent as the 9th was no longer attached here [pointing]. The
16 suture becomes weak, it breaks. It is not -- I am not blaming
17 the patient. I'm not blaming anybody that anything happened.
18 But this had already healed. And she had a skin bridge
19 across. So if it was tension, this [pointing] would have
20 never healed. This [pointing] would have been a wide, gaping,
21 open wound.

22 And, again, this is a small area. Remember the picture I
23 showed you. This [pointing] is the fat out by the areola.
24 This is superficial tissue. We've treated wounds like this in
25 different patients and they feel very well.

1 Q. Is this what you are referring to?

2 A. Sure. So, again, what you're seeing there, the yellow
3 part, is this (pointing), and it's very superficial.

4 There -- now everybody has talked what would cause it.
5 It could have been as simple as a suture failure, not a -- not
6 a prob- -- not a result of anything the patient did wrong and
7 nothing that I did wrong. This was now, what, five weeks
8 after surgery.

9 This tissue is inflamed. It is irritated. What you can
10 see here, too, is this discussion about the suture that I
11 placed. I will go back to that for a minute, why I placed the
12 suture. The reason for it was, again, because that implant
13 was my main concern. Taking tension off, so to speak, off of
14 that implant, I didn't -- I only put one here [pointing]. I
15 didn't close the whole thing. I didn't entrap any bacteria.
16 The things that they said were just not accurate. This was
17 solely to preserve the implant.

18 This is -- this is an issue with a breast. But all
19 efforts should be made to preserve the implant. Because when
20 you don't preserve the implant you go down a very slippery
21 road that becomes very difficult to manage, and it becomes
22 costly. It takes a long time. The patient ends up unhappy.
23 Two or three more weeks of aggressive care and this would have
24 healed eventually.

25 Q. Okay. Thank you, Doctor.

1 THE COURT: Mr. Smyth, now is probably a good time?

2 MR. SMYTH: Yes, sir.

3 THE COURT: All right.

4 Ladies and gentlemen of the jury, we're probably at a
5 good time to go ahead and take our lunch break for today. So,
6 unfortunately, we did not get Jimmy John's; so you'll be on
7 your own. But I think that we will probably resume about
8 1:30. So give you a little over an hour.

9 All right? Fair enough? All right. We will see you
10 back then. Have a wonderful lunch.

11 [Whereupon, the jury exits the courtroom 8/29/19, 12:21
12 p.m.]

13 THE COURT: All right. See you back here. We'll resume
14 the trial at 1:30.

15 Dr. Schimpf, again, you're under oath. Just don't
16 discuss it with your attorneys, but you can feel free to talk
17 to anybody. Okay?

18 THE WITNESS: Yes, sir. Thank you.

19 THE COURT: All righty. You're more than welcome.

20 [Whereupon, a lunch recess is taken 8/29/19, 12:21 p.m.
21 to 1:32 p.m.]

22 THE COURT: You can go ahead and take the witness stand.

23 THE WITNESS: Oh, I'm sorry.

24 THE COURT: That's okay.

25 (Whereupon, witness takes stand]

1 [Whereupon, the jury enters the courtroom 8/29/19, 1:32
2 p.m.]

3 THE BAILIFF: Your Honor, the jury is complete.

4 THE COURT: All righty. Thank you so very much. Mr.
5 Smyth, you may resume.

6 MR. SMYTH: Thank you, Your Honor.

7 THE COURT: Yes, sir.

8 **RESUME DIRECT EXAMINATION BY MR. SMYTH OF DR. SCHIMPF:**

9 Q. All right, Doctor. I think when we left off, we were
10 talking about kind of the conclusion of your relationship with
11 Ms. Whitfield. I want to go back to the last visit that you
12 had with her, which I believe was July the 11th?

13 A. Yes, I believe that's correct.

14 Q. Okay. Can you tell the jury what your recollection of
15 that visit was, please?

16 A. You know, at that point I obviously had had a call from
17 Dr. Kalus about her care. She was definitely upset to some
18 degree about what was going on. I think she was anxious.
19 And, you know, I don't -- I don't remember any words that we
20 specifically talked about. And I just remember that we did --
21 I believe that is when a suture was placed because her wound
22 had opened more.

23 Q. Okay. Let's talk about that for a second.

24 A. Sure.

25 Q. There's been a suggestion that you placed that suture

1 without any kind of numbing cream or anesthesia. Is that
2 something that you would do?

3 A. I did do that, yes.

4 Q. Okay. Can you tell the jury why you would do it that
5 way?

6 A. Well, she had conveyed at the time of the surgery she was
7 very anxious about needles, she had had a bad experience with
8 needles. I remember when looking at the pre-anesthesia -- or
9 the anesthesia record of some sort, that even the
10 anesthesiologist had mentioned how anxious she was. And she
11 had conveyed to me that she hates needles.

12 My plan, as I spoke earlier a little bit about, and I can
13 show it on the diagram, was to simply put one suture. Because
14 something had changed in that -- in that time period. And,
15 again, my concern and goal was solely implant salvage. I was
16 not concerned at that point with the skin or the fat.

17 So when you go to numb something, you have to basically
18 inject it a few times around the skin area, and you're
19 injecting a needle in the exact same spot. It takes about
20 fifteen to thirty seconds for the numbing medicine to work,
21 and then you put the suture in.

22 So my rationale for that was simply it's going to hurt
23 the same. You saw the size of the needle. It's very tiny and
24 the same size or your gauge as the numbing medicine. I knew I
25 was going to put one stitch through one side of the skin and

1 one through the other, tie it, and it'll be done.

2 And so that's just -- it's commonly done with folks who
3 have open wounds, mainly because that area -- it's commonly
4 done in the sense that you don't always have to put numbing
5 medicine. I've done it multiple times. And just to save the
6 patient extra trauma, basically.

7 The point of that was, again, not to close the wound, not
8 to fix the incision, not to do anything therapeutic from that
9 standpoint. It was solely to try to keep from -- as you
10 remember, there was a skin bridge in that one photograph. I
11 wanted to try to preserve that. As long as you have skin
12 touching like that, it can re-up the healizing and granulate
13 and close.

14 And so I did do that. I did put it in and did not give
15 her numbing medicine for it.

16 Q. Were you trying to injure her; was this in any way
17 retribution or frustration on your part?

18 A. No, I was trying to save her trauma, actually.
19 Ironically enough, the exact opposite, by not having her be
20 stuck with a needle multiple times.

21 Q. We heard a suggestion, I believe from Dr. Kalus' video
22 testimony, that he thought this was a plastic surgery urgency.
23 Was that your impression after seeing the wound?

24 A. No, it was not.

25 Q. Did you believe at that point that she needed surgery?

1 A. No. I still felt very strongly -- you know, we have our
2 own operating room at that office. If surgery was necessary,
3 it would have been easier for me because Dr. Kalus actually
4 does not have an operating room in his O.R. -- or an O.R. in
5 his office. So rather than have somebody go to a hospital I
6 could have done it there, and would have done it there had it
7 become necessary.

8 My goal in -- and, you know, it's a judgment call for
9 sure. I don't agree with the experts who've testified. But
10 it's a judgment call. I think preservation of the implant was
11 my number one concern.

12 Q. Okay. Did you also provide Ms. Whitfield with
13 prescriptions that day?

14 A. Yes.

15 Q. What would you have given her?

16 A. I would have to check; but I believe she had an
17 antibiotic and a pain medicine.

18 Q. Okay.

19 A. But I'm not positive.

20 Q. Okay. And why would you have given those medications?

21 A. She has an open wound. So there's pain associated with
22 it. She's only five weeks or so from surgery. She has an
23 implant in place. So treating with an antibiotic is -- with
24 an open wound, you have a possibility of contamination, skin
25 flora accumulating.

1 Q. What is skin flora?

2 A. So all of our skin has bacteria on it. And as weird as
3 that may be to think, we naturally and intrinsically, every
4 day, have bacteria. We have all different types of bacteria,
5 from staff and strep and different things.

6 And a normal and, you know, a competent person, meaning
7 somebody with a normal immune system, keeps that bacteria sort
8 of in check.

9 It's the same thing as the intestine. We have obviously
10 flora that affect -- or bacterial flora of the intestine.
11 When it gets out of whack, you know, people get, you know,
12 CDPT or strains of different infections when one bacteria gets
13 out of whack. So obviously that tissue at that point has been
14 traumatically compromised. Because you saw it was intact, and
15 then it wasn't.

16 So the antibiotic can have a couple of effects. One is
17 it can prevent infection or progression of infection. So my
18 thought on an infection is that when tissue becomes injured,
19 it's unwell or it's not profused well and so bacteria can
20 accumulate.

21 Q. What does profused well mean?

22 A. Blood flow to the tissue. So if it's -- because, again,
23 in a normal immune competent person, if they have blood flow
24 to an area, you know, they're more than likely to be okay in
25 terms of the infection.

1 And antibiotics have two purposes. One is treatment of
2 bacteria, and they also have an anti-inflammatory effect. So
3 a lot of the issue, or almost all of the issue, in breast
4 surgery and wound dehiscence and healing, is in inflammation
5 and swelling.

6 So one of the things that they did not tell you is that
7 you can suture the wound together and it can be very tense in
8 three or four days. And it's not because you sutured it
9 tensely; it's because it becomes inflamed, swollen. And
10 breasts swell very bad -- you know, significantly.

11 If you've seen somebody who has breast augmentation for
12 the first time, their implants are up by their chin, they seem
13 extremely large, people are very worried. So that all -- that
14 swelling makes that suture line, you know, tight.

15 And so the same thing happens over time if a wound's been
16 opened or had some inflammation or changes or trauma. So the
17 antibiotic serves two purposes in that scenario.

18 Q. Did you ever diagnose Ms. Whitfield with an infection?

19 A. I did not.

20 Q. Did you think she had an infection?

21 A. I did not.

22 Q. If there was any additional treatment that you felt Ms.
23 Whitfield needed that day would you have given it to her?

24 A. Yes.

25 Q. Okay. What was your plan after this visit?

1 A. She had a follow-up appointment I believe on the 16th
2 scheduled, which was about five days. Basically, you know,
3 she -- I understand that she was frustrated. I wanted -- I
4 was hopeful that she would -- you know, sort of things would
5 begin to change for her a bit and it would get better.

6 Where she was at that point, I wasn't -- I still wasn't
7 worried or convinced that taking the implant out and going
8 that route was necessary. Certainly, if it were, we could
9 have done that.

10 But in that bottom picture -- I know that we can show the
11 bigger one. You know that -- yeah [photo displayed].

12 That tissue -- she has fat breast tissue coming out of
13 the opening. So there's not a defect. There's not a loss of
14 fat.

15 Q. Does that help [adjust picture] ---

16 A. Yeah. Sure. Sorry.

17 Q. --- to be able to point to it?

18 A. Yeah. This is actually full of in tissue. Good, red,
19 granulation tissue. She still has skin intact. The bottom is
20 actually healing very superficial. That's common in almost
21 all reductions or lifts.

22 So she's -- to the average person and to a patient, I
23 understand there's stress. But this is a very salvageable
24 situation at this point. And, again, the reason for being
25 hesitant is because of the consequences of not.

1 Q. Is it fair to say you thought the most reasonable
2 approach was a conservative management?

3 A. At that point I still did, yes.

4 Q. Were you -- there's -- you've obviously heard Ms.
5 Whitfield's version of what happened during this last
6 encounter.

7 A. I have.

8 Q. Were you angry at her?

9 A. I was not. And I feel badly that she took it that way.
10 You know, I want patients to be happy. In reading her
11 testimony, you know, we -- they're steel sinks and they're
12 steel instruments, so I guess that can be misconstrued by
13 folks.

14 But I certainly was not angry with her. I didn't -- as I
15 said today, I don't blame the patient for this. I mean, I
16 think this is part of surgery.

17 Q. Were you still committed to taking care of her?

18 A. Yes. And I actually was surprised when Kalus called me.
19 Because when she left I didn't think there was a problem. I
20 was unaware that there was.

21 Q. Okay. And do you remember getting a call from Dr. Kalus?

22 A. I do.

23 Q. All right. And what do you recall from that?

24 A. My daughters were playing in a tournament at Kiawah on
25 Sunday. I believe it was the 13th of July. And, you know,

1 I've gone back and looked at that now with the calendar, so I
2 do believe that's accurate.

3 He called and said that the Whitfield's had called him,
4 that they couldn't take care of the wound ---

5 MR. SLOTCHIVER: Your Honor, objection. Hearsay.

6 THE COURT: Who -- who is he indicating?

7 MR. SMYTH: Dr. Kalus.

8 MR. SLOTCHIVER: A conversation he had with Dr. Kalus.

9 Q. You can't say what he said, but you can say what your
10 recollections were.

11 A. Oh, okay. My recollection is -- I can't say he said?

12 MR. SLOTCHIVER: No.

13 A. We talked about her care, that her family and her were
14 sort of worn out by ---

15 MR. SLOTCHIVER: Your Honor, we talked about it is still
16 hearsay.

17 THE COURT: Yeah, so you can't say what he said. You can
18 say what you did as a result of the conversation.

19 THE WITNESS: Okay.

20 A. She wanted to have -- can I say that? Wanted to have
21 care with Dr. Kalus. That they -- that she wanted to be
22 admitted to a hospital and treated by him.

23 And I said, okay, and if there's anything that I can do,
24 please let me know.

25 Q. Did Dr. Kalus request any information from you at that

1 time?

2 MR. SLOTCHIVER: Your Honor, the same objection.

3 Hearsay.

4 THE COURT: Come up here real quick.

5 [Whereupon, an off-the-record bench conference is held]

6 THE COURT: All right. I'll sustain the objection.

7 You just can't say what you and Dr. Kalus said. You can
8 say what you said, but not what he said. Okay?

9 Q. Were you asked to provide any documents?

10 A. Yes, sir.

11 Q. And have you had the opportunity to -- oh, before I
12 forget, Defendant's Exhibit 39, which is already into
13 evidence, I'm going to ask you if you recognize this document.

14 A. Yes.

15 Q. What is that, please?

16 A. This is a scheduling form at the front desk the girls use
17 and the guys use to schedule folks. I believe when they call
18 in this is how the appointments are listed and the dates, the
19 times, the doctor. And occasionally they'll write in, I
20 believe, what comes from the patient to them when they call.

21 Q. Okay. Is there a reflection on that document of a
22 follow-up appointment after the 11th?

23 A. Yes.

24 Q. Okay. Did that appointment happen?

25 A. No.

1 Q. Was it -- how did that get there, then?

2 A. It was scheduled at -- for 10:45 on July 16th, 2014. But
3 it did not happen.

4 Q. And at that point had Ms. Whitfield changed doctors?

5 A. She had. And I believe she was admitted on the 13th and
6 then had surgery with Dr. Kalus.

7 Q. Have you had the opportunity to review the photographs of
8 Ms. Whitfield and her subsequent care?

9 A. I have.

10 Q. Okay. And during the time that you were caring for her
11 was there ever any problem associated with her left breast
12 that you were aware of?

13 A. No, sir, not that I remember.

14 Q. All right. And have you had the opportunity to see the
15 photos from after Dr. Kalus' surgery?

16 A. Yes.

17 Q. All right. And can you tell the jury what you see in
18 this particular photo?

19 A. I see her right breast is well-healed. She still had
20 some pinkness in the vertical end, so the up and down part
21 that I talked about, how this would have been -- I'm sorry.
22 So she had some redness and pinkness, because this obviously
23 is a newer scar.

24 The upper part has faded some, so it's an older scar.
25 The left side has redness appropriate for scar healing. She

1 has some flatness to her breasts, which is definitely common
2 when there is still scarring and still healing. So that scar
3 is not completely loosened.

4 Breast lifts and reductions are very flat and boxy across
5 the front for the first three to six or even nine months until
6 the breast drops.

7 The right side, I think she has very good shape to her
8 breast. Her nipple and areola are intact and well-healed.
9 Her left breast has nice fullness. It is flat at the bottom.
10 That's still changing. And she has some redness to her scar
11 and an intact areola and nipple.

12 Q. Had you been taking care of Ms. Whitfield at this time
13 what would you have advised her to do?

14 MR. SLOTCHIVER: Objection. Speculation.

15 THE COURT: He can answer it ---

16 A. My ---

17 THE COURT: --- as to what you'd do.

18 THE WITNESS: I'm sorry, sir?

19 THE COURT: You can answer as to what you'd do.

20 THE WITNESS: Okay.

21 A. What I would do at that point, would discuss with her her
22 goals and what her -- you know, where she's at with the
23 process, understanding at this point it's been a pretty long
24 process.

25 The standard treatment for that really is basic. It is

1 insertion of implant, reinsertion if the patient would like
2 symmetry at that point.

3 That breast is well-healed. It has very good shape. You
4 may need to put in slightly larger implant initially because
5 of some of the tissue that was excised, that five centimeter
6 by two or three centimeter area.

7 But that's really a classic example. The next step is if
8 the patient is willing to do something and wants to do
9 something, it would be reinsertion of implant.

10 Q. Is there any reason, based on what you've seen in these
11 photos, that you would have taken the left implant out?

12 A. No. And the right side too, the other thing is that that
13 is a -- if you look at the shape of the breast and the -- it's
14 what -- we use the word supple or it looks soft and is sitting
15 correctly. There's no tightness there. So there's no reason
16 that a reasonable size implant to match can't be inserted.

17 In breast reconstruction, which obviously was my main
18 stuff in the first years of practice, when women lose their
19 whole breast or they lose a large section of it, then folks
20 talk about tissue expansion. That's putting a balloon in
21 because there's -- for cancer you have to remove a large, you
22 know, it can be a 10, 12 centimeter portion of the skin. That
23 wound you can't put an implant in. It has to be stretched and
24 kind of blown up.

25 But in this scenario, this is a -- this is a very

1 classic -- that looks like a breast that we would augment any
2 day of the week for a woman who wants larger breasts.

3 Q. Doctor, in summary, do you believe you performed the
4 surgery on Ms. Whitfield according to the standard of care?

5 A. Yes. Absolutely.

6 Q. Did you use too much tension when you operated on her?

7 A. No. The pictures and the way the surgery was done and my
8 experience of doing the surgery, I absolutely do not think
9 that happened.

10 Q. Was the complication that Ms. Whitfield experienced a
11 complication you warned her about prior to surgery?

12 A. Yes.

13 Q. Did you do anything to cause that complication?

14 A. No, sir.

15 Q. Did you do any surgery on Ms. Whitfield without her
16 permission?

17 A. No.

18 Q. Did you provide care that you felt was reasonable and
19 appropriate?

20 A. Yes, at that time.

21 Q. Did you ever ignore, dismiss, or abandon Ms. Whitfield?

22 A. No. And I feel badly that that was the message. I
23 didn't -- I wouldn't want anyone to feel that way.

24 Q. Did you ever provide any care to her that you didn't feel
25 was in her best interest?

1 A. No.

2 Q. Did you ever do anything with the intention to harm her?

3 A. Absolutely not.

4 Q. Could your paperwork have been better?

5 A. Absolutely.

6 Q. Did the issues with the paperwork that we've talked about
7 cause her any harm that you're aware of?

8 A. Not that I'm aware of, no, sir.

9 Q. Would you have continued to take care of Ms. Whitfield
10 had she remained your patient?

11 A. Yes.

12 Q. And would you have charged her for any of that additional
13 care?

14 A. No.

15 Q. Do you believe you would have been able to get her healed
16 on the right breast without having to do surgery?

17 A. Without having -- initially, yes. Yeah.

18 Q. And would that have avoided all these years of
19 litigation?

20 A. I would hope so.

21 Q. Do you believe you're responsible for any of the choices
22 that Ms. Whitfield and her subsequent doctors made after she
23 left your care?

24 A. No.

25 Q. Even though she's filed this lawsuit against you, do you

Examination of Dr. Dennis Schimpf - Cross by Mr. Slotchiver

1 bear Ms. Whitfield any ill will?

2 A. Absolutely not.

3 MR. SMYTH: Doctor, I believe those are all my questions.
4 Please answer any opposing counsel may have.

5 THE WITNESS: Yes, sir. Thank you.

6 THE COURT: All right.

7 MR. SLOTCHIVER: Just one moment, Your Honor.

8 [Off the record momentarily]

9 **CROSS-EXAMINATION BY MR. SLOTCHIVER OF DENNIS SCHIMPF:**

10 Q. Doctor, before -- we've met before?

11 A. Yes, sir.

12 Q. Good afternoon.

13 A. Good afternoon.

14 Q. Before I jump in to my full cross-examination I wanted to
15 ask you a couple of things about things you discussed a few
16 moments ago.

17 A. Yes, sir.

18 Q. You referenced this picture [displaying]?

19 A. Yes.

20 Q. Just a moment ago?

21 A. Yes.

22 Q. Is this the condition she was in when you last saw her?

23 A. No.

24 Q. Okay. You used this as a reference when you were talking
25 about the stitches.

1 A. Right.

2 Q. Correct?

3 A. Yes.

4 Q. And you said this time when you stitched her up, you did
5 not use any kind of anesthetic, anesthetic cream or needles;
6 correct?

7 A. Well, that was on the 13th. I think I saw her on the
8 11th. Correct.

9 Q. How do you know the dates on all these pictures?

10 A. Well, that one has -- or that's actually the 14th,
11 because that has operating -- it's draped out. It's
12 preoperative.

13 Q. None of the photographs were in your file ---

14 A. In what?

15 Q. --- that you have maintained?

16 A. No, I just saw that from Kalus' record last night.

17 Q. Correct.

18 A. Yeah.

19 Q. This wasn't the first time that you put stitches into Ms.
20 Whitfield after the surgery of her; correct?

21 A. I don't remember the other time, but it may -- if she
22 says we did, then we may have. But I don't remember that.
23 And the only reason, because looking at the photograph there's
24 two Prolene sutures and it's well-healed. But I don't know
25 that if I did or didn't. I don't remember doing it, so.

1 Q. Why would you have used anesthetic on the first time but
2 not on the second time?

3 A. I wouldn't have, I don't think. And looking at that
4 photograph that I finally saw, the Prolene is intact.

5 So I'm not disputing her claim. I just don't think I did
6 that. But I don't know that for sure.

7 Q. Was there a reason ---

8 A. That's the rest of my answer.

9 Q. Well, if you -- is there a reason why you could not have
10 used an anesthetic the second time before you sewed her up?

11 A. There's not. But as I said, if you -- and this is just a
12 theory of one way that it's done. You -- my plan was to only
13 put one suture in. So there's two sticks of the skin with
14 that. So to anesthetize it, you have to do at least two
15 sticks to the skin and then stick it again. So ---

16 Q. Different needles?

17 A. No. They're about the same. I mean, they're anywhere
18 from 27-gauge to 30-gauge needles.

19 Q. Would that be something that would be referenced in your
20 notes if you had notes?

21 A. Yes. But I can see there is a suture in the picture.

22 Q. That wasn't the question, sir. Would ---

23 A. I said yes.

24 Q. And is it your testimony that -- I believe you testified
25 earlier today ---

1 A. Uh-huh.

2 Q. --- that if she had done nothing, she would have healed
3 on her own?

4 A. Nothing in terms of surgical intervention was my -- what
5 I meant. So I apologize if I misspoke. I didn't mean
6 nothing. As in terms of ongoing wound-care treatment.

7 Q. Doctor, let me go through a little bit -- a little bit
8 about your background. You covered that ---

9 A. Sure.

10 Q. --- on the stand. You went to college at a school called
11 Daemen; correct?

12 A. I did. Yes, sir.

13 Q. That is in upstate New York?

14 A. Yes.

15 Q. And you have a degree, I believe you testified, in
16 philosophy and in humanities?

17 A. Yes, sir.

18 Q. But then you went to medical school in the Caribbean,
19 correct?

20 A. The first two years at Ross University, yes, sir.

21 Q. Well, you actually graduated from Ross University;
22 correct?

23 A. Yes. But the schooling is done the first two years there
24 and the second two years in the U.S. and ---

25 Q. That's -- that's in the Dominica, correct?

1 A. Yes. Absolutely.

2 Q. And are the admission requirements to get into Ross the
3 same as the admission requirements to get into a medical
4 school in the United States?

5 A. No. The GPAs are generally lower. They're in the 3.2 to
6 3.5 range. The U.S. is more in the 3.7 range.

7 Q. Okay. Do you take the MCATs in order to go to Ross
8 University?

9 A. It is not required. I actually -- I know in the first
10 deposition, said I didn't. I actually did take it, but it's
11 not required.

12 Q. In the first deposition you said you did not take it, and
13 now you remember that you did take it?

14 A. I took a practice MCAT. But it was not required, so you
15 did not have to take it. You do not need it for admission.

16 Q. Did you actually take the MCAT?

17 A. I did.

18 Q. Why, in the first deposition, did you tell us you did not
19 take the MCAT?

20 A. Because you caught me I guess off guard and I hadn't
21 really thought about it in fifteen years or whatever, twenty
22 years. But it is not -- it's not a requirement of the school.

23 Q. Would you agree with me that you don't know if you're
24 able to practice medicine in other states in the United States
25 and other states within our country, after going to Ross

1 University; you know you can practice here in South Carolina;
2 is that correct?

3 A. That's what I stated. And I have subsequently looked
4 into it. And you can practice in all 51 or 50 states, or
5 whatever you want to call it.

6 What you cannot do or what they don't do, is have
7 students in every state because of the competition for
8 training spots when you're a student. But you can absolutely
9 obtain a medical degree. Twenty-percent of the physicians in
10 this country went to school off shore.

11 Q. So this is something different than you remembered at the
12 time of your deposition? You've looked into it since then?

13 A. I did, yeah.

14 Q. Okay.

15 A. But I didn't want to tell you the wrong answer at the
16 time.

17 Q. Okay. Doctor, I believe you testified that you have
18 hospital privileges at East Cooper; correct?

19 A. I do.

20 Q. I'll get back to that in a moment.

21 And I believe testimony came in earlier regarding
22 documents from Sonovus Bank; is that correct?

23 A. I don't know.

24 Q. Do you remember ---

25 A. Nobody asked me about it so ---

1 Q. --- filling out a financial application -- let's see if I
2 can get the right terminology for you.

3 Do you remember filling out a financial statement for
4 Sonovus Bank?

5 A. I do.

6 Q. And when you filled out that form -- let me show you a
7 copy of it and ask you if you are -- if everything on the form
8 is honest and truthful. Have you seen that form before?

9 A. I have.

10 Q. Take a moment to look at it.

11 [Whereupon, the witness reviews documents]

12 A. I believe it is. I haven't checked it so.

13 Q. Take a moment, because I'm going to ask you about it in a
14 moment.

15 A. Sure. To the best of my knowledge, it is. At that time,
16 anyway.

17 Q. Have you looked at all three pages?

18 A. No.

19 [Whereupon, the witness reviews documents]

20 A. Yes.

21 Q. Did you sign the form?

22 A. I did.

23 Q. When you sign forms do you tend to attest to the fact
24 that they are accurate and truthful before you sign them?

25 A. Yes, to the best of my knowledge.

1 MR. SLOTCHIVER: Okay. I've got a quick matter to bring
2 up with the Court.

3 THE COURT: All right. Ladies and gentlemen, we're going
4 to take up a matter of law. If you'll just take a five-minute
5 break and we'll try to get you right back in.

6 [Whereupon, the jury exits the courtroom 8/29/19, 1:57
7 p.m.]

8 THE COURT: All righty.

9 MR. SLOTCHIVER: Judge, I don't want to do anything to go
10 outside of your orders ---

11 THE COURT: Okay.

12 MR. SLOTCHIVER: --- that you have stated to date. But
13 as you are aware from sitting here for the last four days, a
14 lot of this case come to do with credibility and truthfulness,
15 especially as Dr. Schimpf has testified to facts different
16 than my client has testified to and different events he has
17 recalled that she has testified to.

18 This is a financial form that he filled out with the bank
19 that he's testified is honest, accurate, and truthful. And
20 what I'll bring to the Court's attention -- and this applies
21 to two forms, this and the East Cooper form. East Cooper has
22 an explanation. This does not. Is that on this form one of
23 the questions he was asked was are you a defendant in any
24 suits for legal actions, and the answer is no.

25 It's relevant, Your Honor, because at the time that this

1 form was signed, he was a defendant in this case. He is a
2 defendant in a second case that my firm and Brent Halversen
3 have brought against him. He is the defendant in a third case
4 brought against him by a different law firm, at the time that
5 he signed this form.

6 It dovetails, Your Honor, to a different form that he
7 signed when he applied to become a participant or to get
8 privileges at East Cooper Hospital. They asked him the same
9 question, do you have any lawsuits. That was several years
10 ago. This form was 2018. With regard to East Cooper
11 Hospital, he once again said no. But he was a litigant. He
12 was involved in a lawsuit. He's -- and I know there's
13 testimony about that, which he understood. He could say no,
14 because he was being sued while he was at MUSC.

15 But this time he directly misrepresented the truth on the
16 financial form that he filled out. And I believe I should be
17 able to go into it.

18 The question is I don't want to go against your order
19 regarding other lawsuits. But at the same time, I've got a
20 false statement that was submitted.

21 MR. SMYTH: If I may, Your Honor? I think it's okay for
22 him to ask the question were there other lawsuits and did you
23 not answer this question the right way. I don't think it
24 opens the door into the allegations of those lawsuits.

25 I think that goes a step too far. If he wants to impeach

1 him that there was litigation pending and he answered no, I
2 think that's fair game. But anything beyond that -- this
3 doesn't open the door to anything beyond that, obviously. And
4 we believe the Court's prior rulings were appropriate on that.

5 Again, you know, we're here about a medical malpractice
6 case. This is not about whether he filled out a form for a
7 bank.

8 THE COURT: Yeah, I mean this is a rare time where you're
9 almost agreeing with him and I'm going to go against both of
10 you. I mean, this is -- like I said, we cannot agree on
11 anything together.

12 So I just -- and my -- and my concern, of course, is just
13 the confusion that it gives ---

14 MR. SMYTH: Right.

15 THE COURT: --- the jury. I mean, we're -- now all of a
16 sudden we started talking about a Sonovus form. And I was
17 thinking to myself, I don't -- I'm confused. And so I ---

18 MR. SMYTH: Judge, I don't think it has any relevance
19 under 401 or 403. I mean, I think the prejudicial value is
20 outweighed as well. But, you know ---

21 MR. SLOTCHIVER: Your Honor, this whole case is about
22 credibility ---

23 THE COURT: No, this whole case is not. It's all a case
24 of did he deviate from the standard of care. That's what it's
25 about.

1 Now, the fact that he testifies in one way and your
2 client testifies another way, that's why we're here in the
3 trial. And, I mean, I don't think his credibility has been
4 brought into -- I mean ---

5 MR. SLOTCHIVER: I believe his credibility is all over
6 the testimony in this case, and that's why we'd like to go
7 into it. We would be okay with the ruling that you agreed to.

8 MR. SMYTH: I wasn't -- I wasn't even finished.

9 [Whereupon, momentarily off record]

10 THE COURT: All right. I mean, I don't find it to be
11 overly -- overly prejudicial. I mean I just don't find it to
12 be overly relevant.

13 MR. SMYTH: That's our objection, Your Honor, 401 and
14 403.

15 MR. SLOTCHIVER: And, Judge, if I may, we believe that
16 it's -- this is a credibility case. He says, I was given
17 authority. She says, he wasn't. He says, I did nothing wrong
18 and the procedure is right and I did everything correctly.
19 And our versions would say he did not.

20 And it's a credibility case. It's very rare in a medical
21 case, I would agree, that you would have a credibility issue.
22 But here we have two statements he has signed. Both he's
23 acknowledged he signed. And he signed them inaccurately,
24 blatantly inaccurately.

25 MR. SMYTH: Your Honor, with all due respect, that's for

1 the jury to decide who they believe on these issues.

2 MR. SLOTCHIVER: I don't have to submit them into
3 evidence. I would like the opportunity to ask him about it.

4 MR. SMYTH: Well, that's improper. He can't ask him
5 about documents that aren't in exhibits.

6 MR. SLOTCHIVER: I was actually suggesting I was going to
7 ask him the same lines that you had, isn't it true that you
8 filled out a form and made a representation that was false
9 when it came down to lawsuits.

10 THE COURT: All right. If you want to impeach his
11 credibility based on a form that he filled out with Sonovus, I
12 mean, I guess that's fine. I mean ---

13 MR. SLOTCHIVER: Yes, sir.

14 THE COURT: I mean ---

15 MR. SMYTH: I guess the relevance, I mean, this is not a
16 fact at issue in the case. The claims in the case are did he
17 deviate from the standard of care. It's a medical malpractice
18 case, so I don't see how in the world this is relevant under
19 401.

20 And if it is relevant, I still think it's prejudicial
21 because it confuses the issues. That's the main thing, is
22 this is a confusing document to the jury. It's totally out of
23 context, and it has nothing to do with the medical care.

24 MR. SLOTCHIVER: It's not being offered for the medical
25 care. It's being offered as to truth, veracity, as to his

1 statements that he gives, to his honesty in his statements.
2 Especially because he has interjected the facts in the case.

3 He's not an opinion witness. He's a fact witness. And
4 he's given his own recitation of the facts. And I believe a
5 jury has the right to hear that there is a dispute about his
6 integrity, as he -- as he states, because of records he
7 signed.

8 It's no different, Judge, than when they've asked my
9 client about a form, the fact that you signed this form, which
10 she signed. But she certainly never signed anything that said
11 that they gave a false answer. Or maybe they'll insinuate she
12 did.

13 THE COURT: Well, they're talking about forms that relate
14 to the ---

15 MR. SMYTH: Case.

16 THE COURT: --- to the case.

17 MR. SLOTCHIVER: Yes, sir.

18 THE COURT: You're trying to bring in something
19 completely extrinsic.

20 MR. SLOTCHIVER: No different than bringing in an outside
21 deposition from another case that goes to his truth. And he's
22 given a statement to a bank and he's given a statement to a
23 hospital, both of which are false.

24 And I'll show you the form, Judge, if you'd like to see
25 it. There's no -- either you are -- you are a participant in

1 a lawsuit or you're not. There's no gray area, that I'm aware
2 of, that could exist.

3 [Whereupon, Mr. Slotchiver proffers documents to the
4 Court]

5 [Whereupon, the Court reviews documents]

6 THE COURT: What was the -- can you ---

7 MR. SLOTCHIVER: Yeah.

8 THE COURT: Can you tell me what the last -- last
9 question was?

10 THE COURT REPORTER: And we don't have that marked for
11 identification yet either if you want it marked.

12 [Whereupon, the last question is read back to the Court
13 and counsel]

14 THE COURT: Thank you.

15 I mean, it's your jury to confuse. I mean, that's what
16 I'm just trying to think of. I wouldn't want it in. I
17 wouldn't want to try to get it in that way. But, all right.
18 So let's do this. What's going to be your next question.

19 MR. SLOTCHIVER: Doctor, would you look at Page 3 of the
20 form; and there is a question on it midway through the page;
21 are you a defendant in any other suits or legal actions?

22 And the answer you have is -- I am assuming he will say
23 no.

24 And I would say: Isn't it true, Doctor, that that is a
25 false statement that you gave on this form?

1 THE COURT: Well, I thought we weren't going to talk
2 about other lawsuits.

3 MR. SLOTCHIVER: That's -- well, then, if you'd prefer,
4 how about if I rephrase it and I say isn't it true --- look
5 on -- but it is fine. Looking at Page 3 of the form, midway
6 through the page, there is a question that asks you -- there
7 is a direct question asking you about an event, and you denied
8 it. The truth is --

9 I'm trying -- I think it comes in, Judge; but I'll do it
10 however you want me to.

11 The problem is they sat him at the end of his
12 deposition -- of his testimony and they went through this
13 whole litany of would you do anything to harm her, are you
14 trying to put her in harm's way, are you doing the best you
15 can. And I understand why he said it. It's exactly what I
16 would expect anybody to say who's in his shoes.

17 But I don't -- I don't know how to address it, other than
18 to read the form. But I'll do whatever you want me to do with
19 it. But I want it to come in.

20 THE COURT: I understand you want it to come in. I think
21 that I'm just too nervous about it. I mean, I just really am.
22 I've just never seen it, you try to impeach somebody based on
23 a form that they filled out, that goes directly against what I
24 want to come out, which is that there's other pending
25 lawsuits. I think that's just way too prejudicial to him.

1 MR. SLOTCHIVER: What if I -- what if I -- phrase it,
2 isn't it -- isn't it true, Doctor, that after having an
3 opportunity to look at this form you would agree with me that
4 the form is actually not filled out correctly?

5 THE COURT: What's your position as to that?

6 My major concern, of course, is -- confusion,
7 potentially. But, again, this is y'all's jury, y'all's trial,
8 not mine. But I just don't want to go into other lawsuits. I
9 think that's too perpetual. So that's my issue.

10 MR. SMYTH: And I agree, Your Honor.

11 THE COURT: So if you want to ask it that way, and he's
12 going to say, yep, it is not, then -- I don't know what he's
13 going to say. I don't want to put words in his mouth. That
14 will be fine.

15 MR. SLOTCHIVER: Okay.

16 THE COURT: All right. I mean, that'll be a good
17 compromise.

18 MR. SLOTCHIVER: Okay.

19 THE COURT: All right. Mr. Robinson, if you'll grab them
20 please.

21 MR. SMYTH: And, Your Honor, it will stop there; right?

22 THE COURT: I assume. Yeah.

23 MR. SMYTH: Okay.

24 THE WITNESS: Do I get a chance to explain it?

25 THE COURT: Oh, yes, this is cross-examination. You have

1 to say yes or no and then explain that.

2 MR. SLOTCHIVER: But if he explains, he could open the
3 door.

4 THE COURT: That's right.

5 MR. SMYTH: Yeah.

6 THE WITNESS: Okay.

7 [Off the record awaiting jury momentarily]

8 [Whereupon, the jury enters the courtroom 8/29/19, 2:13
9 p.m.]

10 THE BAILIFF: Your Honor, the jury is complete.

11 THE COURT: All righty. Thank you so very much.

12 All right. You may resume your examination.

13 MR. SLOTCHIVER: Thank you, Judge.

14 Q. Doctor, if you'll please turn to Page 3 of the form that
15 we've been referring to.

16 A. Yes.

17 Q. The Sonovus document.

18 A. Yes.

19 Q. And there are a series of questions that are asked.

20 Would you agree with me that the form that you filled out is
21 actually inaccurate?

22 A. One line of it is, yes, sir.

23 Q. One line isn't accurate? It's not correct?

24 A. It's not correct, no, sir.

25 Q. Doctor, would you agree with me that there is a

1 statutorily-imposed duty to make a record of all patient
2 interactions?

3 A. There is a written rule to do that, yes, sir. We make
4 every effort to do that.

5 Q. There is a rule; correct?

6 A. Yes.

7 Q. Would you agree with me that at the time that Jeane
8 Whitfield came to your office, that rule was not followed?

9 A. We made every effort to do that, and a document was
10 created but it was incomplete.

11 Q. Doctor, would you agree with me that at the time she came
12 to your office that rule was not followed?

13 A. The chart was incomplete.

14 Q. Do you have any notations about calls that she made?

15 A. Not off the top of my head, no.

16 Q. Do you have any information about preoperative
17 information, other than the forms that you had signed?

18 A. No, sir.

19 Q. Do you have any information about postoperative
20 consultations or meetings with her?

21 A. No, sir.

22 Q. Do you have any notes, other than the operative note,
23 about what happened at the procedure?

24 A. No, sir.

25 Q. All of those things should have been there; correct?

1 A. They should have, yes, sir.

2 Q. Are you familiar with the fact that it is an actual
3 statute in South Carolina which can be grounds for a variety
4 of repercussions?

5 A. I am aware now, yes.

6 Q. Were you aware of it then?

7 A. Of the actual legal writing, no. But I understand as a
8 physician my duty to do that and make every effort to do that.

9 Q. Were you aware of it then?

10 A. I was aware that it was my duty to make every effort to
11 have complete medical charts. And we did not do that.

12 Q. Do you remember previously testifying that you were not
13 aware of it at the time, they had not taught you that at Ross
14 University, and you weren't aware of that while you were at
15 Medical University?

16 A. Right, well, I had read my testimony; and what I believe
17 I meant was that I had not read the official legal document.
18 But I should be aware and I am aware as a physician that it
19 should be done; and we did not do it.

20 Q. That's not what you stated, was it?

21 A. No, we did not. It was not.

22 Q. I am going to show you a copy of the rule and ask you if
23 you've seen this before.

24 MR. SMYTH: May I see this document?

25 [Whereupon, Mr. Smyth reviews documents]

1 MR. SMYTH: Your Honor, we need to take a matter up with
2 you.

3 THE COURT: All right. Ladies and gentlemen of the jury,
4 there's a matter of law that I need to take up. If you'll
5 just excuse us for a couple of minutes. We'll try to get you
6 right back out.

7 [Whereupon, the jury exits the courtroom 8/29/19, 2:19
8 p.m.]

9 MR. SLOTCHIVER: Let me see it. I believe it's the same
10 thing we looked at earlier.

11 [Whereupon, the Court reviews documents]

12 THE COURT: I've never seen it. The only thing we had
13 earlier was the statute and code section concerning the record
14 keeping.

15 MR. SLOTCHIVER: You're right, it was the other one. You
16 are right. Yes, sir.

17 MR. HORTON: If you would like the whole code section
18 rather than an excerpt, Your Honor, I have them here.

19 THE COURT: Sure.

20 MR. HORTON: That's 110.

21 MR. SLOTCHIVER: All right.

22 [Whereupon, Mr. Horton proffers documents to the Court]

23 THE COURT: All righty. What is your objection, Mr.
24 Smyth?

25 MR. SMYTH: Well, obviously, Your Honor, this is

1 something we covered previously. This is from the medical
2 board regulations, which has its own jurisdiction over the
3 discipline of doctors. I don't believe it's intended for the
4 purpose that it's being used here today for.

5 In addition to that, I think there's some very highly
6 prejudicial information in there. This doctor has not been
7 convicted of any misconduct.

8 All disciplinary board matters are strictly confidential,
9 and I think this is being pulled out of context in an effort
10 to create a rule that is inapplicable to this proceeding.

11 THE COURT: All right. What's your position?

12 MR. SLOTCHIVER: Your Honor, I believe it shows there is
13 a duty. I believe -- he's testified that he's read it since
14 then, and I wanted to add -- and I believe that it's relevant
15 to the case because he knows there's certain duties and
16 requirements he's supposed to follow that he didn't follow.

17 THE COURT: Ask him.

18 MR. HORTON: Your Honor, he has asked him. He said at
19 least five times that he had a duty to keep a record. So I'm
20 not sure -- I mean, at this point it's also cumulative.

21 THE COURT: All right. Ask him about it. Don't show him
22 this. And I don't want to talk about any pending medical
23 disciplinaries. I think that's ---

24 MR. SLOTCHIVER: I wasn't going to go there.

25 THE COURT: All right. Let's do this. We've got two

1 options, all right. And I'm going to let y'all make the
2 election. Option A is y'all show me everything that you're
3 going to show him the rest of the day throughout the rest of
4 his testimony and I'm going to make decisions right now. Or
5 I'm going to do everything in front of the jury. I'm not
6 sending them back out again.

7 MR. SLOTCHIVER: Let me see if there's anything else that
8 we have that hasn't already come in, Judge.

9 [Off the record momentarily]

10 MR. SLOTCHIVER: I think other than financial documents,
11 everything else has come out.

12 THE COURT: What financial documents that are not in
13 evidence are you going to show him?

14 MR. SLOTCHIVER: We plan to go into his tax returns, into
15 his financial statements. It goes to the punitive damage
16 aspect of the case.

17 THE COURT: Oh, those are in -- I thought they came in
18 through the accountant?

19 MR. SLOTCHIVER: So I think everything is coming in or
20 has already come in.

21 THE COURT: Roll that dice.

22 Bring them back out, Mr. Robinson.

23 THE COURT REPORTER: If you would like to ask those
24 exhibit numbers; the tax return, balance sheets, balance
25 sheets that I do have marked for identification?

1 [Whereupon, pause awaiting jury]

2 [Whereupon, the jury enters the courtroom 8/29/19, 2:23
3 p.m.]

4 THE BAILIFF: Your Honor, the jury is complete.

5 THE COURT: Thank you so very much.

6 You may resume your examination.

7 MR. SLOTCHIVER: Thank you, sir.

8 THE COURT: Yes, sir.

9 **RESUME CROSS-EXAMINATION BY MR. SLOTCHIVER OF DR. SCHIMPF:**

10 Q. Doctor, would you agree with me that it is your duty to
11 maintain patient records?

12 A. It's our duty to make every effort to do that, yes, sir.

13 Q. You said every effort. It's -- is it ---

14 A. Yes, sir.

15 Q. --- every effort, or is it a duty to maintain records?

16 A. It's our duty to make every effort, yes.

17 Q. Is it your duty to maintain medical records?

18 A. It's our duty to do everything we can to maintain
19 records, yes.

20 MR. SLOTCHIVER: Your Honor, I would ask if you would ask
21 the witness to answer the question.

22 THE COURT: This is cross-examination. You can ask him
23 to say yes, no, then he has every opportunity to explain.

24 Q. Is it your duty to maintain medical records of patients?
25 Yes, or no.

1 A. Yes.

2 THE COURT: Now you may explain.

3 A. We make every effort to do that. Unfortunately, medical
4 records are a fluid structure. Different parts of the medical
5 record are compiled by different people. And so a medical
6 record is extremely important and everything should be done to
7 make sure that we make every effort to make it accurate. But
8 I have come across very few, if none, in terms of a complete
9 perfect medical record in my career.

10 Q. Doctor, your record-keeping on Ms. Whitfield isn't just a
11 little imperfect; you're missing all the photos and all of
12 your notes and all of your records, aren't you?

13 A. We are missing that portion, yes.

14 Q. All of them?

15 A. I agree with you.

16 Q. Would you agree that it's your duty to maintain the
17 records in a timely manner? Yes or no.

18 A. It is our -- oh, yes. Yes.

19 Q. In a legible, accurate manner?

20 A. Yes.

21 Q. And to maintain complete medical records?

22 A. Yes. And we make every effort to do that. As you may
23 know, as time goes on things appear to not be complete. And
24 we do make an effort. You are exactly right. It is our
25 responsibility to make sure and make an effort to make sure

1 that the records are complete.

2 Q. What efforts were made to maintain accurate records on my
3 client's chart; her file, her procedures, her complaints?

4 A. We had 120 pages of your client. We were missing pages,
5 but we did have 120 pages of documents.

6 Q. Have you got any photographs? I think we discussed this
7 already.

8 A. We have.

9 Q. No photographs, no notes; ---

10 A. No, sir.

11 Q. --- none of those things; they aren't there, are they?

12 MR. SMYTH: Objection, Your Honor.

13 A. No, they're not.

14 MR. SMYTH: Ask and answered.

15 A. They're not.

16 Q. What ---

17 A. And that's a small portion of the chart. And it's an
18 important part. And they are not there.

19 Q. What ---

20 A. I am agreeing with you.

21 Q. What efforts were made to maintain them?

22 A. The same efforts that are made with any chart in any
23 medical facility. Dictations are attempted to be done and in
24 a timely fashion. Paperwork is compiled in a chart. Just
25 like it was before EMR, it was written on a piece of paper and

1 put in a chart so.

2 Q. Do you have independent specific recollection of what
3 efforts were made with regard to Ms. Whitfield?

4 A. Of her specific, I do not. Independently from five years
5 ago, no, I don't.

6 Q. Would you agree with me that you have a duty, you and
7 your office have a duty, to have a written, signed, informed
8 consent for every procedure you are going to undertake?

9 A. We have a duty to do that.

10 Q. That duty was not followed in this case, was it?

11 A. I -- it was -- we do not have the document. I do not
12 know why we don't, but it -- the end result is we do not have
13 them.

14 Q. It wasn't followed in this case, was it?

15 A. Based on the fact we don't have it, no.

16 Q. Well, let's look a little different. It's not on the
17 proposals; correct?

18 A. Yes.

19 Q. It's not on the pre-op forms?

20 A. Sure.

21 Q. Not on the post-op instructions?

22 A. No.

23 Q. And you would agree with me that you have different post-
24 op instructions that you provide to patients when they have
25 liposuction to the neck than when they have liposuction to

1 their thighs; correct?

2 A. I can't speak to that a hundred percent. I would believe
3 that we do have different language at the top outlining what
4 the procedure was. But if you're asking me ---

5 Q. Do you remember testifying to that at your deposition?

6 A. I do. And that's why I was thinking about it.

7 Q. Okay.

8 A. I testified for eight hours. I'm trying to remember.

9 Q. Was it truthful at your deposition?

10 A. Yes.

11 Q. Okay. So you have got a different form for post-op. You
12 don't have anything in reference to the neck?

13 A. No.

14 Q. Doctor, you discussed earlier what you called a timeout.

15 A. Yes, sir.

16 Q. Okay. And a timeout is an opportunity to make sure that
17 everything is correct?

18 A. Yes, sir.

19 Q. If you have a timeout, what prevented you from getting
20 something signed in the office by Jeane Whitfield confirming
21 that she agreed to have a procedure to her neck?

22 A. Well, I think what happened was that she did give verbal
23 consent to her. And the nurse must have been aware or she
24 would have stopped us from doing that portion of the
25 procedure.

1 So I believe we failed to provide her with the paperwork.
2 And if we didn't provide her with the paperwork ahead of time,
3 then we certainly wouldn't have given her the paperwork
4 afterwards. The front office wouldn't have known that.

5 So if that's my explanation for it? The timeout, as I
6 mentioned, all of the people in the room have to agree and I
7 can't -- or no surgeon can go randomly doing procedures
8 without the group agreeing.

9 Q. But ---

10 A. So ---

11 Q. --- it was done, wasn't it?

12 A. It was. And that's ---

13 Q. And it was done without -- without the timeout
14 effectively working?

15 A. I disagree. I would look at it the other way. I think
16 they knew that it was going to be done and that's why they
17 allowed it to be done; because she had verbally consented to
18 it but had not completed the paperwork, ---

19 Q. Which ---

20 A. --- which is our fault.

21 Q. The timeout is to go through a checklist of things to
22 make sure everything is in order; correct?

23 A. Yes.

24 Q. And part of it is because you -- you do a lot of
25 procedures on a yearly basis; correct?

1 A. I do now. At that point I was slower, for sure.

2 Q. Okay. And the timeout also ensures protections from
3 making a mistake in your memory?

4 A. It does.

5 Q. Correct?

6 A. Yes.

7 Q. And that's why one of the reasons you want to have a
8 checklist before you cut on somebody and potentially cut on
9 the wrong person, wrong part of the body?

10 A. Right. And so it was entered on the timeout. I didn't
11 type it in there. It had to be typed in by the nurse. And
12 she would not have typed it had she not been under the
13 impression it was being done.

14 Q. That's speculation, isn't it?

15 A. It's just basic knowledge of the process. But I don't --
16 I'm not a lawyer. I don't know if that's speculation.

17 Q. You have no independent knowledge of ---

18 A. I didn't do ---

19 Q. You have ---

20 A. I didn't type it in, so I can't ---

21 Q. Who did?

22 A. I just said the nurse.

23 Q. Who?

24 A. Dawn. The nurse's name is on the document.

25 Q. Dawn, who is no longer with us?

1 A. Unfortunately, you're correct. She passed away.

2 Q. I believe you testified a few moments ago on direct
3 examination that before the procedure was done you went
4 through the timetable ---

5 MR. SLOTCHIVER: Let me get the document real quick.

6 Q. And I believe the document showed that the procedure
7 began at 8:30 and the anesthesia began around 8:30; correct?

8 A. I believe so. I don't ---

9 Q. And ---

10 A. I am not looking at the document.

11 Q. And you had testified as to the reference -- do you have
12 that document right there?

13 A. I don't.

14 Q. As to the reference of 9:45 is when your nurse would have
15 written the documents into the computer. Do you remember that
16 testimony?

17 MR. SLOTCHIVER: Let me find that document real quick.

18 A. No, I didn't testify that's when the checkmarks would
19 have been put in for the procedure. But, again, I don't do
20 the process, so.

21 Q. Why would the checkmarks not just have an accurate
22 timestamp?

23 A. Because when you start a surgery the patient's obviously
24 being prepped and prepared for surgery. The nurse has to run
25 around the room getting equipment and prep and drapes and

1 things like that, as we start. Most of the material that we
2 need to do the surgery, sutures, instruments, special things,
3 are at the beginning of it. And it usually takes some time
4 for her to have time to do something else.

5 Q. Why wouldn't the checkmark accurately reflect what time
6 the surgery began? Why would you have it represent at 9:45
7 that they did the checklist if it really took place at 8:30 or
8 8:40? Why is the form inaccurate?

9 A. Because at the form I believe counts when you check the
10 time you checked it. So that's ---

11 Q. It's just a computer. You can change the timeframe and
12 enter it, can't you?

13 A. I don't know. I don't -- I don't know.

14 Q. And ---

15 A. I mean, that's ---

16 Q. --- is it not concerning to you that your form that
17 you're using is inaccurate?

18 A. No, because that form is not. If you go in a hospital,
19 the time -- when the stuff is done and checked, it's -- the
20 nurses do not do it at the moment the patient is put to sleep.
21 I've never ---

22 Q. So the fact ---

23 A. --- I've never seen that done.

24 Q. So the fact that it says 9:45 doesn't mean that it really
25 was 9:45?

1 A. No, I'm saying the fact that she doesn't do the paperwork
2 at the exact same moment the patient's put to sleep. So the
3 timeout is done -- it has to be done before you're asleep,
4 obviously, the patient.

5 This isn't just in our operating room. This is done
6 worldwide. In every institution I've ever been in, it's been
7 done the same way.

8 Q. Doctor, why can't it accurately reflect when it was done?

9 A. I didn't write the system. I don't know. I can't answer
10 that.

11 Q. It doesn't concern you that you have an inaccurate form?

12 A. The way that Nextech designed their system? I can't
13 speak to that. I don't -- I don't know.

14 Q. Your testimony ---

15 A. I didn't have anything to do with that.

16 Q. --- is that the system that's been created has a flaw and
17 it has an arbitrary timeframe put into it?

18 A. You're asking me about that document.

19 Q. Yes, sir.

20 A. I am telling you what I know about it. That's all I'm
21 telling you. That's my extent of my knowledge about it. I
22 have never entered information into it in that scenario, so I
23 don't know.

24 Q. You've testified about consent forms. Would you agree
25 with me that you have no independent recollection of ever

1 discussing the forms with Jeane Whitfield?

2 A. Specifically with her, I do not.

3 Q. And do you have any independent recollections of any
4 questions that she may have had about the procedures that were
5 going to go forward?

6 A. I don't, from five years ago.

7 Q. Doctor, Nextech is a recording device; is that right?

8 A. Nextech? No. It's EMR.

9 Q. That's the EMR?

10 A. Uh-huh.

11 Q. Separate from that, you've got dictation equipment;
12 correct?

13 A. Yes.

14 Q. And at the time this took place, you had dictation
15 equipment available to you at the office of Dr. O'Neill; ---

16 A. We did.

17 Q. --- is that correct?

18 A. Uh-huh.

19 Q. And you were sharing space with him; not working with
20 him, but sharing space, correct?

21 A. I don't know what you mean by working. We weren't
22 working with each other. We just had our own LLCs and things.

23 Q. And part of your -- or your arrangement with him was you
24 had access to use his dictating equipment; correct?

25 A. I did. Yeah.

1 Q. Okay. And you didn't like his dictating equipment?

2 A. I didn't -- I didn't like Dragon, no.

3 Q. Okay. So instead, you decided to use, I believe you
4 testified ---

5 A. Uh-huh. Yes.

6 Q. --- to a system that you had seen another doctor had
7 used, which was handheld equipment?

8 A. Yes.

9 Q. Okay. Would you agree with me, sir, that your handheld
10 equipment was repeatedly going in and out of service?

11 A. There were points where it didn't work, sure.

12 Q. Would you agree with me, sir, that when they didn't work,
13 you would -- and you realized they didn't work, you would
14 throw them away and order new ones just like them?

15 A. Yeah. I mean, we had multiple ones. So if one wasn't
16 working -- we didn't necessarily have to order more each time.

17 Q. And that you continued repeatedly to order the same types
18 of machines that repeatedly wouldn't work and would break,
19 until they weren't sold anymore?

20 A. We ordered probably -- well, we at least ordered it one
21 time, maybe twice. But that's correct, yes. And the
22 transcriptionist was getting ready to retire.

23 Q. Is your testimony you did it one or -- once or twice;
24 that's it?

25 A. I don't remember the exact number; but that would be my

1 guess, yes. And we may have -- and I think they came in packs
2 of two, so we probably got four of them.

3 Q. Did you remember testifying previously that they stopped
4 recording and we ordered a bunch of them often off of eBay and
5 Amazon; do you remember testifying to that?

6 A. I do. Yeah, we did. We ordered ---

7 Q. It's not once or twice, is it? A bunch?

8 A. Well, as I said, they come -- I believe they came in
9 packs of two. I can't tell you the exact number we ordered.
10 And it was not -- I don't know the number.

11 Q. Okay. And do you remember me asking you before why are
12 there no pre-op or post-op records for Mrs. Whitfield?

13 A. I remember you asking me, sure.

14 Q. And why are there no pre-op or post-op records for Mrs.
15 Whitfield?

16 A. Well, I think, as I -- and I don't know what -- I know
17 the goal is to make me say something different than what I did
18 at that point ---

19 Q. There's no goal. I'm just asking you what you know.

20 A. --- after eight hours of testimony.

21 But, you know, my feeling is I think -- I could -- it was
22 either an effect of the Dictaphones that we had problems with
23 or, as I said at a later point in that testimony, I may not
24 have done it. And I have, you know, no different answer to
25 that now.

1 Q. So you may not have done it or you had defective
2 machines?

3 A. That would be my -- yes.

4 Q. How about never got transcribed?

5 A. Well, that's a direct result of a defective machine.

6 Q. How about got placed into the wrong machine, into the
7 wrong file?

8 A. Sure. That's always a possibility with any medical
9 chart.

10 Q. How about I thought I dictated it but maybe I just
11 didn't?

12 A. I believe that was my earlier answer. I may not have
13 done it.

14 Q. Okay. Why would you continue -- strike that.

15 The time period of using these machines that would break,
16 reorder, break, reorder, break, reorder, that went over
17 several years; didn't it?

18 A. Yes. We would go -- as time went on, we began to demo
19 new EMRs and see what was coming out or we would look at
20 getting different ones. But I continued to use Dictaphones
21 for probably several years. I don't know how long exactly.
22 Until ---

23 Q. So ---

24 A. Until she actually retired. Which I don't know when that
25 was.

1 Q. So just to be clear, you bought a machine, it would
2 break, you'd replace it with a similar machine, it would break
3 ---
4 A. Uh-huh.
5 Q. --- you'd replace it with a similar machine, it would
6 break ---
7 A. Yes.
8 Q. --- and you continued that for several years?
9 A. I did.
10 Q. And so you knew that these machines had a propensity not
11 to work?
12 A. Well, anything mechanical -- I mean, my car's broken down
13 before; but I still drive it, so ---
14 Q. Would you -- would you agree with me, sir, that you did
15 not keep a log of whose medical records or notations were on
16 each machine that you dictated into?
17 A. We did not at that time, no.
18 Q. Okay. So you knew the machine could break?
19 A. Yes.
20 Q. You knew every time you used it you were taking a chance,
21 but you wouldn't -- you wouldn't catalog what records you were
22 putting on it so that if it broke you could go back and re-
23 dictate it ---
24 A. Well ---
25 Q. --- soon?

1 A. I'm sorry? I didn't mean to cut you off. I'm sorry.

2 Q. No, that's okay.

3 Understanding that you had a machine that had a
4 propensity to break, you would not keep a log of what
5 information was going to go on that machine?

6 A. We did not at that time.

7 Q. And I believe you testified these problems that you're
8 talking about lasted for years; correct?

9 A. I used the device for years; but less and less, so the
10 problem was not an issue later on.

11 Q. And isn't it true that your transcriber was Debbie Long?

12 A. Yes.

13 Q. And Debbie Long would repeatedly come back to you and say
14 we've got another batch of broken tapes?

15 A. I don't think it's fair to say repeatedly. It happened
16 at different times, as it did with doctor -- or the other
17 doctors who used her. But the other doctors have, as I said,
18 been in practice for decades and thought that it was a
19 reasonable system; and I followed it.

20 Q. She would come back to you and tell you we've got another
21 batch of broken tapes; correct?

22 A. Yes. There was more then. Yes.

23 Q. And there's no way to know whose -- which patient's
24 medical records were on the tapes that were broken?

25 A. We did not have a list of it, no.

1 [Whereupon, Plaintiff's Exhibit Number 42, authorization
2 for photo, is marked for identification by the court reporter]
3 Q. I'm going to hand you a document that has the number 42
4 on it and ask you if you've seen this before.
5 A. I can't say that I specific -- I'm sure I have, looking
6 through the chart; but I -- so -- I don't have a specific
7 recollections of it, but I -- I know what it is.
8 Q. This is an authorization for use of photographs; correct?
9 A. Yes.
10 Q. And this was an authorization that would have been signed
11 by my client after she came to your office; correct?
12 A. Yes.
13 Q. And, in fact, there were photographs taken of her;
14 correct?
15 A. I believe there were. She testified that there were,
16 yes.
17 Q. Well, I've seen your answer to the complaint also.
18 A. Yes. Yeah, I believe there were. I didn't take them, so
19 I can't -- I can't say I saw it happen. But I believe that
20 there were.
21 Q. Okay. Do you know where the photographs are?
22 A. I don't.
23 Q. Do you remember testifying that the protocol was for the
24 photographs to be uploaded in Apple machinery that was at the
25 O'Neill Plastic Surgery Center?

1 A. Yes, sir.

2 Q. Okay. And are you aware -- or you were here today.
3 You've heard the testimony. You've heard about the affidavit
4 of Dr. O'Neill and you've heard the testimony of Mr. Abrams,
5 the forensic, that no photographs were found in the machinery?

6 A. Yes, sir.

7 Q. No photographs -- at least no photographs of Mrs.
8 Whitfield were found in there?

9 A. Yes, sir.

10 Q. Understanding that they weren't there, where would they
11 be?

12 A. I don't know.

13 Q. Why would they not have been uploaded into the machine?

14 A. I don't know.

15 Q. Have you scoured your office looking for them?

16 A. We looked in our computers; and we sent an IT person to
17 O'Neill's office, when we first kind of separated offices, to
18 try to have them get all of our patients off of there. Hers
19 were never found in either scenario, that I'm aware of. And I
20 believe with your search, equally.

21 Q. You've heard the testimony that there was an H&P form,
22 we'll come to a few minutes later -- in a few minutes ---

23 A. Okay.

24 Q. --- that was found in your office manager's personal
25 office file cabinet, as opposed to the medical file; correct?

1 A. We don't have paper charts, so the piece of paper
2 wouldn't have been in an actual chart. It's usually scanned,
3 and then obviously once it's scanned I believe they get rid of
4 them.

5 Q. Fair enough. It wasn't found in her file, was it, in Ms.
6 Whitfield's file, was it?

7 A. You're asking me electronically, no.

8 Q. Okay. It wasn't ---

9 A. So ---

10 Q. --- found anywhere physically in a physical file or in
11 her medical file; correct?

12 A. We don't -- we didn't have physical files. So, no, it
13 wouldn't -- it couldn't possibly be found in there. But it
14 had not been scanned into her electronic file, no.

15 Q. So it was ---

16 A. It was in a file with I believe other H&P's.

17 Q. With other -- a big -- a stack of papers [motioning] with
18 a variety of things in them; correct? I believe we talked
19 about that.

20 A. I didn't find -- I don't think that was the size, but I'm
21 unaware.

22 Q. Okay. And we know that your office manager recently,
23 just last week, found a photograph in her old phone that was a
24 photograph of Jeane Whitfield; correct?

25 A. That was her testimony, I believe.

1 Q. Are you disputing her testimony?

2 A. No, not at all. You're asking me what she testified to.

3 Q. So you would agree that you have got a propensity in your
4 office to have miscellaneous records in various places?

5 A. We have, yes.

6 Q. Okay. And my question to you a few minutes ago was have
7 you done anything to scour the office to see if you could find
8 her pictures.

9 A. And I believe I said yes. What I said was that if they
10 were on that file, and we sent an IT person there -- I didn't
11 personally go look for it in the computer. I couldn't -- I'm
12 not an IT person. I wouldn't be able to find them. If others
13 have looked and they couldn't find it, I certainly couldn't.

14 Q. Would you agree with me that there is basically no real
15 explanation as to what happened to the photographs?

16 A. I do not have an explanation for it, no, sir.

17 Q. Doctor, when you see patients for breast augmentations or
18 reduction, do you ever tell them that there are minimal risks?

19 A. I don't remember ever telling somebody that. I think it
20 is a -- for just a straight augmentation I -- what I do tell
21 them is it is a much quicker surgery than people think and
22 that the surgery is simple in terms of -- I have made
23 references to it not being difficult.

24 Q. You wrote a book; correct? You talked about that?

25 A. I did, yeah.

1 Q. Is this your book [indicates]?

2 A. It is.

3 Q. You have a chapter called She Is Already Perfect The Way
4 She Is?

5 A. Yes.

6 Q. I'm going to read you some language and I'm going to show
7 it to you to get you to confirm ---

8 A. Sure.

9 Q. --- this is what you wrote.

10 A. Well, can we speak about how that book was wrote also?

11 Q. You'll be able to explain that ---

12 A. Oh. Okay.

13 Q. --- in a moment.

14 A. Thank you.

15 Q. And your lawyer can ask you all the questions he wants
16 to.

17 A. Okay. I'm sorry. I apologize.

18 Q. Jill had specific ideas about when -- about what she
19 wanted, breast augmentation or a, quote, boob job, end quote.
20 I began by explaining the minimal risks.

21 A. Yes, sir.

22 Q. That's what you said in your book; right?

23 A. Right.

24 Q. Okay.

25 A. That's in my book.

1 Q. Is that not what you do in a normal procedure, though?

2 A. No, that book is written -- is it now when I explain it
3 to you, or not?

4 Q. Did you want to see the page?

5 THE COURT: You can say yes or no, and then give an
6 explanation.

7 THE WITNESS: Okay.

8 A. Yes, that is in my book. The book is written for
9 entertainment purposes. It's not a medical document. I was
10 interviewed multiple times over several months, about a year
11 actually, with a writer. And the writer takes what I say and
12 paraphrase and they write continuous, flowing, hopefully
13 entertaining, text. So there are definitely things in there
14 that are my thoughts and ideas, for sure; but I did not write
15 every word of it.

16 I do think that breast augmentation does have overall
17 less risks than most surgeries or what most people envision.
18 And I know that because when you tell somebody how long it
19 takes, they're often very surprised.

20 Q. Okay. Thank you, sir.

21 A. Thank you.

22 Q. Doctor, would you agree with me that sutured incisions
23 can gap when very tight tissue is pulled together to create
24 the suture?

25 A. Sutures can gap? What? I'm sorry? Please say that

1 again.

2 Q. Would you agree with me that suture incisions ---

3 A. Uh-huh.

4 Q. --- can gap when very tight tissue is pulled together to
5 create the suture?

6 A. Yes. And what that's basically referring to is working
7 out dog ears in tissue. So when we have two wounds you're
8 closing and one is longer or shorter than the other, it's
9 pulled together sort of like an accordion.

10 Q. Well, do you remember telling me in your deposition you
11 would not agree with that?

12 A. No, I don't. I'm sorry. But what that's referring to is
13 massive weight loss.

14 Q. Let me show it to you.

15 A. Well, sir, I'm answering what you're asking me and what's
16 in the book.

17 Q. I'm asking you if you remember telling me that, that you
18 said something different in your deposition.

19 A. Well, I said it in a different -- if I did, and I'm happy
20 to read it, it was in a different context. In that book,
21 it's -- the reason for that is when people take a bandage off,
22 they look and the skin is uneven or kind of like a -- like a
23 mountain, almost, like an accordion, and the first thing they
24 ask is it going to heal, is it going to flatten out.

25 So in that scenario, that's -- wounds for different

1 surgeries are closed in a different manner. So I can't say
2 that no wound ever gaps and that all wounds gap.

3 That's a -- I don't -- I'm happy to answer the question
4 looking at -- in the context that you're referring to. But to
5 blanket say that I said that and to mean that to all ---

6 Q. I was asking you the same question I asked you in the
7 deposition and got a different answer at different times.

8 A. But you were reading it out of -- what's in that book is
9 different.

10 Q. It is.

11 A. Yes, because it's a different context.

12 Q. Do you remember any conversations you had with Jeane
13 Whitfield from the pre-operative visit with her?

14 A. I don't. I remember seeing her, and I remember -- I
15 remember her being there; but I can't honestly say I remember
16 speaking with Ms. Whitfield.

17 Q. Do you remember what procedures you and her discussed?

18 A. Well, I don't really remember even speaking with her ---

19 Q. You can just answer yes or no.

20 A. Yes. I'm sorry. I do not remember. No. I'm sorry.

21 No.

22 Q. If you had your notes, they would have been reflected;
23 correct?

24 A. Yes.

25 Q. You did see her; correct?

1 A. Yes.

2 Q. I believe we've entered this into evidence, the patient
3 registration form. Let me just double check real quickly.
4 But I'm going to show it to you, either way, while I'm
5 looking.

6 A. Okay.

7 Q. Do you remember seeing her patient registration form?

8 A. Yes, sir.

9 Q. Okay. And can you tell me where on that form it
10 references anything at all about an incision to her neck?

11 A. It does not.

12 Q. Okay. Do you remember telling her -- or do you remember
13 her complaining to you about the pain she had under her chest?

14 A. Obviously, I've heard it multiple times. I can't tell
15 you the time that I first heard it, but I remember that being
16 a complaint of hers. I mean ---

17 Q. Do you remember telling her that by removing the scar
18 tissue that she had from the pre- -- from the prior
19 augmentation, that should alleviate the pain?

20 A. I don't remember specifically telling her, but -- so the
21 answer is no. But what I would say in that scenario is that
22 she's had implants for several years, she's had an upper
23 quadrant chest pain that has been extensively worked up; and
24 scar tissue, like I had spoken about earlier, around implants
25 is a poorly-understood phenomena. And so that is why we would

1 have gotten to that point of speaking about it.

2 Q. You don't recall that conversation?

3 A. No, I -- no, sir.

4 Q. You don't have any notes about that conversation?

5 A. No, sir.

6 Q. You did not do an MRI or an x-ray or anything else,
7 medically, to confirm that this would or would not help
8 alleviate the pain?

9 A. I have never done an MRI for a capsule in a cosmetic
10 patient. And an x-ray takes an image of bone, and I have not
11 ordered a chest x-ray for someone.

12 Q. Doctor, you would agree with me she did not come in to
13 you for cosmetic surgery, she came in to you to relieve the
14 pain under her chest; she was perfectly happy with her
15 appearance, correct?

16 A. She -- I don't know the answer to that.

17 Q. Did you ---

18 A. But ---

19 Q. --- ask her if she was happy with her appearance?

20 A. As I said, I don't remember speaking with her; so I can't
21 speak to that. What I was about ---

22 Q. Do you deny it -- do you deny it?

23 MR. SMYTH: Your Honor, ---

24 A. No, I don't ---

25 MR. SMYTH: --- can he finish his response, please?

1 THE COURT: You can finish your response.

2 THE WITNESS: Thank you.

3 A. I don't deny it; but, I don't remember speaking to her,
4 so I can't tell you what I did or did not tell her. Now I
5 have freely admitted that I don't remember that.

6 What I was going to say is that an x-ray is not a test
7 that I as a plastic surgeon would order very often, if ever.
8 And the patient had been worked up by a medical doctor, a GI
9 doctor, and sent to me to be seen. So our -- my job and my
10 specialty is think of things that apply to my field to help
11 her.

12 Q. What workup did she have? She -- the testimony was that
13 she had gone to the GI doctor, he said I don't think it's a
14 GI, why don't you maybe talk with a plastic surgeon and see if
15 it is related to scar tissue. That's all the testimony I've
16 heard about her being worked up.

17 MR. SMYTH: Objection, Your Honor.

18 Q. Am I missing something?

19 THE COURT: Just ask the question, Mr. Slotchiver.

20 MR. SLOTCHIVER: Yes, sir.

21 Q. Am I missing something? Is there something else that was
22 done to work her up before you decided ---

23 A. I went through her medical chart. She had had right-
24 sided pain since I believe several, several years.

25 Q. What medical chart did you look at?

1 A. I don't know. This was last year. Her chart from
2 somewhere.

3 Q. A chart from your file or a chart that you received ---

4 A. No, no. It was one from an outside file.

5 Q. A chart that you got in connection with litigation?

6 A. Yes.

7 Q. Did you look at her medical chart before deciding that
8 she would benefit from having this procedure?

9 A. No. Huh-uh.

10 Q. Okay. Would you agree with me that one of the benefits
11 of looking in medical charts is you can see what's actually
12 happening with a patient and what they've undergone?

13 A. Sure. Yes.

14 Q. I'm going to show you what's been marked as Plaintiff's
15 Exhibit 31.

16 [Mr. Slotchiver confers with court reporter to confirm
17 description of Plaintiff Exhibit 31]

18 Q. You've seen this letter before; correct?

19 A. Yes, sir.

20 Q. You would agree with me that this letter is false;
21 correct? It's got wrong information?

22 A. It has some inaccuracies in it, yes, based on dates.

23 Q. In fact, it has you seeing her after she had surgery by
24 Dr. Kalus, doesn't it?

25 A. It does. That was her follow-up appointment that was in

1 our scheduling system.

2 Q. Well, that's not what it says. It says you saw her;
3 correct?

4 A. Yes. I said it was inaccurate with dates.

5 Q. Where does it say that you've created this letter after
6 you realized you were missing the records?

7 A. Well, I put the date at the top. So this was one year
8 after her issues.

9 Q. Where does it advise her that you're missing her medical
10 records?

11 A. It does not.

12 Q. Today you went and discussed there were a lot of phone
13 calls that went back and forth, concern from Jeane about the
14 problem she was having. Did you at no time look in your chart
15 to see what the medical notes were showing about her
16 complaints or about her issues?

17 A. Well, the timing of when I treated her, because of the
18 dictation system, I wouldn't have -- and I -- and I wouldn't
19 have, honestly, gone back and looked at stuff from months
20 prior, because I had been seeing her.

21 So when I know the patient and I'm the one taking care of
22 her, I don't go to the EMR and open it to look at somebody
23 that I've been actively treating.

24 Q. You did not think the right thing to do, as soon as she
25 transferred to another doctor, would be to send your file

1 over?

2 A. I didn't think about it, to be honest with you. But when
3 he ---

4 Q. Is there no checks and balances to make sure that you
5 actually had files with documents in them?

6 A. There's not, no.

7 Q. Doctor, there's been some conversation about what has
8 been called an H&P form; correct?

9 A. Yes. Yes.

10 Q. I'm going to show you a copy of Plaintiff's 34.

11 MR. SLOTCHIVER: I'm sorry.

12 MR. SMYTH: Thank you, sir. That's all right. Thank
13 you.

14 [Whereupon, document shared with defense counsel]

15 MR. SLOTCHIVER: If you will pull that up. Okay. In a
16 moment.

17 Q. This is the H&P form; correct?

18 A. Yes, sir.

19 Q. All right. And would you agree with me that this form
20 was created on June 6th, 2014?

21 A. Yes.

22 Q. And this is the same day that the surgery would have been
23 performed, ---

24 A. Yes.

25 Q. --- correct?

1 A. Yes.

2 Q. June 6th?

3 A. Uh-huh. Yes, sir.

4 Q. And on that form it shows a variety of procedures that
5 were done; correct?

6 A. Yes, sir.

7 Q. And nowhere on this form does it reference chin or neck;
8 correct?

9 A. No.

10 Q. Would you agree with me that there are several blanks
11 that are not filled in?

12 A. Yes, sir.

13 Q. Would you agree with me that on the bottom of the form
14 it's got your signature?

15 A. Yes.

16 Q. Would you agree with me that on the bottom of the form it
17 shows that the date it was signed was on the same day as the
18 surgery?

19 A. Yes.

20 Q. And it was signed the afternoon of the surgery?

21 A. Yes.

22 Q. Would you agree with me that you read forms and documents
23 before you sign them?

24 A. Yes.

25 Q. And that your memory would likely be better the day of a

1 procedure than it would be a month, two months, six months, or
2 years later?

3 A. Yes.

4 Q. Would you agree with me that that form was not filled out
5 correctly?

6 A. Yes. I didn't -- this is not my handwriting at the top.
7 That's by a staff member, and I inaccurately signed a
8 document. You're correct.

9 Q. You just told me a moment ago, sir, that you read forms
10 before you sign them; correct?

11 A. Yes.

12 Q. Did you not look to make sure that the procedures that
13 you did were on the form?

14 A. Yes. I made a mistake.

15 Q. Assuming that the chin-neck area was never supposed to
16 have any liposuction, that form is absolutely correct, isn't
17 it?

18 A. Well, no, I didn't fill out the rest of it like I should
19 have.

20 Q. But the litany of the procedures done, assuming that this
21 wasn't supposed to be done, it was never done, it's correct?

22 A. The rest of the form is not filled out. That top line,
23 if you were to say that she was not supposed to get it, would
24 be correct, yes.

25 Q. You had a form that your office used when it came to the

1 breast implants, correct, and the surgical procedure; and the
2 form that was used, the operative form, and the notes that you
3 had regarding the implants, was actually written improperly in
4 your office; correct, it reversed the implants?

5 A. The stickers were reversed, I believe. The implants were
6 correct.

7 Q. Okay. So that form was wrong also?

8 A. Yes. I didn't -- I don't put the stickers on the form,
9 but -- so I don't know exactly what the form looks like. But
10 the implants were properly placed.

11 Q. When Dr. Kalus interacted with Mrs. Whitfield, do you
12 remember him calling you on the phone?

13 A. The first time he met her?

14 Q. The first time.

15 A. Yes, I do.

16 Q. Okay. And he didn't take her as a patient then. He
17 actually sent her back to you, didn't he?

18 A. He did.

19 Q. And did he say something to the effect of, Dennis, you
20 need to listen?

21 A. No.

22 Q. Not what he said?

23 A. No. I believe he testified that that's -- that he was
24 not upset with me.

25 Q. I didn't say he was upset at you.

1 A. Well, he didn't speak to me like that. Nor would I
2 expect him to.

3 Q. When you met with Jeane following the procedure on the
4 11th, do you remember there being an odor present?

5 A. I don't specifically.

6 Q. Do you dispute it?

7 A. I don't dispute it. I just certainly couldn't describe
8 it or tell you.

9 Q. Do you remember telling her I guess we'll put in a few
10 more stitches, on that appointment?

11 A. I don't remember saying that.

12 Q. Do you dispute it?

13 A. No.

14 Q. Any reason to dispute it?

15 A. No, sir.

16 Q. Do you remember talking to Dr. Kalus and him telling you
17 that he believed that the most prudent course of operation --
18 or the most prudent course for Jeane Whitfield ---

19 MR. SMYTH: Objection, Your Honor. Hearsay.

20 THE COURT: Not yet. Keep going with the question.

21 Q. --- would be operative revision?

22 A. Do I remember that?

23 Q. Yes, sir.

24 A. No, I don't. He did not instruct me how to treat the
25 patient, that I recall, in any way.

1 Q. Do you take issue with his determination that the most
2 prudent course of action would have been an operative
3 revision?

4 A. Well, I'm not exactly sure what you're asking me. I
5 mean, at that point in time, did I -- he didn't tell me that,
6 so I couldn't take issue with it.

7 Q. I'm asking you now, sir. Do you take issue with it?

8 A. It is not what I would have -- obviously, what I would
9 do. But I don't have -- I don't have an issue with what he
10 did. I think that it is an aggressive treatment and it may be
11 what she needed at that time, but I don't -- from his opinion?
12 Excuse me?

13 Q. It's really -- and you can explain. It's really a yes or
14 no. Do you take issue with his opinion that she needed to
15 have surgery?

16 A. I don't take issue with it. But I don't agree with it.

17 Q. You don't know if you had an informed consense form --
18 excuse me, you don't know if you had a signed informed consent
19 form to do liposuction to her neck, do you?

20 A. I do not, no.

21 Q. You don't have any explanation as to why you don't have
22 one; correct?

23 A. I do, but I believe we discussed it and she agreed to it
24 and we did not obtain the paperwork.

25 Q. You believe you discussed it with her?

1 A. I do.

2 Q. Do you remember testifying previously that it's only your
3 assumption?

4 A. Well, I guess I mean I believe in my mind that I did
5 disc- -- I can't tell you specifically that I did, but I do
6 believe that I did. So ---

7 Q. It's an assumption?

8 A. --- it's my assumption. Yes, sir, assumption. Correct.

9 Q. An assumption that would have been discussed and an
10 assumption she would have given you permission?

11 A. Yes, sir.

12 [Whereupon, Mr. Slotchiver reviews documents]

13 Q. I'm sorry. You answered some things in your direct and
14 that's why I'm reading through the notes.

15 [Whereupon, Mr. Slotchiver reviews documents]

16 Q. I am going to show you what I've got. I'm going to show
17 you a copy of the surgery center form. I believe it's in
18 evidence. It's been discussed at length with you. I just
19 don't know which number it is. I apologize.

20 THE COURT: Ladies and gentlemen, why don't we go ahead
21 and take this opportunity to have our mid-afternoon break? So
22 we'll go ahead and take a break now, and let everybody get
23 reorganized. We will bring you back in in just a little bit.

24 [Whereupon, the jury exits the courtroom 8/29/19, 3:12
25 p.m.]

1 [Whereupon, Plaintiffs Exhibit Number 43, surgical center
2 form, six pages, marked for identification]

3 [Whereupon, a recess is taken 8/29/19, 3:13 p.m.]

4 [Whereupon, resume 8/29/19, 3:26 p.m.]

5 THE COURT: All right. If the jury is ready, Mr.
6 Robinson, bring them out.

7 [Whereupon, pause awaiting jury]

8 MR. SLOTCHIVER: I am wrapping it up.

9 THE COURT: That's okay.

10 MR. SLOTCHIVER: At some point I am going to want to
11 proffer about the stuff that was excluded.

12 [Whereupon, the jury enters the courtroom 8/29/19, 3:24
13 p.m.]

14 THE CLERK: The jury is all seated.

15 THE COURT: All righty. Thank you so much.

16 You may continue.

17 MR. SLOTCHIVER: Thank you, sir.

18 RESUME CROSS-EXAMINATION BY MR. SLOTCHIVER OF DR. SCHIMPF:

19 Q. I want to come back with you, Doctor, to a question I
20 asked you earlier regarding the conversation you had with Dr.
21 Kalus. Do you remember previously telling me that he was
22 trying to make sure that you were listening when he spoke to
23 you?

24 A. I don't.

25 Q. Let me show it to you.

1 A. Sure.

2 MR. SLOTCHIVER: If I may open the deposition?

3 [Whereupon, sealed transcript opened in court and marked
4 as Plaintiff's Exhibit Number 7]

5 Q. I am going to hand you the deposition.

6 A. Great. Thank you.

7 Q. If you'll please turn to Page 97. I'm going to read
8 Line 10. And tell me if this is correct. And this is your
9 response, sir: I'm just saying yeah, he -- I don't know if I
10 would say he was upset, but he was trying to make sure that I
11 was listening.

12 That's what you testified to earlier, isn't it, about
13 your conversation with Dr. Kalus when he called you when Jeane
14 Whitfield was in his office the first time?

15 A. I'm sorry. Which line?

16 Q. Page 97.

17 A. Oh 97. I'm sorry. I was -- okay ---

18 Q. Line 10.

19 A. I was on 96. My fault.

20 Q. I'm just saying, yeah, he -- I don't know if I would say
21 he was upset, but he was trying to make sure that I was
22 listening.

23 That is the conversation -- that is what you testified to
24 at your deposition about your conversation ---

25 A. Well, the line -- yeah, the line above I said -- you

1 said, was he upset in the phone call. I said, no, he wasn't
2 upset; you have to have spoken with Dr. Kalus.

3 Q. Uh-huh. And he did say to you ---

4 A. These are questions of you, Doctor. I'm just saying,
5 yeah, I don't know if I would say he was upset but he was
6 trying to make sure that I was listening.

7 Q. That I was listening.

8 A. Yeah, that ---

9 Q. So that was your prior testimony; correct?

10 A. I don't remember saying that. But I believe you, yes.
11 Obviously it's in here.

12 Q. Okay.

13 A. You asked me if I remember that. As I said, I don't
14 recall anything else.

15 [Whereupon, Plaintiff's Exhibit Number 43, Surgical
16 Center form, was pre-marked by plaintiffs]

17 Q. There's been some comments made about the surgery center.
18 Let me show you a form that I am going to introduce,
19 Plaintiff's Exhibit 43. And it is the entire surgical center
20 form. Have you seen this document before?

21 A. In its entirety?

22 Q. Yes, sir.

23 A. I don't recall that I saw it. But I saw highlights of
24 it, yes.

25 Q. I'm going to ask you about Page 1 only, if you want to

1 take a quick look at 1.

2 A. Page 1? Sure.

3 Q. Yes, sir.

4 [Whereupon, the witness reviews documents]

5 A. Okay.

6 Q. Okay.

7 A. Take it back?

8 Q. Just for a moment.

9 A. All right.

10 [Whereupon, the witness proffers documents to Mr.
11 Slotchiver]

12 Q. You would agree with me, sir, that on this form it says
13 that the pre-anesthesia H&P -- I'll put it on the screen.

14 A. Sure.

15 Q. There's a checklist of everything that was done ---

16 A. Yes.

17 Q. --- on this form.

18 A. Yes.

19 Q. And would you agree with me that the pre-anesthesia H&P
20 is actually -- was actually not completed?

21 A. Yes.

22 Q. Would you agree there are no notes or records of any
23 measurements on Mrs. Whitfield's breasts?

24 A. I would agree.

25 Q. Would you agree with me that putting too much tension on

1 an incision can lead to ischemia and separation of the wound
2 margins?

3 A. Yes. If somebody does put too much tension on an
4 incision, it can separate and open. That is usually in a much
5 shorter -- or it's usually -- let me just say it's usually
6 perioperative, meaning within a couple of days.

7 Q. Do you agree with me that you place no blame on Mrs.
8 Whitfield's outcome in her aftercare?

9 A. I don't believe I've ever blamed a patient for their
10 outcome.

11 Q. And would you agree with me that you have no criticism of
12 the care and treatment that was provided, up until the date of
13 this deposition, of Dr. Kalus to Mrs. Whitfield?

14 A. I believe I've testified to that before. I have not seen
15 her most recent pictures, I don't believe.

16 Q. Okay. Well, let's talk about that.

17 A. Sure.

18 Q. Dr. Kalus' deposition was taken as a treating physician;
19 correct?

20 A. Sure. Yes.

21 Q. Okay. And after it was taken as a treating physician,
22 you had no criticism?

23 A. Can we see my deposition? Can we look at what I said?

24 Q. I'm going -- I'm going to ask you right now.

25 A. Okay. Well, can I see it, or no?

1 Q. You'll have an opportunity. I'm going to ask you ---

2 A. Okay.

3 Q. --- right now.

4 A. Thanks.

5 Q. My turn.

6 A. Okay. Sure. My fault.

7 Q. So at the time of your deposition, he was merely a
8 treating physician and you had no criticism; correct?

9 A. At that time, I did not have any criticism.

10 Q. Since that time, in preparation for an examination, he
11 reviewed more records, as he testified to ---

12 A. Yes.

13 Q. --- and he agreed to testify not as an expert for Jeane
14 Whitfield, but he agreed to testify as to the deviation from
15 the standard of care; today is -- would you agree with me,
16 sir, today is the first day that you've ever suggested that
17 you have criticism of Dr. Kalus?

18 A. No. I would -- it's the first time that I've been asked,
19 obviously, on the record about it. But as I testified in my
20 deposition, that to that point I was unfamiliar with where
21 she -- I had obviously not seen her and I did not know where
22 she was in the process of after his care. So I had not seen
23 the pictures that I've seen since.

24 Q. You had no criticism prior to the time that he decided to
25 testify; correct? Yes or no.

1 A. No. But as I stipulated in my ---

2 Q. I'm sorry. Was that, no, you had criticism, or, yes, you
3 had no criticism?

4 A. No, it is was no; I had criticism. I ---

5 Q. That's not what you said at your deposition, is it?

6 A. I said, no, I did not, at that point in time.

7 Q. Okay.

8 A. And as I stipulated in my deposition, I was unfamiliar
9 with how she had progressed.

10 Q. And since that time, he's now an expert and now you have
11 criticism or he's now offered testimony and now you have
12 criticism?

13 A. That has no impact on her pictures today and how her
14 outcome has been.

15 Q. He's the only physician who's testified, who -- in this
16 entire proceeding, ---

17 A. Right.

18 Q. --- would you agree with me, ---

19 A. Yes.

20 Q. --- who has treated her and maintained accurate records
21 of everything he's done; correct?

22 A. Yes. Because if those records are accurate. But my
23 criticism is not -- I think I made it clear earlier when I
24 said that there's different ways to treat things. I don't
25 criticize how he treated her. I would not have done that.

1 Q. Okay. Fair enough.

2 A. I think I was clear on that.

3 Q. Doctor, by no means to embarrass you or to put your
4 information to the public, but for reasons before the Court
5 I've got some questions I'm going to ask you. And I will.

6 Would you agree with me, sir, that your net worth, at
7 least as of August the 1st of 2018, was \$2,181,000?

8 A. I believe that's what's on there of that date.

9 Q. Is that an accurate statement?

10 A. As of that date, I believe.

11 Q. Would you agree with me, sir, that ---

12 A. In fact -- can I stipulate something?

13 So in terms of that document, I think it's important to
14 give a -- that is what's on that paper. I filled that out for
15 a -- well, that's accurate. That's fine. At that point in
16 time my net worth ---

17 Q. Does it -- does it matter why you fill out a
18 paperwork ---

19 A. No, sir.

20 Q. --- as to what you put down on the information?

21 A. No.

22 Q. Do the numbers change depending on who you are filling it
23 out for?

24 A. They don't change, but they would be -- they don't
25 change.

1 Q. Okay. And would it be fair to say, sir, that as of that
2 date your total income for the year was \$946,000?

3 A. Yes.

4 MR. SLOTCHIVER: Beg the Court's indulgence.

5 THE COURT: Absolutely.

6 [Whereupon, plaintiff counselors confer]

7 MR. SLOTCHIVER: I have got no further questions.

8 THE COURT: All right. Thank you so very much.

9 Anything further?

10 MR. SMYTH: No, Your Honor. I think we had agreed that
11 we would move Dr. Schimpf's facilities chart into evidence in
12 its whole. So that would be Defendant's Exhibit 43.

13 THE COURT: Okay. Any objection?

14 MR. SLOTCHIVER: No, sir. The medical records, no
15 objection.

16 THE COURT: Without objection.

17 [Whereupon, Defendant's Exhibit Number 43 is admitted
18 into evidence by the Court]

19 THE COURT: All right. Dr. Schimpf, you are free to step
20 down, and you're excused. Thank you so very much.

21 THE WITNESS: Thank you, sir.

22 [Whereupon, the witness exits the witness stand]

23 THE COURT: All right. Mr. Smyth, call your next
24 witness.

25 MR. SMYTH: Thank you, Your Honor. The defense calls Dr.

1 James Ballenger to the stand.

2 [Whereupon, Dr. Ballenger is duly sworn by the clerk of
3 court]

4 THE CLERK OF COURT: You may be seated.

5 [Whereupon, the witness takes the witness stand]

6 THE CLERK OF COURT: And for the record, please state
7 your full name, spelling your last.

8 THE WITNESS: James C. Ballenger. B-A-L-L-E-N-G-E-R.

9 MR. SMYTH: Good afternoon, Doctor.

10 THE WITNESS: Good afternoon.

11 MR. SMYTH: Do you need a cup of water to get started?

12 THE WITNESS: Yes.

13 MR. SMYTH: Okay.

14 [Off the record momentarily for water]

15 JAMES C. BALLENGER, M.D., Having Been First Duly Sworn, was
16 Examined and Testified as Follows:

17 **DIRECT EXAMINATION BY MR. SMYTH OF DR. JAMES BALLENGER:**

18 Q. Would you please tell the jury a little bit about
19 yourself?

20 A. I grew up in North Carolina in Raleigh. My father was a
21 college professor there. And I moved here in 1983 to be the
22 new chair of psychiatry at the medical school and have been
23 here ever since.

24 Q. Would you tell the jury about your education and
25 training, starting with your undergraduate, please?

1 A. Let me finish my last answer.

2 Q. Oh, ---

3 A. I have three sons, ---

4 Q. --- sorry.

5 A. --- two of them lawyers. Sad, no doctor. And I still
6 have a third chance. He's 16.

7 I went to college at the University of North Carolina in
8 Chapel Hill. And then much to the dismay of my friends, I
9 went to Duke for medical school; and then I stayed on there as
10 an intern in medicine, internal medicine, until I went to
11 Boston to do my psychiatry training at Harvard at the
12 Massachusetts General Hospital.

13 Q. And what did you do, after completing your training,
14 before you came to South Carolina?

15 A. I had a two-year commitment to the Navy. They deferred
16 me through my specialty training so they could have me. I
17 worked as a psychiatrist. And I went to Bethesda Naval
18 Hospital where the President gets his care. But it's also
19 where the medical school is. And I was on the faculty there
20 for a couple of years and ran the inpatient to the enlisted
21 men, service.

22 While I was there I started working at the National
23 Institute of Mental Health, which is actually across the
24 street, at the NIH. And I was there for three years on the
25 bipolar affect and disorders unit. I was ward chief there.

1 And then after that, I -- I and my family went to
2 Charlottesville, Virginia, where I was on the med-school
3 faculty; and I was director of the inpatient service and
4 director of research, and director of research at Western
5 State Hospital. And I was there for four years before I came
6 here.

7 Q. And are you licensed to practice medicine in South
8 Carolina?

9 A. Yes.

10 Q. All right. Are you board certified?

11 A. I am board certified in psychiatry and neurology and in
12 forensic psychiatry, and was recertified in forensic
13 psychiatry.

14 Q. Can you tell the jury, that might not be familiar with
15 forensic psychiatry, what that is.

16 A. Yeah. Forensic psychiatry is essentially to bring the
17 science of psychiatry and the knowledge of psychiatry to the
18 courtroom to help the trier of fact, which is the jury.
19 And -- or the judge, in other cases.

20 It's essentially -- I don't know your fields, and you
21 don't know mine; but mine is pertinent to this case, and so I
22 bring what I know to try to help essentially the Court, but in
23 particular the trier of fact, with what you don't know, what
24 areas of science and clinical science is pertinent to hear, to
25 help work out the issues, the legal issues in this particular

1 case.

2 Q. Okay.

3 A. And there's a -- there's, you know, a training and ethics
4 that goes along with being a forensic psychiatrist that's
5 different than being a clinical psychiatrist.

6 Q. How is it different?

7 A. It's really very different.

8 A clinical psychiatrist, like Dr. Marcino, and like me
9 two-thirds of the time. I have a practice within walking
10 distance of here. And when I'm there I treat patients and
11 trying always to help them, to figure out how to do that. And
12 my ethical obligation is that, is to always help.

13 Hippocrates said it, and it still stands, to do no harm.
14 And so -- and the APA's guidelines about what that means is do
15 no harm. You are always an advocate for your patient. You
16 help your patient. You don't ever hurt them.

17 Turn that around, and I come over here to function as a
18 forensic psychiatrist. And it's really quite different. As I
19 said earlier, my job here is to help you with whatever -- with
20 the decisions you have to make. I am not here to make any
21 decisions, but to help you do that.

22 The ethics is quite different. I was in a trial recently
23 where the judge said to me, Jim, you and I are the only two
24 who don't have a dog in this fight. And it's true. And I
25 don't have a dog in this fight. I don't care who wins.

1 Q. Okay.

2 A. Let me say one ---

3 Q. Sure.

4 A. --- thing further.

5 So to do my job, I have to bring skepticism to do a
6 forensic psychiatrist's job. In my office, I more or less
7 believe or -- everything the patient tells me or I -- it
8 doesn't matter. If I don't believe them, I just file it and
9 try to help them.

10 My ethical obligation as a forensic psychiatrist is to
11 strive very hard to find the objective truth and then have
12 opinions about it and tell you what my opinions are. I'm only
13 an advocate of what my opinions are.

14 Q. All right. Thank you. Have you been involved in any
15 leadership positions in the field of psychiatrist?

16 A. Yeah.

17 Q. Can you give us a quick overview of some of the things
18 you've done?

19 A. Yeah, I've been a psychiatrist for a long time. I've
20 been president of the South Carolina Psychiatric Association.
21 I've been founding president for Southern Association for
22 Research in Psychiatry. I chaired for the DSM-4, our
23 diagnostic Bible, the I think huge committee that determined
24 what the diagnostic criteria would be for panic disorder.
25 I've been -- chaired twice for the -- of the scientific -- the

1 board of scientific directors for the Anxiety Disorders
2 Association of America. And on the board of trustees for
3 that. But and that's a brief.

4 Q. Okay.

5 A. There are others.

6 Q. Sure. And give the jury an idea about your work
7 experience after moving to this area. What kind of things
8 have you done in the Charleston area?

9 A. Well, I, as I said, became chief of psychiatry. Which
10 and then I was head of the clinical programs. And over the
11 nineteen years, that expanded a lot. We built the Institute
12 of Psychiatry, which I ran for -- from opening from '88 to
13 2000. And we built it to be and it is, was, the best
14 expertise in psychiatry in the region. And that was what we
15 tried to do, and I think we pulled it off.

16 We also built a very large system, outpatient system,
17 some of which I directed and ran but some of which was in
18 collaboration with the Department of Mental Health and the
19 community mental health centers; and we worked together.

20 So we ran the emergency room --- and we hospitalized
21 people. But I opened a branch at Charleston Memorial
22 Hospital, when it existed, so we didn't have to send patients
23 all the way to Columbia.

24 I had, for that entire time, and have for every day since
25 I graduated from my residence in '74, a stable of patients

1 I've taken care of. A lot of chairmen don't do that, but I
2 thought it was important for me to do that. So I've seen
3 patients throughout. I saw patients yesterday.

4 Q. All right. And you mentioned earlier, I believe, that
5 you've got a practice here now, a private practice. When did
6 you open that?

7 A. I opened that in 2003.

8 Q. Okay. And what types of problems do you see in that
9 practice or patient's populations?

10 A. Well, I see more or less everything confined to adults
11 and adolescents. I don't see children below the age of
12 adolescence.

13 Q. And what types of diseases do you treat?

14 A. Well, my areas of expertise -- you know, people in this
15 day and age, they look you up on Google. And I'm an expert in
16 panic disorder and the other anxiety disorders like PTSD;
17 social anxiety disorder, generalized anxiety disorder, and
18 OCD. So certainly anxiety patients.

19 But I'm also a world expert on bipolar affective
20 disorder; and so people with depression, bipolar illness, they
21 call me. But I also see substance abuse. I started and ran
22 the substance abuse center at the medical school. And so I
23 see substance abuse people. And I do a lot of psycho pharm
24 work and a lot of psychotherapy. So it's a -- it's an
25 enjoyable broad-based practice.

1 Q. All right. And have you published any works in your
2 field of psychiatry? Articles, textbooks, those kinds of
3 things?

4 A. The articles that I count are I published somewhere over
5 250 peer-reviewed articles and 16 professional books.

6 Q. Okay. One of which I think you referenced a little while
7 ago, the DSM-4. Can you tell the jury what that is?

8 A. Yeah. The American Psychiatric Association has taken on
9 the responsibility to develop the diagnostic and statistical
10 manual of psychiatry. And it's now in its fifth edition.
11 And it does the background work and pays for it and then gets
12 all the profit from selling everybody in the mental health
13 field in the world at least one DSM.

14 And so -- but for instance, what goes in -- my committee
15 had 222 people from all over the world, and we were charged
16 when the DSM-4 with re-looking at the research that said what
17 should the criteria be, and doing research toward that goal as
18 well. So we refined them a little bit based on world opinion,
19 expert opinion, and new research we did, like how many panic
20 attacks do you have to have to meet the criteria was part of
21 the -- was part of the thing. We did research to figure that.
22 How many symptoms you have to have for it to be a full panic
23 attack, that kind of thing.

24 Q. Okay. And have you also talked and lectured on the
25 topics in the field of psychiatry?

1 A. A lot. I've taught at the medical schools that I've been
2 at, both medical students, psychiatry residents, fellows,
3 advanced-training people.

4 But I also consider it very important for all sorts of
5 reasons. At least two I will mention. To teach postgraduate
6 lectures. And I stopped counting at 1,000. But one of them
7 is that I've helped develop understanding particularly about
8 the anxiety disorders, and so I've done a lot of that
9 lecturing.

10 I'm also -- eighty-five percent of the care of psychiatry
11 is delivered by non-psychiatrists, non-mental-health people,
12 actually. It's by GPs. And so I figured it's very important
13 to try to help them do as good a job as they possibly can. So
14 I lecture a lot to them.

15 Q. And those lectures would include topics that might be at
16 issue in this case?

17 A. Yes.

18 Q. And do you believe you possess the requisite knowledge,
19 skill, training, in the fields of psychiatry and forensic
20 psychiatry to help this jury understand some of the issues in
21 this case?

22 A. I do.

23 MR. SMYTH: At this time, Your Honor, we would offer Dr.
24 Ballenger as an expert in the field of psychiatry and forensic
25 psychiatry.

1 THE COURT: All right. Any objections?

2 MR. SLOTCHIVER: No objection.

3 THE COURT: All right. As we stated previously, ladies
4 and gentlemen, he's an expert. He can give his opinion.

5 Q. Doctor, did I hire you to review this case to help me
6 understand?

7 A. You retained me, and for an hourly rate. And for your
8 next question, what I was supposed to do is to review all the
9 records, examine the plaintiff, develop relevant opinions to
10 the legal questions you're going to have to decide, write a
11 report, make myself available for depositions and trial
12 testimony.

13 Q. Does the fact that you're being compensated for your work
14 in this case affect your ability to give us fair and accurate
15 opinions?

16 A. Yeah, I need to be paid. But absolutely, that's how I
17 pay my mortgage. But it doesn't matter who pays me, whether
18 it's you, the defense, in this case the plaintiffs, in other
19 cases the Court, and other cases, doesn't have any influence
20 on what my opinion is. I'm the preverbal umpire. It is what
21 it is. You've got to live with it ---

22 Q. Okay.

23 A. --- and still pay my bill.

24 Q. Do you know Dr. Schimpf in any way?

25 A. No, I met Dr. Schimpf about two hours ago.

1 Q. All right. And I think you said this earlier, but you do
2 work for both plaintiffs' lawyers and defense lawyers?

3 A. I absolutely do. And, in fact, I like that. Some people
4 only one side. I don't -- I really don't like that. And so I
5 do very much work for both sides. It is the sides, when you
6 get in the courtroom.

7 I also do criminal work twenty-five percent of the time.
8 And I work about equally defense and prosecution in criminal
9 cases, for the same reason.

10 Q. Have you been appointed by courts to serve as an expert
11 witness?

12 A. Yes. It's -- courts ask experts to help do several
13 things. Sometimes there's a dispute among experts. And
14 recently in a big case against Wal-Mart the judge said, please
15 come in and tell me which of these two experts is right. And
16 that's a nice job to have, sort of. You don't make any
17 friends.

18 But what you're smiling about is in the courtroom around
19 the corner and to the left, I was asked by the judge -- no,
20 actually it was across the street in federal court -- the
21 judge in the Dylan Roof case to do his competency exams. And
22 I did two for the court. And, in fact, it was the judge in
23 that case who said, Jim, you and I are the only two here that
24 don't have a dog in that fight. Because they were -- that was
25 a very controversial case, as you know.

1 Q. And in connection with work that I've retained you to do,
2 have you reviewed some of the medical records in this case?

3 A. I would almost say I have reviewed all the medical
4 records. I reviewed an awful lot. And I have.

5 Q. Do you remember which -- any particular records stand out
6 as to which ones you've reviewed?

7 A. Yes. Certainly her psychiatrist records which ---

8 Q. Dr. Marcino?

9 A. Dr. Marcino, who's seen her since, you know, for over a
10 decade. But her GP or cardiologist, two -- records from two
11 long treatments by dermatologists; and the records by Dr.
12 Widenhouse, another plastic surgeon she had seen.

13 Q. And have you also reviewed the deposition testimony of
14 the witnesses in this case?

15 A. I -- I think all of them.

16 Q. And were you also given an opportunity to meet with Ms.
17 Whitfield and perform your own evaluation?

18 A. I did. And we did. And we met for about three hours in
19 Dr. Marcino's office, actually with Dr. Marcino sitting almost
20 beside her in that office. And as I said, we met for about
21 three hours.

22 Q. And is that a fairly common thing for you to do, to
23 interview patients in the forensic world?

24 A. I like to do it every time that it's possible. Sometimes
25 I'm involved in cases where the person is deceased and I

1 don't -- and I don't necessarily. But I like to do it in
2 every case. And it's always helpful.

3 Q. And you mentioned that Dr. Marcino was present for this
4 evaluation. There was some testimony yesterday that Dr.
5 Marcino appeared to question whether Ms. Whitfield was able to
6 give reliable answers during your evaluation. What was your
7 impression of that?

8 A. Well, Ms. Whitfield is certainly smart and capable and
9 quite verbal and can do that. She didn't want to do the
10 interview, was afraid of me. And I think that's fair to say.
11 Certainly distrusted me because I was from the other side and
12 that I would be not nice to her.

13 I -- it's become my -- because attorneys on the side
14 where I'm not retained often don't want me in the case; and so
15 they say, oh, it will be terrible, it'll traumatize her, she's
16 already, or he's already traumatized, so it'll be terrible.

17 So it's become my pattern over the last probably maybe
18 ten years, maybe, to ask people afterwards how was it, because
19 of those reasons. I mean did I -- was I nice to you.

20 Ms. Whitfield said, yes, you were very nice. And was I
21 respectful? Yes, very respectful. And then she went on to
22 say, yes, it was not -- essentially it wasn't traumatic, it
23 wasn't anywhere near as bad as I thought it would be.

24 And as I was walking out, she stopped me to thank me;
25 again, saying you made it actually a pleasant experience.

1 Now, in the interview, particularly when I've got to --
2 the way I do the interview, briefly, if I can, is I ask, as I
3 asked her, what happened, please tell me in your own words
4 what happened to you. And I let people talk for as long as
5 they need to to answer that.

6 I asked a question, well, tell me more about this or what
7 you mean by that. And then after that, then I essentially say
8 I need to fill in some gaps that you didn't talk about and so
9 can we talk about this and this and this.

10 And so, as I started to do -- now one of the things I
11 wanted to talk about, which she had not talked about, is all
12 the trauma that she's been through, more than a dozen things
13 that she's talked to her psychiatrist about. And, I mean I
14 wanted to know the facts behind them and what was it like for
15 her to do that.

16 And right up front she said, I don't want to talk about
17 any of that. And I said, not any, I mean, not even the
18 harassment of the ex-wife? No.

19 So in that case, was she able to do it? She was able,
20 but didn't want to. I don't know why. Could be all sorts of
21 reasons that she didn't want to do that.

22 Q. Based on the medical records that you've read, the
23 deposition testimony that you read, and your own personal
24 evaluation, have you come to some opinions or conclusions as
25 to what diagnosis you believe that Ms. Whitfield has?

1 A. Yes. I mean, it's much easier when I have a -- good
2 records. It was mentioned this morning with Dr. Marcino of a
3 competent psychiatrist -- she trained at my place. And it's
4 uncommon to have a decade worth of records. So for instance,
5 that was very helpful. And in examining her I came to the
6 conclusion there were multiple diagnoses that are very clear.

7 Q. And in reaching these diagnoses and conclusions, are you
8 in any way trying to demean or embarrass Ms. Whitfield?

9 A. No, it's -- I've been real worried about coming here
10 today. Because one of the things that Ms. Whitfield has been
11 plagued by, hurt by, is that she reacts strongly to things
12 that happen that are not good. I've been -- labeled as not
13 good. Although that was not her experience when I was there.

14 But -- so I'm afraid that many of the things I will say
15 will hurt her, and I hate that. But it's my job to help the
16 Court help deal with the lawsuit that she brought. And it's
17 absolutely not to demean Ms. Whitfield at all or to be
18 disrespectful in any way. I admire how she's fought through
19 various parts of this through her history.

20 Q. And in coming to the diagnoses that you're about to tell
21 us about, did you rely on published standards within your
22 field?

23 A. Yes. Can I -- can I add one sentence ---

24 Q. Sure.

25 A. --- on my previous thing? I've spent my life trying to

1 remove any stigma from psychiatrist problems. They're not any
2 different than diabetes or hypertension. I formed a
3 foundation to try to convince the world of that. Because it's
4 not fair for this one group of illnesses to be stigmatized.
5 It's just not fair.

6 So, anyway, your next question -- oh, yes, I used the
7 DSM-5 criteria. The DSM is really -- and we say it again and
8 again in it, this is a guide. Well, it's not used as a guide
9 around the world. It is used as a Bible. It is used in
10 courtrooms all over the place as an authoritative text. So it
11 gets -- everybody uses it in every country who does work in
12 that field, my field.

13 Q. And so based on your work what conclusions did you reach
14 in terms of diagnoses?

15 A. Well, starting with the one I think in some ways is the
16 most important, although the second -- is the second most
17 important. The most important is panic disorder. And Dr.
18 Marcino said she started treating her for panic disorder when
19 she started in 2009, although it even started before that.
20 She labeled it as severe, as you brought out this morning.

21 It clearly is a severe, and it has a lot -- a lot, to do
22 with her life and has a significant amount to do with this
23 trial.

24 I've spent the last forty years researching, treating,
25 writing about, teaching about, panic disorder. And it's a

1 terrible disorder.

2 Q. As a matter of fact, you've earned a nickname with regard
3 to the panic disorder field. What is that?

4 A. I went -- was invited back to Harvard to give grand
5 rounds one time. And George Valliant I mean introduced me.
6 And I'm impressed George knows my name. He's a giant in the
7 field. But George introduced me as, you know, welcome back
8 our own trainee, Jim Ballenger who is the father of panic
9 disorder.

10 I'm not. Years later I was invited to give the principle
11 thing at a Festschrift, which is when you do great work for a
12 long time and retire. Some universities hold a day where they
13 invite people to talk about you and what great things you did
14 in your field.

15 Well, I was invited to do that for Don Kline. Don Kline
16 is the father of panic disorder. And I said there, I'm not
17 the father; but I was there when Don Klein came out of the
18 birthing room and maybe I took the baby and ran with it.

19 Q. Well, tell us some of the symptoms that are associated
20 with the disorder, please.

21 A. The criteria for panic disorder -- we did the DSM-4 and
22 still are. They are recurrent, meaning at least two, panic
23 attacks, which are the worst thing that happens to human
24 beings. And I can lecture about this for a long time, but I
25 won't.

1 They are a sudden surge, spike of anxiety of the worst
2 ever. Many people think they are dying. They literally think
3 I'm dying within a minute or two. I see some of you know
4 that. It's horrible.

5 So people rush to the emergency room because they think
6 they're dying usually of a heart attack. And so the fifty-
7 five percent -- the first place they go is the emergency room.
8 Fifty percent, the second place, they go to see a
9 cardiologist.

10 Now, they have other symptoms, too, like dizziness. And
11 Ms. Whitfield's is one of -- that's one of her symptoms in her
12 panic attack. Shortness of breath is one. Usually the heart
13 beats incredibly fast. I mean, 180 beats a minute, 200 beats
14 a minutes. I mean, your heart beats are somewhere between 80
15 and 100.

16 And so when they get to the emergency room, for the first
17 five or ten minutes, sometimes the emergency room people freak
18 out because they've never seen a pulse of 220. You can't even
19 count that fast. They've never seen a blood pressure of 210
20 and over 160.

21 Now, all of that is a ten-minute phenomena and then it's
22 poof, it's gone. The pulse comes back to 80, blood pressure
23 comes right back down.

24 They often have chest fullness or pain, often a headache.
25 Some people have GI disturbance. Some people are so dizzy

1 they can't -- they can't stand up. I once saw a woman who
2 lived in a chair for five years because every time she stood
3 up, she fainted, that she got so dizzy she fell back down.

4 The rest of the criteria are that you change your life
5 after that, or your life changes, based on the experience of
6 having had a panic attack.

7 Some people have one panic attack and never -- a lady in
8 Washington I saw never left her house again for forty-five
9 years.

10 But a lot of people think I'm sick, there's something
11 really wrong with me, I think there's something wrong with my
12 heart. Ms. Whitfield has struggled with that.

13 A cardiologist here in Charleston keeps working her up
14 and finding nothing and not finding panic disorder. Which
15 it's right under her nose. And I haven't called that doctor
16 yet, but I've mentioned it to her.

17 And some people see neurologists for dizziness or
18 migraine headaches. Some people see GI doctors. We
19 contributed to that research. Forty-five percent of the
20 people have been diagnosed as irritable bowel to go to the GI
21 clinic. They -- they have panic disorder too.

22 Q. Okay. And in your review of the records in this case,
23 did you -- are there any particular incidents or examples that
24 you found where this diagnosis was evidence?

25 A. Multiple times she talks about panic attacks and panic

1 disorder. For me, the most important panic attack here today
2 is the one she had on June 20th when she went to Roper with
3 chest pain.

4 Q. That was right after the -- two weeks after the surgery?

5 A. Yes.

6 Q. Okay.

7 A. And they ended up hospitalizing her for the -- for the
8 weekend because of her chest pain. And she has a positive
9 family history of early cardiac disease. So that makes sense
10 that they did that.

11 But the workup then, and innumerable workups after that,
12 have all been normal, which is what you find in panic
13 disorder. I spent years trying to find what's really wrong
14 with the heart. And it's apparently nothing. It's like the
15 alarm ringing the button -- the button that the brain has
16 pushed and the person thinks six tigers are coming to eat them
17 and they panic as if that were happening. But it's not. So
18 it's a very weird syndrome.

19 Q. Does a panic disorder have any effect on the person's
20 ability to trust others, like doctors for instance?

21 A. In some way, they never do. So, I mean -- I mean, I do a
22 lot of lectures, as I mentioned; and I tell the doctor, you
23 know, making the diagnosis is easy, I'm going to teach you in
24 the next half an hour which medicines to use.

25 The issue is getting people to take them and to take

1 them -- to take the medicines in correct doses, high enough
2 doses, and 365 days a year. That's going to be your task,
3 doctors.

4 And because no patient will do that to start out with.
5 And I've said that for years until I actually started
6 seeing -- I have now about fifteen percent who say, oh, okay,
7 Doc, sure, I'll do it and they do it.

8 But the other eighty-five percent I say four milligrams
9 and they come back and say, I've been taking .5, a half a
10 milligram, is that -- is that good? Well, it's good you took
11 some, now we need to work our way up to four, because the
12 average patient needs five-and-a-half.

13 And then -- and I tell the doctors, it's going to take
14 you a long time to get people on and then to keep them on it.
15 They'll stop it on their own.

16 MR. SLOTCHIVER: Your Honor, I'm going to object to the
17 relevancy of this testimony at this point.

18 THE COURT: All right. Ask your -- I mean, do you -- do
19 you need to proffer him any further concerning this?

20 MR. SMYTH: Not on that. I'm ready to go to the next ---

21 THE COURT: All right. We'll do the next question. All
22 right.

23 Q. So that's the first diagnosis that you came to. Doctor,
24 what's the -- what's the next one?

25 A. The next one, and in the level of importance for her in

1 life, is the bipolar affective disorder type two. Type one is
2 when you have big manic episodes and you go in the hospital.
3 Type two is you have depressions and smaller hyper-manias.
4 They can be big.

5 But Dr. Marcino has correctly wrestled back and forth, is
6 this why she had so many depressions and why she has these
7 episodes where she wakes up at night, the bursts of energy
8 that would carry over to the next thing, is that hypomania?
9 She thinks she is; so she's giving her big medicines like
10 lithium, antipsychotics, mood stabilizers, to help treat that.

11 She also has the diagnosis of a depression not otherwise
12 specified, which means that -- which means it doesn't quite
13 fit in the diagnostic criteria. That's why we say not
14 otherwise specified.

15 She has another really important issue. The last two are
16 important in this case. One of them is what's called the
17 somatic symptom disorder. Very nondescript.

18 In the DSM-5 they merged three or four different
19 syndromes that we've been seeing for years. One of them, the
20 somatization disorder where people have four different
21 categories of pain. One of them is GI. And they go to see
22 doctors a lot, get a lot of diagnostic procedures and a lot of
23 general surgeries.

24 Well, if -- before the DSM-5 that would have been the
25 diagnosis I would have given Ms. Whitfield. So I now gave her

1 somatic symptom disorder, which is over-emphasis or worrying
2 about one or more somatic symptoms and spending a great deal
3 of time, energy, and money getting it worked up.

4 Q. Can you give us some examples that you've seen?

5 A. Well, in this case, the reason why she --- as I started
6 looking in her records, she saw a neurologist (sic), Dr.
7 Warren, from 1998 on very, very frequently about skin issues
8 like the actinic keratosis we -- those of us who grew up in
9 the south have them because we got sunburned too many times.
10 She literally had hundreds of them frozen off. Now I have
11 them too; and my dermatologist says, I'll take it off if it's
12 huge and gets in your way or it bleeds a lot or but ---

13 MR. SLOTCHIVER: Your Honor, I believe this is outside of
14 his scope of his expertise.

15 THE COURT: What was the original question? To give
16 examples ---

17 MR. SMYTH: Examples of the somatic syndrome.

18 A. I'm sorry. Okay. Yeah. So a whole lot of going to see
19 that dermatologist over -- still.

20 Then the medical spa where she's gotten a lot of Botox, a
21 lot of skin treatment on her neck, right up to the surgery,
22 and injections to deal with that. And then -- and then sees
23 Dr. Widenhouse for body-contouring, and that for years. But
24 that's just the sort of body over-emphasis.

25 She has nineteen different pain complaints that take her

1 to a doctor. Some of them, three, four, five, six times. And
2 I ended up with a number of diagnostic procedures, and there
3 were twenty-seven. Again, some of them repeated three, four,
4 five, six times, like MRI of the brain, the internal auditory
5 canal, the shoulder, the back; CAT scans of the head,
6 shoulder, elbow, abdomen; GI, because she has diverticulitis,
7 part of what -- how they got into it. But innumerable looking
8 down with scopes three or four times with an upper GI,
9 colonoscopies; cardiovascular procedures. All of them
10 multiple times, almost all of them normal. All of them.

11 Things like a whole-body PET scan, which I don't know how
12 much in the world that costs. But looking for cancer in 2004.
13 But, again, twenty-seven different procedures.

14 All of that time going to doctors and obviously with
15 concerns and some of them pain concerns. It qualifies for
16 somatization disorder but -- for the new diagnosis, somatic
17 symptom disorder.

18 Q. And is there any other diagnosis that you made too?

19 A. Absolutely. And the third, which is very critical to my
20 opinion about what happened here, is that in my opinion she
21 has -- or they're two. One of them is as to -- histrionic
22 personality disorder; the flamboyant, big personality,
23 histrionic reactions that her psychiatrist talks about.

24 It's pertinent that she comes close to having PTSD but
25 doesn't meet the criteria. Started off with, right out of the

1 gate, the first criteria; the required one is you have to have
2 been exposed to something that where you thought you were
3 going to be killed or maimed.

4 Well, she's had, as I said, at least a dozen trauma.
5 Being beaten up by a boyfriend many years ago, being raped
6 thirty years ago, those qualify for PTSD then. Certainly not
7 what happened with Dr. Schimpf; that's not a qualifying event.

8 The other symptoms of PTSD are re-experiencing,
9 nightmares, flashbacks where you actually think you're -- it's
10 happening to you again, or thinking about it all the time.

11 Now, she has that -- the intrusive memories thinking
12 about Dr. Schimpf all the time. She has nightmares. I've
13 heard about the pit bull and about people breaking into her
14 house. But I asked her not about Dr. Schimpf.

15 The second criteria is avoiding reminders of it. Now,
16 she doesn't avoid going by where his office was. She doesn't
17 avoid talking about it. She ran into him in Wal-Mart the
18 other day and she left. I tried very hard, was that because
19 you were -- it made -- it made you get really upset in your
20 body and your psyche, which is why people avoid because they -
21 - if they are reminded they throw up, get diarrhea, and get
22 really upset psychologically and physically. And she could --
23 she would never answer that question. But I was -- it was my
24 conclusion that it was avoidance.

25 She doesn't really have enough of those symptoms to meet

1 the criterias. And she definitely doesn't have the first one
2 related since the rape thirty years ago or the boyfriend
3 beating her up. The pit bull maybe -- maybe could. But
4 not -- not quite.

5 Q. One of the things that we've prepared for your testimony
6 is a list of some of the things that you talked about that
7 were traumatic. Can you kind of go through that list and tell
8 us if those are things that you found evidence of in the -- in
9 the records?

10 A. Well, that's -- and that's how I know about them, because
11 she told me she didn't want to talk about them. But she talks
12 a lot with her psychiatrist that these really bother her and
13 it's led her psychiatrist to say, as a descriptor, that some
14 bad things happen and she has a big reaction to it. And she
15 said Dr. Schimpf was a bad thing and she has a big reaction to
16 it. When good things happen, she has a big reaction to that.

17 MR. SLOTCHIVER: I'm sorry. I haven't seen that
18 document. I don't know what it is.

19 MR. SMYTH: This is just a summary from the medical
20 records. I'm not putting it into evidence ---

21 MR. SLOTCHIVER: Whose summary is it?

22 MR. SMYTH: Doctor.

23 MR. SLOTCHIVER: I don't believe this is proper to show
24 the doctor -- he can talk about his testimony.

25 MR. SMYTH: I've already laid the foundation with him

1 that these are ---

2 MR. SLOTCHIVER: He's -- he's not ---

3 THE COURT: It's a ---

4 MR. SLOTCHIVER: --- disputing it. He's not trying
5 to ---

6 THE COURT: Are you utilizing it for demonstrative
7 purposes ---

8 MR. SMYTH: Yes, sir, it's just for demonstrative. It's
9 based on the -- his work in the files.

10 MR. SLOTCHIVER: It's no different than bringing your
11 notes up with you and referring to your notes.

12 THE COURT: Well, has he testified that he -- that these
13 are the things that he has put in his report?

14 MR. SMYTH: Yes, sir.

15 MR. SLOTCHIVER: Which was the same issue we had when my
16 client brought notes with her and they said they objected to
17 it. I don't know why -- -- it is the same ---

18 THE COURT: This is a demonstrative that was -- he's not
19 utilizing it to refresh his recollection. He's just asking
20 him is this information that's contained in his report. And
21 he can testify ---

22 MR. SLOTCHIVER: I don't mind that. I just didn't want
23 him to show -- hand it to the jury and show it to him.

24 MR. SMYTH: I will be happy to go through the list ---

25 MR. SLOTCHIVER: It's also leading -- okay. Thank you,

1 sir.

2 Q. All right. Doctor, you were saying?

3 A. Well, each of these she's talked to her psychiatrist
4 about, some of them at great length, as very significant
5 things that she's had reactions to.

6 And the divorce from her first husband, I asked her if
7 she would tell me about that, and she said it was -- she
8 putzed around and ultimately said it was a very amicable
9 divorce. She talked to her psychiatrist about how horrible
10 and how hard it was for her.

11 Her father died from cancer in 2004, and that's why --
12 that was thought to be why she started having anxiety
13 disorders. Although panic disorder is a genetic condition.
14 It's often kicked off by things.

15 She was raped, by her report, when she was nineteen,
16 twenty, in a parking lot. She was attacked by a pit bull
17 about four or five years ago and had -- and reported to her
18 psychiatrist very frequent nightmares about that.

19 Perhaps the biggest and the one most contiguous to the
20 surgery is for the three years prior to her surgery that this
21 lawsuit is about, is her husband's ex-wife and his son began
22 an ongoing, repetitive, frightening, irritating harassment
23 program going to -- walking by their house, parking outside
24 their house, knocking on their door, going through their mail,
25 walking out on their dock, and up and including threats that

1 one of them would shoot her, that she took to be quite serious
2 so that she got a firearm to defend herself. And that I'm
3 glad to hear settled somehow. But that's great.

4 Her husband has a lot of medical problems, including a
5 heart attack, atrial fibrillation, gout, which are hard on
6 her. And she talks to her psychiatrist. Tragically, the day
7 after her surgery her mother died; and she couldn't even go to
8 the funeral, which bothered her greatly.

9 Her sister started bugging her about, you know, I want my
10 share. And that's not my assessment. I've never met her
11 sister. But her sense was her sister's being greedy and
12 pushy.

13 One thing she did tell me about. I said, would you tell
14 me about the stillborn that happened to you, I know it was
15 horrible. And she said, no, but his name was -- his name was.
16 And she had -- as she did many things in my examination, she
17 was quite demonstrative, angry, at me; sort of threw that in
18 my face. Or wanted me to know his name but wouldn't talk
19 about it.

20 Abuse by a boyfriend, talked about being beaten by him.
21 Husband's business has been struggling. And an employee stole
22 300,000. She -- her job is to run herd over all this -- this
23 business. And she still works full-time doing that.

24 Her sister died from cancer after she was extraordinarily
25 involved in her sister's care. She got J.K. -- J.K.

1 whatever ---

2 Q. Rowling?

3 A. Yes.

4 Q. Harry Potter author?

5 A. Harry Potter author to -- because her sister was a big
6 fan, to participate in a wish.

7 I asked her about this. Allegedly she had a boyfriend
8 who died in a terrible industrial accident that she had to go
9 and identify his charred remains. And then in another place
10 she said actually he was cheating, she had caught him and beat
11 his car with a baseball bat. I don't know which is true.

12 Guilt over -- she lost a child during pregnancy.

13 Her mother had bad Alzheimer's, had to be
14 institutionalized at the Institute of Psychiatry and at
15 Somersby. And eloped and she had to get lawyers involved to
16 keep her from eloping. And she got real mean toward the end.

17 She had a cousin die. She's had a tumultuous marriage;
18 by her report, a lot of screaming in the household, a lot of
19 trouble. Niece developed thyroid cancer, and it bothered her
20 a lot. Sister, sister-in-law and her boyfriend, all died
21 within a week in '17. And just another one, a niece with
22 frequent visits to the Mayo Clinic. She takes care of a lot
23 of people and therefore participates in their sadness because
24 they get sicker and die.

25 Q. Based on your review of the records was there any

1 indication that Ms. Whitfield made Dr. Schimpf aware of any of
2 the stuff that was kind of going on behind the scenes?

3 A. No. One of the things that figures into my ultimate
4 opinions about this is that she didn't tell him anything, and
5 she didn't tell Marcino anything about this. It was all on
6 her own. And Dr. Schimpf needed to know a whole bunch of
7 stuff to help her adequately. Not -- help her adequately to
8 tolerate getting ---

9 MR. SLOTCHIVER: Your Honor, this is beyond his expertise
10 as to what Dr. Schimpf needed to know.

11 MR. SMYTH: From his field of psychiatry, Your Honor.

12 THE COURT: I'll overrule it.

13 Q. Did you also, Doctor, help us compile a list of some of
14 the medications that Ms. Whitfield has been prescribed, based
15 on your review of the records?

16 A. Absolutely.

17 Q. And does this accurately reflect that list?

18 A. Well, it's at least -- she's been on at least those. And
19 this is not a trivial list. There are -- there are multiple
20 antidepressants, Lexapro; there are multiple mood stabilizers
21 like lithium; but also she's been on the newer ones, Latuda,
22 for instance, which is an antipsychotic, a second generation
23 antipsychotic, as are three or four others on there. And --
24 well, I actually don't even have -- yeah, there is Risperdal.
25 It's on there. So she's on -- been on four or five. And

1 they've actually been the most helpful. Zyprexa has actually
2 been the one that she goes back to when she needs help,
3 because it is probably our best medicine in psychiatry if you
4 had to -- on a desert island and you only had one, that might
5 be the one to take with you.

6 So antidepressants, mood stabilizers, antipsychotics, and
7 importantly, very important to this case, that benzodiazepines
8 to treat panic disorder. So Klonopin and Xanax and Valium.

9 The way most panic patients are treated in America is on
10 an antidepressant, usually an SSRI like Celexa and a
11 benzodiazepine. Both need to be in adequate doses. I've
12 actually done the studies that show that both of them have to
13 be more than what they are usually used. So you have to use
14 forty to sixty of Lexapro-type medicine.

15 The average patient in this huge study I did worldwide on
16 Xanax took 5.4 milligrams. That means half of the people took
17 more than that. So to get people up to that dose is
18 essential. So half need at least 5.4 and another half need
19 more.

20 And those medicines have withdrawal if you don't take
21 them every day. If you take Xanax for seven days and you
22 don't take it the next day, you get real sick and anxious.

23 Q. I was going to ask you that. Based on your review of the
24 psychiatry records did you identify any patterns in terms of
25 Ms. Whitfield's compliance with the prescriptions she'd been

1 ordered?

2 A. Yeah. She would start those and more, and -- or not
3 start them, and never do thirty days out of thirty days for
4 the first six months; and would repeatedly, on her own, stop
5 the medicines.

6 Now this is common in panic disorder patients who have a
7 hard time trusting that the doctor is not going to kill them
8 with the medicines, and their hypersensitivity to side
9 effects. And so this is not the first time I've seen this.

10 But her noncompliance is worse than what I normally see.
11 And two bad problems with that. One, you don't get well. You
12 might get better for a few days, and then many people stop it.
13 She'd stop it. So you don't -- you don't take enough to get
14 well.

15 And, two, if you do that as she did with Klonopin and
16 Xanax, you'll get better; and then you'll get not only worse
17 and relapse, you'll lost the effect but you'll have piled on
18 top of that withdrawal symptoms of a whole lot of anxiety,
19 inability to sleep, hand shaking sometimes.

20 And so what many people do is then they go back on it and
21 then they feel okay, and they feel good enough to stop it
22 again. Stop it again. And so it's sort of a perpetual
23 rollercoaster kind of a thing.

24 Q. Moving towards the decision to have surgery in this case,
25 do you have an opinion as to whether Ms. Whitfield's

1 psychiatric condition played a role in the outcome of this
2 case?

3 A. I think it had a huge role. And I would say the whole
4 psychiatric thing; but in particular, certain pieces of it.

5 One -- I would firmly be -- if they -- if she or anybody
6 had asked me is this a good time to do the surgery, I'd say I
7 can't think of a worse time. She's trying to come off all her
8 medicines. Every time she does it, she relapses. In the two
9 months before, the harassment was the worst ever and she
10 finally got trespassing orders. The son knocked on the door,
11 was on the property during that time. She was having
12 nightmares that people were going to break in into her house.
13 She had just came off of a drinking episode March and April.

14 And in particular, the session before she -- the last
15 psychiatric session she had before she had the surgery,
16 something had happened - I think it's the harassment - and she
17 felt, her words to Dr. Marcino, violated and it immediately
18 made me feel just like I felt when I was raped thirty years
19 ago in the parking lot and when I lost my son through
20 stillbirth. That was three or four weeks before the surgery.

21 That -- so in a couple of ways. Not telling him the
22 medicine she's on, the psychiatric conditions, that she had
23 panic disorder, and that she was not taking her medicine, made
24 it very difficult for him to take good care of her.

25 And then I put in my report he was blind-sighted by the

1 anxiety level. And ---

2 MR. SLOTCHIVER: Objection, Your Honor. May we approach?

3 THE COURT: Sure.

4 [Whereupon, an off-the-record bench conference is held]

5 THE COURT: All right. Ladies and gentlemen, disregard
6 the last statement that speculated that the doctor was blind-
7 sighted by the anxiety. Strike that from the record.

8 Q. So, Doctor, you've given us the opinion about her
9 condition prior to surgery. Do you have any opinions, based
10 on your review of the case, about how she responded to the
11 complication of this case?

12 A. Yes. And, again, the psychiatric conditions of the panic
13 disorder and her somatic symptom disorder and the histrionic
14 personality, I think when I -- I asked her, you know, what
15 happened to you.

16 She said Dr. Schimpf didn't care about me, he rejected
17 me, he dismissed me, as that's the reason that she was so
18 upset with him.

19 I think as she had the difficulties with the wounds, it
20 seems to me that the evidence, to me, convinces me that she
21 became increasingly worried and anxious about it and tried to
22 convey that in the week before the 20th in a way that would do
23 something different, and exploded into a panic attack on the
24 20th and went to Roper for the weekend.

25 And she came out and when she saw Dr. Schimpf on the 25th

1 and I think it was the twenty- ---

2 Q. Are you talking about the last visit they had together?

3 A. Well, we'll just get to the last visit on the 11th. At
4 that point because he didn't show up on the 7th and see her,
5 she told me that that was the last time he ever called her,
6 angrily; he never called her again after that. And she was
7 really mad that he wasn't there, because she was feeling that
8 she was ---

9 MR. SLOTCHIVER: Your Honor, I object to the relevance of
10 this. I don't know how this is responsive to the question.

11 THE COURT: All right. Can y'all come up here real
12 quickly?

13 [Whereupon, an off-the-record bench conference is held]

14 THE COURT: All right. I'll sustain the objection.

15 MR. SMYTH: Doctor, wrapping up. We're trying to be
16 conscious of the jury's time.

17 Q. In your opinion, does Ms. Whitfield have the same
18 diagnoses now that she had prior to this incident?

19 A. Yes.

20 Q. Okay. And do you believe that she's going to continue to
21 have those diagnoses into the future?

22 A. Well, yes, she'll have -- the future. Whether or not she
23 takes the medicines that Dr. Marcino recommends, in higher
24 doses, then she'll do a lot better, in my opinion.

25 Q. And do you hold all the opinions that you've expressed

Examination of Dr. James Ballenger - Cross by Mr. Slotchiver

1 here today to a reasonable degree of medical certainty as an
2 expert in psychiatry and forensic psychiatry?

3 A. Yes.

4 MR. SMYTH: All right. Thank you for your time, Doctor.
5 Please answer any questions opposing counsel may have.

6 THE COURT: All right.

7 MR. SLOTCHIVER: Thank you, Your Honor.

8 **CROSS-EXAMINATION BY MR. SLOTCHIVER OF DR. JAMES BALLENGER:**

9 Q. Doctor, this compilation of medicines, this is medicines
10 that she's taken since 2009 at different times and different
11 doses; that's not referenced on the chart, it's just a list of
12 different medicines she's taken; correct?

13 A. Correct.

14 Q. Okay. Thank you, sir.

15 And you would agree with me that Dr. Marcino has had a
16 significant amount of time to spend with the patient while you
17 have had, in your interview, three hours; ---

18 A. Yes.

19 Q. --- correct?

20 You said earlier that her husband's business struggled.
21 Does a struggling business change the way that people can act?

22 A. Can you ask that again, please?

23 Q. Does the fact that someone's business is struggling, can
24 that change the way that they act? Just yes or no, please.

25 A. Yes. And to qualify, it clearly can change ---

1 Q. Changes a lot of things, I guess; would that be fair to
2 say?

3 A. Well, in 1928, people acted jumping out of windows. But
4 it also clearly has a huge impact on how people feel.

5 Q. It could be a motivator, it could be a non-motivator, it
6 can make them say things they wouldn't otherwise say; all
7 those factors apply, correct?

8 A. Well, a lot. A lot of different feelings and actions.

9 Q. Thank you, sir.

10 Prior to meeting with Jeane Whitfield, you gave a
11 deposition; and in that deposition you gave opinions, correct?
12 Yes or no, please.

13 A. Yes.

14 Q. Okay. And since that point, the Court authorized you to
15 meet with her at request; and you met with her and interviewed
16 her and she actually asked you, pled with you, and wrote you a
17 letter: Please don't interview, I don't want you to interview
18 me? And I'm -- it's a little more than that; but essentially
19 what she said, isn't it? She didn't trust you, she didn't
20 want you to interview her, and she asked you to please let
21 somebody else do it who would be neutral, in her opinion?

22 MR. SMYTH: Objection, Your Honor. Counsel is ---

23 A. No.

24 MR. SMYTH: --- testifying.

25 A. Did not do that. She did not ask me to let somebody else

1 who would be neutral.

2 Q. Okay.

3 A. She made a whole bunch of legal arguments.

4 Q. Okay. It's my understanding that my lawyers have offered
5 Dr. Schimpf's lawyer the right to have a neutral physician ---

6 MR. SMYTH: Objection, Your Honor. Can we approach?

7 Q. --- before on this; do you remember that?

8 THE COURT: Hold on. Come up.

9 [Whereupon, an off-the-record bench conference is held]

10 THE COURT: Ladies and gentlemen of the jury, if you'll
11 just give us five minutes; I promise to try to get you back in
12 here.

13 [Whereupon, the jury exits the courtroom 8/29/19, 4:42
14 p.m.]

15 THE COURT: What are you trying to ask him about, a
16 letter that she wrote him?

17 MR. SLOTCHIVER: He's testifying that she was happy to be
18 there, and friendly to be there, and had no problem with it.
19 She wrote him a letter, handed it to him at the time of the
20 deposition, pled with him not to do it.

21 And you can read it. It's a short letter. But basically
22 it said: I'm pleading with you not to do it. I want somebody
23 neutral. You're not neutral. Consider yourself in my
24 position. How would you feel? All of this stuff is happening
25 to me. Please let somebody else do it.

1 THE COURT: What's the -- what's the relevance of that?

2 MR. SLOTCHIVER: The relevancy of it, Your Honor, will
3 come up in a few minutes I believe.

4 THE COURT: Well, I mean ---

5 MR. SLOTCHIVER: He could have had somebody else do it.

6 THE COURT: Why? What would be the -- what's the point
7 of the questioning? I mean, how did -- did she know him?

8 MR. SLOTCHIVER: She knew that he had -- he had already
9 given a deposition in the -- in the case. He'd already given
10 opinions in the case. She cited a copy of the case ---

11 THE COURT: My point is he's just as neutral as Mr.
12 Robinson. He's a psychiatrist. She doesn't know him. It's
13 not like it's a friend of hers.

14 MR. SLOTCHIVER: He's not as neutral, because he's been
15 hired by the defense and has already given opinion ---

16 THE COURT: That's the -- that's the way this works.

17 MR. SLOTCHIVER: I understand.

18 THE COURT: You hire one, they hire one.

19 MR. SLOTCHIVER: But it doesn't make him neutral.

20 THE COURT: That doesn't matter. I mean, the fact that
21 she didn't like him, that doesn't have any relevance that -- I
22 mean what relevance does it have that she didn't want him to
23 interview her?

24 MR. SLOTCHIVER: The fact that he could have stepped down
25 and let somebody that was neutral do it.

1 THE COURT: Absolutely not. He's hired to do a job.

2 MR. SLOTCHIVER: I'm not saying that he can't do it. I
3 just want to be able to address the fact. And his -- his ---

4 THE COURT: I think that you asked him that, and he said
5 absolutely not.

6 MR. SLOTCHIVER: But the statement says yes. He said no.
7 But in the letter it says, please let somebody neutral do it.

8 THE COURT: Okay.

9 MR. SLOTCHIVER: And that's what I was asking. And then
10 I was approaching him and I was reading it, and that's when --
11 that's when we got called ---

12 THE COURT: Well, just ask him. Say -- say you earlier
13 testified that she seemed happy and responsive and all --
14 isn't it true that when you got there she wrote you a letter
15 saying that you didn't want -- she wanted you not to interview
16 her.

17 I mean, you can ask him about it. I don't -- I think the
18 concern the defense has was just reading the letter to him.

19 MR. SLOTCHIVER: And I wasn't -- okay. That's fine. I
20 mean I get to impeach him.

21 THE COURT: Sure.

22 MR. SLOTCHIVER: I think you said I can. It's cross-
23 examination.

24 THE COURT: Absolutely.

25 MR. SLOTCHIVER: Okay. Thank you, sir.

1 THE COURT: All right. Bring the jury back in, please.

2 [Whereupon, the jury enters the courtroom 8/29/19, 4:47
3 p.m.]

4 THE BAILIFF: Your Honor, the jury is complete.

5 THE COURT: All right. Thank you very much.

6 You may proceed.

7 MR. SLOTCHIVER: Thank you, sir.

8 Q. A few moments ago before we took a break I was asking you
9 isn't it true that before you met with Ms. Whitfield, she
10 handed you a letter and asked you and begged you not to
11 perform the examination on her?

12 A. She handed me a letter. No, she did not beg me.

13 Q. I will hand you a copy of the letter and let you look at
14 the last paragraph.

15 A. I know what it says.

16 Q. What's the last line saying, Doctor?

17 A. I beg you to please not make me undergo this IME.

18 Q. Thank you, sir.

19 A. Can I explain the other, the no -- other part of that
20 answer?

21 Q. I'm sorry?

22 A. Well ---

23 Q. That was what I -- your lawyer can cross-examine you. I
24 just wanted to ask you that question right now.

25 You testified a little while ago that ---

1 MR. SMYTH: Your Honor, the witness is entitled to
2 explain his answer.

3 THE COURT: If he wants to explain it. I'll briefly give
4 you the opportunity to explain it. That's not a problem.

5 A. It's not my experience at all that people ordered by the
6 Court to have an examination get to say I don't want to do it
7 and then not do it.

8 And eighty percent of what I read in that letter was the
9 legal arguments that she -- for an appeal. And that's really
10 what I saw in the letter.

11 And, frankly, and I'm sorry I didn't see the I beg;
12 because it didn't make sense. She was just making another --
13 an argument for another person.

14 MR. SLOTCHIVER: May he read the letter out loud? It's
15 not eighty percent. I'd like to be able to ask him about it.
16 I know the Court's prior ruling, but ---

17 THE COURT: Ask him what you want to ask him.

18 Q. Eighty percent of the letter says it's an appeal?

19 A. Eighty percent of the meaning I took from reading the
20 letter ---

21 Q. The meaning you took from it. Okay.

22 A. Yeah.

23 Q. Fair enough. I'll move on.

24 A little while ago you testified, sir, when asked about
25 your opinion you said you are paid. You are paid \$680 an

1 hour; correct?

2 A. That is -- I am paid \$680 an hour. But I didn't say that
3 a little while ago.

4 Q. Okay. But that's what you're paid; correct?

5 A. Yes.

6 Q. Okay. And you said you needed to be paid, that's how you
7 pay your mortgage; correct?

8 A. Yeah.

9 Q. Okay. Isn't it true, sir, that you're not paying your
10 mortgage and a foreclosure action was filed on you just this
11 month for \$2,175,000; you haven't paid it since January?

12 THE COURT: All right, ladies and gentlemen of the jury,
13 I'm going to excuse you for the night. All right. And so
14 what we're going to do is we're going to resume this tomorrow
15 morning. But for right now if you'll just retire to the jury
16 room and I'll excuse you in just a moment. Okay?

17 [Whereupon, the jury exits the courtroom 8/29/19, 4:54
18 p.m.]

19 THE COURT: What in the heck are you trying to ask him
20 about his mortgage got to do with this case?

21 MR. SLOTCHIVER: He is -- he just testi- --

22 THE COURT: Who cares?

23 MR. SLOTCHIVER: Judge, it goes to credibility. It's ---

24 THE COURT: What do you mean?

25 MR. SLOTCHIVER: --- cross-examination.

1 THE COURT: He says that -- he made an off-the-cuff
2 comment about, yes, I get paid, this is how I pay my mortgage;
3 and you brought up the fact that he was in foreclosure for
4 two- -- that has nothing to do with this.

5 MR. SLOTCHIVER: Judge ---

6 THE COURT: That is completely inappropriate and probably
7 sanctionable. I mean, you're trying to embarrass this man.

8 MR. SLOTCHIVER: I'm not trying to embarrass him.

9 THE COURT: What has it got to do with his testimony
10 about being an expert about you bringing up a foreclosure of
11 his home? That's just nothing but demeaning and embarrassing.

12 MR. SLOTCHIVER: Judge, that's not the intent of what I
13 did. It's cross -- my understanding is it's cross-examination.
14 No different than when they asked the doctor we had yesterday
15 about his lawsuits he had. We're allowed to question him. In
16 fact, he testified earlier ---

17 THE COURT: What is -- what is the relevance of that?

18 MR. SLOTCHIVER: Because he testified earlier that people
19 under financial strain act differently in many, many ways,
20 including ---

21 THE COURT: So you're saying that he's acting differently
22 because he's under a financial strain?

23 MR. SLOTCHIVER: Absolutely, sir. He's paid \$680 an
24 hour. He did a fifty-two page report. And he's given an
25 opinion. And I've got affidavits -- and I've got documents to

1 show that he's under significant financial strain.

2 I'm not trying to embarrass him, but my job is to protect
3 my client and to question somebody when they testify to an
4 opinion; and I have the right to impeach him.

5 THE COURT: He testified to an opinion to a -- as a
6 medical doctor, and you're bringing up his financials.

7 MR. SLOTCHIVER: Yes, sir. And my -- and the expert we
8 had yesterday testified to an opinion and they brought up the
9 fact he had been sued. This is for impeachment purposes.
10 Nothing else.

11 THE COURT: My point is what is the relevance of the
12 impeachment?

13 MR. SLOTCHIVER: The impeachment goes -- it goes to his
14 credibility when he's testifying. People under financial
15 strain, as he's testified himself, act differently ---

16 THE COURT: So you think he's acting differently here
17 today and giving a different testimony of his medically -- or
18 his medical opinion because he, from what you assume, is under
19 some type of financial strain?

20 MR. SLOTCHIVER: I certainly have the right to ask him
21 about it and let the jury consider it.

22 THE COURT: I don't think you do. I certainly don't
23 think you do. I think it's highly inappropriate, and I think
24 it's -- I don't see any purpose whatsoever. He is a medical
25 doctor who is coming in, getting paid to give a testimony.

1 MR. SLOTCHIVER: He is -- he is an expert in ---

2 THE COURT: The other guy was asked about lawsuits that
3 he -- that he would have been sued before. That had -- that
4 has -- and I didn't even find it to be relevant, either. I
5 actually just thought it was kind of a blasé question.

6 But the fact that you're bringing up this man's
7 financials when we're trying to -- you're cross-examining him
8 and impeaching him on his report, fifty-two page report.

9 MR. SLOTCHIVER: In every civil case on cross-examination
10 witnesses are subject to being cross-examined on their
11 credibility, and that's all I'm doing.

12 THE COURT: And all I know is I've been told that my
13 job is to make sure that the admissibility of the evidence
14 is relevant, and I get to make the decision. We are not
15 going into that man's finances whatsoever. I have every
16 intention ---

17 Sir, do you have anywhere you need to be?

18 THE WITNESS: I'll finish tonight, if you'd like, Judge.

19 THE COURT: Bring them back.

20 THE WITNESS: But I point out he's already -- can it be
21 expunged from the record?

22 THE COURT: I will.

23 [Whereupon, the jury enters the courtroom 8/29/19, 4:54
24 p.m.]

25 THE BAILIFF: Your Honor, the jury is complete.

1 THE COURT: All right. Thank you so very much.

2 Thank you very much. Ladies and gentlemen, I assured the
3 parties I was trying to have y'all out of here by five o'clock
4 today, so they -- I thought that they were going to continue
5 to go a little longwinded. So they've assured me that they
6 are going to have you out of here by 5:00. I just didn't want
7 to keep you any longer than what we needed to do.

8 And so if y'all don't mind, and we hang in there a little
9 bit longer I think we can conclude this witness. I think the
10 doctor has somewhere to be tomorrow, so I certainly don't want
11 to inconvenience him again.

12 Please proceed.

13 MR. SLOTCHIVER: Thank you, sir.

14 THE COURT: Yes, sir.

15 Q. Would you agree that you have no baseline of trust with
16 my client, Ms. Whitfield?

17 A. No, I can't agree with that. I realize that that's a
18 problem and that she stated that up front and it was in her
19 psychiatrist's records. We did reach a level of trust,
20 improved.

21 I don't expect full trust. I was amazed that Dylan Ruth
22 did trust me. But I don't expect it from people who have been
23 forced to have an examination, which she was.

24 Q. You spent three hours with her; correct?

25 A. Yes.

1 Q. You were hired by the law firm that is representing the
2 doctor and the medical practice that she is suing; correct?

3 A. I was retained by them, yeah.

4 Q. You gave opinions for the first deposition without even
5 having spoken to the doctor; correct?

6 A. I asked and asked and asked and asked would you please
7 let me talk to the plaintiff.

8 Q. With the defendant, sir? With Dr. Schimpf? You gave an
9 opinion, your opinions in the first deposition without ever
10 having spoken to Dr. Schimpf; isn't that correct?

11 A. I almost never speak to the defendant.

12 Q. Is that correct?

13 A. Yes. I expect ---

14 THE COURT: Okay.

15 A. --- the defendant to be biased in tell the stories.

16 Q. Do you agree that psychologic injuries that people are
17 predisposed to, or have, can get worse by new events?

18 A. Yes.

19 Q. Do you know of anybody who looked in the mirror and saw
20 that [displaying photo board], that would not have anxiety?

21 A. I'm not a plastic surgeon expert.

22 Q. You're a psychiatrist speaking today about people and
23 anxiety. I'm asking you, sir, do you know anybody that
24 looked -- do you know of anybody who could look in the mirror
25 and see their body look like that and not have anxiety from

1 it?

2 A. Are you -- are you going to let me talk about her anxiety
3 about ---

4 Q. I'm just ---

5 A. --- the surgery ---

6 Q. --- asking you to answer yes or not, please, sir.

7 A. I ---

8 Q. You have talked about her anxiety.

9 A. I ---

10 Q. I am just asking do you know anybody ---

11 A. I ---

12 Q. --- that would not have anxiety.

13 A. I don't -- you know, then it is a terrible-looking
14 picture. I don't even know what it is. And the ---

15 Q. It's her breast.

16 A. --- magnification issue ---

17 Q. It is her breast, sir. You haven't seen this picture
18 before?

19 A. No.

20 Q. Okay.

21 A. It's a terrible-looking picture.

22 Q. Have you seen this one [displaying photo board]? Would
23 this cause anxiety to somebody?

24 A. It could. And they would ask their doctor should they
25 feel anxious or ---

1 Q. Should this cause somebody anxiety [displaying photo
2 board]? Would this cause somebody anxiety?

3 A. I don't -- no, I would expect the person to ask their
4 doctor should this -- this yellow stuff, is this -- is this
5 fat or is this infection.

6 Q. So in your experience, someone could look in the mirror,
7 see their body, their chest, look like that and not have
8 anxiety about it?

9 A. I didn't testify to that. I would think they would be
10 anxious and then ask their doctor, not make a judgment
11 themselves.

12 Q. What if they called their doctor and the doctor wasn't
13 there and wouldn't take the call? Would that make them
14 anxious?

15 A. Probably.

16 Q. What if they called the doctor at some point and asked
17 for their medical records and they weren't available because
18 they weren't in a file and they were nonexistent; would that
19 make somebody anxious?

20 A. It would certainly make them feel some feelings. Anxiety
21 might be one of them.

22 Q. A lot of your testimony on direct examination dealt with
23 a period of time before, during, and after Jeane Whitfield
24 went to Dr. Schimpf. So I'm asking if some of these things
25 that she would have learned about - for example, all the

1 photographs that were taken are nonexistent - would that make
2 somebody anxious?

3 A. Potentially could be one of the feelings they would have.

4 Q. Okay. What if they had paperwork for everything that was
5 approved to be done, but -- and they went into the facility
6 understanding they were going to get procedures done and they
7 came out and they learned later on that there was a different
8 procedure done that they had never agreed to and they went
9 back and they looked at the paperwork and they said, oh, my
10 God, I knew I didn't agree to it and it's not even on the
11 paperwork. Would that make somebody anxious? Would that give
12 them pause? Could that cause them some problems?

13 A. Not somebody who's put in her journal before that I'm
14 going to have my chin done, which is one of the records I saw.

15 Q. Do you know the context of that comment?

16 A. It was her journal. That's all I know.

17 Q. Do you know the context of it?

18 A. No. I don't -- no.

19 Q. Could the context of it be relevant?

20 A. Yes.

21 Q. Okay. Well, I will tell you she testified to the context
22 of it.

23 MR. SMYTH: Objection, Your Honor. Counsel is
24 testifying.

25 THE COURT: All right. I'll sustain the objection.

1 Q. How about purchasing equipment that you knew repetitively
2 was defective? Remember talking about that before, Doctor?

3 A. Yeah.

4 Q. Do you remember your -- do you remember your response
5 when you spoke last time, that somebody who would repeatedly
6 buy equipment that was defective would -- should get -- do you
7 remember our conversation?

8 A. Yeah. Your question, when I answered flippantly, the
9 very last after a very long deposition, your question was
10 somebody's dictating into something he doesn't know -- he
11 knows doesn't work, he knows it doesn't work but he's
12 dictating into it, what does he need? And I said a brain
13 transplant.

14 Q. Someone who repeatedly purchases equipment ---

15 A. No, that wasn't your question. It was ---

16 MR. SLOTCHIVER: Excuse me one second.

17 [Whereupon pause for defense counsel]

18 A. I'll stipulate to whatever you think the answer is in
19 there and save time, if you'll let me add a sentence to it.

20 Q. Sure, Doctor. What I understood the answer to be was
21 anybody who repeatedly bought equipment and used it knowing
22 that it kept on breaking and replacing it - and then your
23 response, that was the response - needs their brain examined.

24 What did you want to add to it, sir?

25 A. That in my briefcase I have two Dictaphones that I bought

1 that I keep buying because it's the best system I can find.
2 But they don't work reliably, and so I have to repeat that.
3 Because I can't find a better system.

4 Q. Do you keep track of people whose names you put and
5 information you put on those Dictaphones so that if you lose
6 the information you could know who to re-dictate?

7 A. I make sure it has a function that shows me that it's
8 been retained. And I check it again. Because I hate it when
9 I dictate it and it doesn't work.

10 Q. So you ---

11 A. It drives me crazy.

12 Q. So you do safeguard to make sure that it worked after you
13 dictate?

14 A. Yes.

15 Q. Okay. That's different than not safeguarding it, putting
16 it aside, and then when you find out it doesn't work,
17 replacing it; ---

18 MR. SMYTH: Your Honor, I object to the relevancy ---

19 MR. SLOTCHIVER: --- correct?

20 MR. SMYTH: --- of the questions.

21 THE COURT: Okay. I agree.

22 MR. SLOTCHIVER: Okay. I'll move on.

23 THE COURT: I will sustain the objection. It's not
24 relevant as to how he dictates and what he determines. We
25 will move on.

1 Q. I believe you testified that a lot of the information
2 that you wanted to speak to my client about from her prior
3 history, she would not speak about it and therefore you
4 gleaned it from the records; correct?

5 A. That was all I could do. Yes. I wanted her to expand on
6 that, tell me her side of ---

7 Q. You would ---

8 A. --- those things.

9 Q. You would agree with me that the diagnoses that you have
10 are different than that of her own doctor that she's been
11 treating with for twelve years?

12 A. Only slightly. Let me explain. And the diagnoses that
13 are different is that Dr. Marcino went back and forth about
14 whether she was diagnosing PTSD. I never was clear; but I
15 understand she's come down finally saying, yes, PTSD. I say I
16 don't come down on PTSD.

17 And then the histrionic personality, she said she's got
18 many of those traits. But I never diagnosed it.

19 Q. She's had about a hundred visits over the last many
20 years, and you've had about three hours in a setting where she
21 was uncomfortable to begin with; correct?

22 A. I've had three hours with her, yeah.

23 MR. SLOTCHIVER: Beg the Court's indulgence.

24 THE COURT: All righty.

25 MR. SLOTCHIVER: Nothing further, Judge. Thank you.

1 MR. SMYTH: Nothing further, Your Honor.

2 THE COURT: All right. For the record, ladies and
3 gentlemen, I would ask that you -- I'm going to have the
4 question that was pertaining to Dr. Ballenger' finances
5 stricken from the record and you are not to consider that
6 whatsoever in your deliberations. Okay?

7 All right. Well, ladies and gentlemen, we are done for
8 the day. And we got you as close to 5:00 as we could.
9 Tomorrow we were going to resume around 9:30. No reason for
10 us to be early. I know the young lady in the back with the
11 Clemson, she's got a game to watch tonight; so she's going --
12 she needs -- she needs the rest. So we'll see.

13 And so if you'll just report back to the jury room
14 tomorrow morning at 9:30 we'll resume the trial. All right.
15 Thank y'all very much. Have a wonderful evening.

16 [Whereupon, bailiff presents note from jury, which is
17 marked as Court's Exhibit Number 8]

18 THE COURT: Hold on. Stay right there. Oh, well
19 backwards.

20 We can't. A, the courthouse doesn't open until 8:30; and
21 so the deputies and the clerks and everybody is on a set
22 schedule and certain things that they have to do.

23 I'll do this for you, do y'all want to start at 9:00?

24 JURY FOREPERSON: Uh-huh.

25 THE COURT: All right. Well, let's do that. So what

1 we'll do is we'll just start. So just be in the jury room
2 tomorrow morning around 8:45. But we will go ahead and start
3 at 9:00.

4 I assure you I don't know any reason -- I always
5 hesitant, as you can see, to make promises, because I end up
6 breaking them. And I don't like to break promises.

7 But I'm not going to make a guarantee, but you can -- you
8 can take a lot of money to the bank we're going to be done
9 tomorrow. Okay? I can -- I can make sure of that, okay.
10 We'll work as hard as we need to get going. And I appreciate
11 y'all's willingness to be early. So we'll go ahead and start
12 at 9:00. Okay?

13 All right. Thank y'all so very much.

14 [Whereupon, the jury exits the courtroom 8/29/19, 5:08
15 p.m.]

16 THE COURT: All right. Dr. Ballenger, thank you so very
17 much. I hope you have a wonderful evening.

18 THE WITNESS: Thank you. You too.

19 THE COURT: Thank you.

20 [Whereupon, the witness exits the witness stand]

21 THE COURT: All right. Julie is going to -- I've got
22 your proposed jury charge. I've read all I think it's
23 twenty-seven of them. They're -- some of them are encompassed
24 in what we already have.

25 What I'm going to do is I am going to send over what we

1 have compiled to this point. Don't change it or anything like
2 that, just because we have to keep it in the format in which
3 it's in.

4 Take a look at it. We're going to start at 9:00. What I
5 want to do is take a break around 10:30 and have, you know, a
6 charge conference so Julie can go back there and print it out
7 and have it all correct.

8 I want y'all to be here at -- I mean, when the doors open
9 at 8:30 I want y'all talking about it. Even if y'all have got
10 to do it tonight. I don't want to hear I haven't taken a look
11 at those jury charges or whatever. I want you to stipulate to
12 every one that you can.

13 If there's some that you can't agree on, we'll go over
14 them one by one. But I want y'all to have looked at them and
15 say, Your Honor, we agree to 1 through 9, 11 through 14, you
16 know, however you want to do it like that, and so we don't
17 have to take up a whole lot of time.

18 She's also going to send you a proposed verdict form.
19 Or, excuse me. Y'all send over y'all's proposed verdict
20 forms. We'll put them together, and at that charge conference
21 I'm going to give them to y'all and I'm going to give y'all as
22 much time as you need to see if you can agree on it. And then
23 what we're going to do is we're going to --

24 I know you've just got one witness left; correct?

25 MR. SMYTH: Yes, sir.

1 THE COURT: We're going to go into that witness first
2 thing. We're going to take a break, do the jury charge.
3 Depending upon how long we are, I may limit a little bit of
4 y'all's closing time. I don't know, you know, if we're
5 depending upon -- I mean, I didn't think that two witnesses
6 were going to take all day. So we will just going to have to
7 see how long the witness takes.

8 And how long do you think you'll need for closing?

9 MR. SMYTH: I'm quick. Usually thirty minutes,
10 unless ---

11 MR. SLOTCHIVER: It should be -- it should be about the
12 same.

13 THE COURT: Okay. Then we're going to go straight into
14 closing arguments, charge the jury. And I'm hoping to do that
15 by 11:30.

16 MR. SLOTCHIVER: I did -- Judge, I did want to proffer.
17 And I can do it tomorrow. I just wanted to let you know I do
18 want to proffer three things.

19 And I understand your ruling, but I wanted to proffer the
20 evidence as to Dr. Ballenger's -- as to Dr. Ballenger's
21 financials and the foreclosure. I wanted to proffer -- if I
22 could put it on the record now. As long you tell me I've
23 satisfied what I need to do.

24 And I wanted to proffer the evidence as to the Sonovus
25 documents as they applied to the financial form that he filled

1 out and misrepresented that he had no lawsuits.

2 And I wanted to proffer the financial documents that he
3 filled out -- or the document filed with East Cooper Hospital
4 where once again he denied that he had any lawsuits, despite
5 the fact that he did.

6 THE COURT: All right.

7 MR. SLOTCHIVER: I just wanted that preserved for the
8 record.

9 THE COURT: Sure. And I think my ruling is clear as to
10 the first two. And I believe that I made a very good record
11 about the doctor's financials.

12 MR. SLOTCHIVER: Yes, sir. Thank you.

13 [Whereupon, the jury trial adjourns for the evening,
14 8/29/19, 5:11 p.m.]

15 [Whereupon, resume 8/30/19, 9:02 a.m.]

16 THE COURT: Go ahead.

17 MR. SLOTCHIVER: Thank you, sir.

18 I just want to mark three documents for identification.
19 Exhibit 44, which is a copy of the East Cooper medical staff
20 reappointment application; Document 45 which is a copy of the
21 personal financial statement of Dr. Schimpf with Sonovus Bank;
22 and Exhibit 46 which is a copy of the foreclosure proceeding
23 on Dr. Ballenger. All pursuant to the proffers that we have
24 made.

25 THE COURT: Well, hold on. I struck everything as to Dr.

1 Ballenger.

2 MR. SLOTCHIVER: I am not marking it for the jury. I am
3 just marking it for identification. I heard -- I understand
4 your ruling, but I still ---

5 THE COURT: Does he need to put that in as a Court's
6 Exhibit?

7 THE COURT REPORTER: No, he can do it for identification
8 and just ---

9 MR. SLOTCHIVER: Identification only.

10 THE COURT REPORTER: The only ones that are going to go
11 back are the ones that are admitted. So if it is just ID it
12 will not go back to the jury.

13 THE COURT: Okay. That's fine.

14 MR. SLOTCHIVER: Right, none of these will go back to the
15 jury as I understand.

16 [Whereupon, Plaintiff's Exhibit Number 44, East Cooper
17 Medical, was marked for identification]

18 [Whereupon, Plaintiff's Exhibit Number 45, bank financial
19 statement, was marked for identification]

20 [Whereupon, Plaintiff's Exhibit Number 46, foreclosure,
21 was marked for identification]

22 MR. SMYTH: And, Your Honor, I think we have a
23 housekeeping matter as well. There were some exhibits that
24 were attached to Dr. Kalus' video trial depositions that we
25 would move into evidence.

1 THE COURT: All righty? Any objection?

2 PLAINTIFF'S ASSISTANT: The numbers are off from where we
3 are right now.

4 THE COURT REPORTER: Defendant's Exhibit 53, 54, 55, and
5 56.

6 [Whereupon pause for counselors to confer and discuss
7 exhibits]

8 MR. SMYTH: I moved them into evidence during the trial
9 deposition without objection, so we are just formalizing it.

10 THE COURT: All righty.

11 MR. SMYTH: So those are in by agreement.

12 THE COURT: All right. Without objection.

13 [Whereupon, Defendant's Exhibit Number 53, 54, 55, 56,
14 trial deposition exhibits, marked for identification]

15 [Whereupon, Defendant's Exhibit Number 53, 54, 55, 56,
16 admitted into evidence]

17 THE COURT: All right.

18 THE COURT REPORTER: And we also had one other issue with
19 exhibits, substituting the ones that are going back to the
20 jury as far as the boards.

21 MR. SLOTCHIVER: Oh, yes.

22 THE COURT REPORTER: Okay.

23 MR. SLOTCHIVER: Yeah, we -- Judge, for the exhibits that
24 we had put in on the big boards we have substituted all of
25 those with the exception -- and we have mark them on them with

1 an "S", with the only exception being that we are at the time
2 it goes to the jury we are withdrawing exhibit -- Exhibit
3 Number 17. And 17 is -- it's been covered in all the other
4 photographs that we have got. There is no reason to leave it
5 there. Okay.

6 MR. SMYTH: That's -- that's the same one as our exhibit
7 that is already in so.

8 MR. SLOTCHIVER: Correct.

9 MR. SMYTH: Okay.

10 THE COURT: All righty.

11 (Whereupon, Plaintiff's Exhibit Number 17 withdrawn]

12 [Whereupon, large photograph display boards with pictures
13 were substituted with 8 1/2 x 11 size as follows: Plaintiff's
14 Exhibit Number 14-S substituted for 14, 18-S substituted for
15 18, 19-S substituted for 19, 20-S substituted for 20, 21-S
16 substituted for 21.

17 THE COURT: All righty. If you will bring in the jury.

18 And we have one witness. I am just going to let them
19 know. I think they are worried that we are going to be here
20 to midnight. That was -- because -- oh, by the way, the
21 letter said can we start tomorrow at 8:00. I thought ya'll
22 got that when I was saying don't rush in, we are going to
23 start at 9:30; and then they -- the letter came and they
24 wanted to start at 8:00. But I am just going to let them know
25 there is only one more witness; is that correct?

1 MR. SMYTH: Yes, sir.

2 THE COURT: Okay.

3 MR. SMYTH: And my best guess is an hour, hour and a
4 half. But I'm -- again, I am terrible at estimating that.
5 But I thought --

6 MR. HALVERSEN: And I don't really have -- max a half
7 hour I think ---

8 THE COURT: All right.

9 MR. HALVERSEN: --- on cross so.

10 THE COURT: All right. Perfect.

11 [WHEREUPON, jury enters 8/30/19, 9:07 a.m.]

12 THE BAILIFF: Your Honor, the jury is complete.

13 THE COURT: All right. I Hope y'all had a wonderful
14 evening. Congratulations to the one juror on your big win.
15 So excited about that. I didn't know who he was until last
16 night. I really had no idea. I had never heard of him. So
17 that was a new thing for me. So I hired two millennials, and
18 they never told me anything about it. So I learned how to do
19 it. So I was proud of myself.

20 So just so y'all know. I know y'all's question yesterday
21 was you want to start a little earlier. I am assuming that
22 was a concern of we would be going in late into the evening.
23 We only have one more witness. So I failed to mention that
24 yesterday and didn't realize until I excused y'all to let
25 y'all know.

1 So we will probably be done around lunchtime, which is
2 why I went ahead and ordered y'all delicious Jimmy John's
3 again. So we tried to order Mellow Mushroom, but apparently
4 it is being renovated. So sorry, you got stuck with Jimmy
5 John's again.

6 So just didn't want you to worry. There is only one
7 witness left. And then at that point in time I will allow
8 them to give their closing statements, I will charge you on
9 the law, and then we will have lunch and begin the
10 deliberation. All right. All righty.

11 Yes, sir?

12 MR. SMYTH: Please the Court, Your Honor?

13 THE COURT: Yes, sir.

14 MR. SMYTH: The defense calls Dr. Jorge Perez to the
15 stand.

16 THE COURT: Good morning, sir.

17 [Whereupon, Dr. Perez comes forward]

18 [Whereupon, Dr. Perez is duly sworn by the clerk of
19 court]

20 THE CLERK OF COURT: You may be seated.

21 [Whereupon, the witness takes the witness stand]

22 THE CLERK OF COURT: And for the record, please state
23 your full name, spelling your last.

24 THE WITNESS: My name is Jorge Perez. Actually, I'll
25 spell my first name, also. Because it's spelled J-O-R-G-E.

1 Alexander is my middle name. And Perez, P-E-R-E-Z.
2 JORGE A. PEREZ, M.D., Having Been First Duly Sworn, was
3 Examined and Testified as Follows:
4 **DIRECT EXAMINATION BY MR. SMYTH OF DR. JORGE PEREZ:**
5 Q. Good morning, Doctor.
6 A. Good morning.
7 Q. Could you please introduce yourself to the jury and tell
8 them a little bit about yourself?
9 A. Sure. My name is Jorge Perez. I'm a plastic and
10 reconstruction surgeon in Fort Lauderdale, Florida. I trained
11 in New York and I've been in Florida since 1991. I've been in
12 practice for about twenty-eight, twenty-nine years there.
13 I practice mainly aesthetic surgery, but I -- in the
14 past, and I still do some reconstructive surgery as well.
15 Q. Okay. And being from Fort Lauderdale, I imagine you're
16 keeping an eye on the storm?
17 A. I am. I may stay with y'all for a few more days.
18 Q. I hope it misses you.
19 A. It's actually headed to my back yard.
20 Q. Would you please give the jury an idea of your education
21 and training, starting with your undergraduate degree?
22 A. Yes, sir. I trained in New York in -- outside of New
23 York City. I went to college at a small liberal arts school,
24 Iona College. I was a major in mathematics.
25 I went to medical school at the Albert Einstein College

1 of Medicine in New York City. I graduated in 1984, so I've
2 been a physician for about thirty-five years. I

3 I immediately after medical school I trained in general
4 surgery for four years. I served as chief resident in general
5 surgery for a year. And then I was awarded a spot in the
6 plastic surgery department, and so I did an additional two
7 years of training in plastic surgery, plastic and
8 reconstructive surgery at the same institution, at the Albert
9 Einstein College of Medicine Montefiore Medical Center in New
10 York City.

11 So I stayed there in training for -- in medical school in
12 training for a period of about ten years total, and then when
13 I finished I had -- I was uncertain about where I wanted to
14 set up my practice. So I was invited to stay as a member of
15 the faculty, and I practiced with the faculty there training
16 medical students and training residents for about a year, and
17 then decided that I preferred the warm weather of Florida and
18 moved to Fort Lauderdale. I've been in practice in Fort
19 Lauderdale since 1991.

20 Q. And are you board certified?

21 A. Yes, sir, I am.

22 Q. And in what areas?

23 A. I'm board certified in plastic and reconstructive
24 surgery. I was board certified in 1993, which was the first
25 available opportunity to become board certified, based on my

1 timeframe. And I have a lifetime certificate, so I do not
2 require recertification.

3 Q. And are you a member of any professional organizations in
4 your field?

5 A. I am. Over the years I've been a member of local, state,
6 national and international societies, both in medicine in
7 general and also within my field of plastic surgery.

8 Q. And have you done any consulting work in your experience
9 as a plastic surgeon?

10 A. Consulting in terms of?

11 Q. Were you affiliated with a professional baseball team at
12 some point?

13 A. Oh. Well, I -- yeah. Back when I first started my
14 practice, the Yankees would do their spring training in Fort
15 Lauderdale. They have since long gone. But I -- early in my
16 practice I did a lot of trauma, facial trauma, hand trauma,
17 all types of bodily-injury traumas from car accidents and
18 those kinds of things. And of course baseball players do get
19 injured, and so they asked me to do some consulting work for
20 them when they were in spring training back in the early '90s.

21 Q. Have you done any work for the FDA or for the State of
22 Florida?

23 A. I have a colleague who is a member of the FDA on the
24 plastic restorative committee. He is a general surgeon, he's
25 not a plastic surgeon. So he would periodically call me for

1 opinions and input in terms of some of the products that he
2 would manage and -- within the FDA.

3 Q. And have you been invited to speak or present lectures on
4 topics in your field?

5 A. Yes. I've been privileged to speak in many different
6 places. I probably -- I've been to dozens of countries in
7 Asia, Latin America, Europe, all over North America. I enjoy
8 teaching. I enjoy sharing my experience.

9 I was a clinical investigator, early on in my practice,
10 with several products that would warrant invitations for me to
11 speak and do training.

12 I would do live surgery and have surgeons watching on
13 closed-circuit television in different countries, which is
14 very rewarding and a wonderful experience for me.

15 Q. All right. And do you routinely, as part of your
16 practice for the last thirty-five years, perform the
17 procedures that are at issue in this case?

18 A. Yes, I do. Breast -- breast augmentation and mastopexy,
19 which is the term we use for breast lift, are very common
20 operations that most plastic surgeons who have busy aesthetic
21 practices would perform on a regular basis. And I've perform
22 those procedures many times.

23 Q. Do you believe you have the requisite knowledge,
24 training, and experience to inform the jury about issues
25 related to the standard of care and the surgeries that Ms.

1 Whitfield had in this case?

2 A. I do, sir.

3 MR. SMYTH: All right. At this time, Your Honor, we
4 would offer Dr. Perez as an expert witness in cosmetic and
5 reconstructive surgery.

6 THE COURT: All righty. Any objections?

7 MR. HALVERSEN: No objections, Your Honor.

8 THE COURT: All righty. Without objections.

9 Again, ladies and gentlemen, as you are fully aware, he's
10 a doctor and he's been qualified as an expert and he can give
11 his opinion.

12 Q. Doctor, did I retain you to review this case?

13 A. Yes, you did.

14 Q. All right. And have you spent time away from your
15 practice and dedicated it to reviewing the materials that
16 we've provided to you in the case?

17 A. I have. Quite a bit of time, actually.

18 Q. And are you being paid to be here today?

19 A. I am.

20 Q. Will the fact that you're being paid to be here affect
21 your opinions in this case?

22 A. No, sir.

23 Q. Have you served as an expert witness before in other
24 cases?

25 A. Yes, I have.

1 Q. Tell the jury a little bit about why you do that.

2 A. Well, it started -- I've been doing it for about
3 twenty-five years. It started back in the '90s when attorneys
4 would hear about my teaching and my presentations. And I
5 would often get calls asking me to review cases on their
6 behalf, either on behalf of the patient or on behalf of a
7 doctor or either side of a party, and to give them my expert
8 opinion.

9 And it's something that I -- I enjoy doing it. I think
10 it's a valuable experience. I take it very seriously, because
11 obviously there's a lot at stake for both sides. And it's
12 something that I have continued to evolve over the years.

13 Q. And would you tell the jury what you have done in terms
14 of the scope of your review in this case?

15 A. Well, I was asked by Mr. Smyth about a year and a half
16 ago to review this case. He explained that he was
17 representing Dr. Schimpf in a medical malpractice case, and he
18 asked me if I would review the case and give him my opinions
19 about whether or not Dr. Schimpf's care and treatment was
20 consistent with the standard of care within our profession of
21 plastic surgery.

22 And that's how the initial contact began. And, of
23 course, it has evolved into volumes and volumes of materials
24 that I have read over the past year and a half, probably
25 thousands of pages of materials that I have read. And, of

1 course, I have been deposed twice by Ms. Whitfield's
2 attorneys. And, of course, I'm here at trial also to share my
3 opinions with you.

4 Q. Have you read all of Ms. Whitfield's medical records in
5 this case?

6 A. Yes.

7 Q. And have you read all of the deposition testimony that's
8 been provided by the witnesses?

9 A. Yes.

10 Q. And have you had the opportunity, also, to personally
11 meet and examine Ms. Whitfield?

12 A. I did. About three or four weeks ago, I -- I had
13 insisted that I wanted an opportunity to examine Mrs.
14 Whitfield personally. I think that's a very important part of
15 being able to come here and give opinions to the jury and gain
16 information.

17 The -- Ms. Whitfield's attorneys were reluctant to allow
18 that to happen, but it was worked out in the court and I was
19 given permission.

20 So last month, I flew up here and had an opportunity to
21 examine -- meet and examine Mrs. Whitfield. I took a history
22 from Mrs. Whitfield. I examined her. I did certain
23 measurements. And I did photographs of her breast area as
24 well.

25 Q. As you know, this is a medical malpractice case; and one

1 of the terms that we use a lot is standard of care. Are you
2 familiar with that term?

3 A. Yes, sir.

4 Q. What does it mean?

5 A. Well, I mean, in layman's terms, the standard of care,
6 which is often confused by physicians, is not what I would do,
7 what Dr. Perez would do, it's not what Dr. Kalus would do,
8 it's not what Dr. Schimpf would do, it's not what Dr.
9 Rosenberg would; it is what a reasonable physician with a
10 similar training would do under a similar set of
11 circumstances.

12 And it's very often similar to the way we talk to
13 patients in consultation. I often have patients who come to
14 me in consultation and they say, gee, Doctor, you're the
15 fourth doctor I've been to and everybody has a different
16 opinion of what should be done, everybody gives me different
17 recommendations. And, you know, we joke in plastic surgery
18 that if you go to four doctors, you'll get five opinions
19 because everybody does it their own way.

20 And in many ways the standard of care really kind of
21 correlates to that. Because it doesn't mean that one is right
22 and the other four are wrong. I

23 And the analogy that I give patients in my home town of
24 Fort Lauderdale is if patients ask me how do I get from Fort
25 Lauderdale to Miami, well, you can take I-95 but on a given

1 day that might be a parking lot with bumper-to-bumper traffic
2 so that may not be appropriate; you could take U.S. 1, Federal
3 Highway; you can take the beach; you can take the turnpike.
4 So there are -- there are many routes that will get you to
5 your destination. Under different circumstances, one might be
6 more correct than the other; but they are all equally correct.

7 And so the idea of recognizing the standard of care is
8 not what I as an individual would do, but what a reasonable
9 doctor might do in a similar set of circumstances.

10 Q. And looking globally at this case, have you formed an
11 opinion as to whether Dr. Schimpf met or exceeded the standard
12 of care in this case?

13 A. Yes, I have.

14 Q. And what is that opinion?

15 A. Well, Dr. Schimpf's experience with Mrs. Whitfield was
16 relatively short. It was a period of about five weeks from
17 the time of surgery to the time that Mrs. Whitfield chose to
18 leave his care.

19 During that time she underwent a complicated procedure.
20 The procedure itself, because it's a combination procedure of
21 both augmentation and lift is -- has certain additional
22 potential risks and complications which she was made aware of.

23 The surgery itself was, by report -- in the operative
24 report was conducted according to conventional standards. She
25 did have a compli- -- a wound-healing complication

1 postoperatively. I believe that the care and treatment
2 postoperatively was appropriate.

3 We've heard talk about putting stitches in, putting
4 stitches in without anesthesia; and I'd like to address that
5 if I may, either now or later.

6 Q. We'll get to that.

7 A. Pardon?

8 Q. We'll get to that in just a second.

9 A. Okay. But those were all appropriate treatments. And I
10 believe that the care and treatment rendered by Dr. Schimpf
11 was appropriate. I believe it was within the standard of
12 care. I believe that Mrs. Whitfield made a decision on her
13 own to leave his care and take on care with a different
14 doctor.

15 But Dr. Schimpf's care and treatment, in my opinion, was
16 certainly within the standard of care in plastic surgery.

17 Q. All right. Let's talk about some of the issues that have
18 been raised this week. We've talked a lot about records in
19 this case. Do you agree that Dr. Schimpf could have done a
20 better job on keeping his records, in some aspects?

21 A. Absolutely. And I'm sure that he regrets not having done
22 so.

23 Q. Do you believe the existence of preoperative photographs
24 or some of these follow-up notes would have changed the
25 outcome in this case?

1 A. Well, the photographs are always helpful. We do that as
2 part of our record-keeping in plastic surgery. I don't think
3 it would have changed the outcome of the case or the course of
4 treatment, however.

5 Q. And just because there some were mistakes made in term of
6 the record-keeping, do you believe that that falls below the
7 standard of care?

8 A. No. You know, records are a real thorn in the side of
9 most doctors, plastic surgeons included. You know, we --
10 obviously, we try to treat the patient; we try to take care of
11 the patient. But nowadays both for billing purposes and also
12 for documentation purposes, the record is obviously an
13 integral part of that. We all try to maintain the records as
14 best as we can.

15 I happen to have a handwritten practice. I have an old-
16 fashioned handwritten practice; and I don't do electronic
17 medical records, which is a greater thorn in the side of any
18 of my colleagues. And despite that, I have forgotten to make
19 an entry in a chart.

20 I just had an episode recently where I had a patient who
21 I was -- I had just interacted with her. I went back to check
22 something in the chart and we couldn't find it. And the
23 patient had been in the office only a couple of hours earlier.
24 And I had my staff tear the office apart looking for the
25 chart, which we'd not looked for -- not been looking for if I

1 hadn't forgot to put something in there. And it turns out
2 that the chart was left in the room and the patient when she
3 packed up her belongings accidentally took her entire chart and
4 put it in a bag and took it home. And so we called the
5 patient at home and said do you happen to have the chart. And
6 she said, yeah, it's right here in my bag. And she -- she
7 brought it back.

8 Now, had I not been looking to put something else in that
9 chart who knows when I would have found out that that entire
10 chart was missing.

11 I mean, we're human. Those kinds of things can happen.
12 It doesn't impact the care and treatment of the patient. It's
13 really a clerical issue.

14 With electronic medical records, it's even more of a
15 nightmare because we can dictate on a day -- I've dictated
16 operative reports at the surgery center where I work, and I
17 don't find out until a month later that the dictation never
18 went through, or I might have forgotten to do it, or there was
19 a glitch in the computer.

20 And, in fact, that's something that happens so commonly
21 that surgical centers and hospitals have a mechanism to remind
22 doctors that the dictation wasn't done. They even have
23 sanctions, if necessary, for doctors who fall behind on a --
24 on a regular basis.

25 So it's something that happens very commonly. And

1 electronic medical records has been a real -- a real thorn in
2 the side of many of us, because sometimes you don't find out
3 that records are missing until in a situation like this where
4 you're looking for them years later and you realize that
5 they're gone. So medical records are always a challenge.

6 Q. And in your review of the deposition testimony of the
7 witnesses did you find that Dr. Kalus or any of Ms.
8 Whitfield's other physicians were in any way prohibited from
9 providing her the care that she needed?

10 A. No. That's an issue that I heard here as well. The care
11 and treatment of Mrs. Whitfield was independent of whatever
12 records issue has occurred here.

13 Mrs. Whitfield went to see Dr. Kalus on July 10th. He
14 was there as a consultant, as a second opinion. He correctly
15 referred the patient back to the original surgeon. And then
16 for whatever reason, when Mrs. Whitfield felt that her
17 condition deteriorated, went back to Dr. Kalus.

18 Dr. Kalus spoke to Dr. Schimpf. Now, records are
19 valuable; but they're not anywhere near as valuable as talking
20 to the man who did the surgery.

21 So on both occasions, the original consultation and when
22 Dr. Kalus assumed Mrs. Whitfield's care on July 13th when she
23 went to the hospital, Dr. Kalus had every opportunity to ask
24 any question he needed to know from Dr. Schimpf.

25 He could have asked for the operative report. He could

1 have asked any question of Dr. Schimpf. He didn't. I assume
2 because he felt that he had adequate information. I think
3 that's reasonable.

4 And so the fact that the records didn't exist had no
5 input and no effect on the outcome of the decision that Dr.
6 Kalus made to proceed with this surgery.

7 Q. Since you were talking about Dr. Kalus, have you also
8 reviewed his records?

9 A. I did, sir.

10 Q. Were there any deficiencies in his record-keeping?

11 A. Yes. The -- I mean, I don't hold it against Dr. Kalus,
12 either; but he kept very sloppy records. He made -- a lot of
13 entries were failed to be made. And to an extent where it was
14 somewhat hypocritical because -- because Dr. Kalus, for
15 example, in his testimony went on in a very erudite and very
16 professorial way about how photographs are so important to the
17 medical record and yet he operated on Ms. Whitfield's legs and
18 didn't even have photographs of her legs, not before and not
19 after. He did multiple surgeries on her chest and did not
20 have after photographs until this year in March when he saw
21 her for follow-up.

22 There were entries in the medical record related to
23 physical examinations that were deficient. There were a lot
24 of deficiencies in Dr. Kalus' own records.

25 I don't hold that against him. But I do have an issue

1 with the fact that he was critical of Dr. Schimpf and claimed
2 that Dr. Schimpf's lack of records was below the standard of
3 care when he himself, Dr. Kalus, failed to measure up to his
4 own standard of care. That I do have an issue with.

5 Q. Let's move on to the topic of informed consent. Have
6 you -- are you familiar with that topic, obviously?

7 A. Yes, sir.

8 Q. All right. Do you believe Dr. Schimpf met the standard
9 of care in terms of the informed consent process concerning
10 the surgeries Ms. Whitfield had?

11 A. I do. The -- and just by point of education, the term
12 informed consent is thrown around a lot. And it's -- informed
13 consent is not a document. It's not a piece of paper.
14 Informed consent is a process that we as professionals engage
15 with our patients. So the moment we start a doctor-patient
16 relationship, we initiate that process of informed consent.
17 And it starts from the very first interaction.

18 In this case the very first interaction from Mrs.
19 Whitfield was a dishonest one. Mrs. Whitfield filled out an
20 online form and there were several questions related to her
21 mental health, very specific questions. She answered no to
22 all of those. She did not disclose the serious psychiatric
23 medications that she was on.

24 And so that initiated a doctor-patient relationship that
25 was based on dishonesty. I think that's -- that's a very bad

1 start to engaging in the process of informed consent.

2 But the process of informed consent involves interacting
3 with the patient. It involves discussing the procedures. It
4 involves discussing the possible alternative, the different
5 options, the scars associated, the recovery associated, pretty
6 much everything related to what is entailed in that procedure.

7 It's an ongoing dialog. It happens over several --
8 sometimes several visits. Sometimes it may happen in one
9 visit. And then it's often memorialized and confirmed in the
10 document that we call a consent form. The consent form in and
11 of itself is not the entire informed consent process. The
12 whole process is involvement. And that includes the dialog.

13 So -- so I mean in this case it's pretty clear that
14 several procedures were discussed with Ms. Whitfield and she
15 did consent to the procedure -- procedures, that were done.

16 There is -- I know that an issue in this case has been
17 that there is not a specific form that says that Mrs.
18 Whitfield acknowledged that she wanted to have liposuction on
19 her neck. And I think there is sufficient controversy there.

20 But I believe that that -- that that -- that there was
21 sufficient evidence to suggest that Mrs. Whitfield was at
22 least entertaining neck liposuction and understood that she
23 was having it, and certainly did not -- was not harmed in any
24 way from having it done, other than having a free neck
25 liposuction.

1 There is no evidence at all that Mrs. Whitfield has had
2 any complaints about that neck liposuction, and there's no
3 evidence at all that she was harmed in any way by that neck
4 liposuction.

5 Q. Going back to the informed consent form, just one other
6 question on it. Do you believe that Dr. Schimpf properly
7 informed her of the complications that could arise from the
8 surgery?

9 A. Yes. Dr. Schimpf actually uses the consent forms that
10 are -- they're produced by the American Society of Plastic
11 Surgeons. They're pretty lengthy. They are many, many pages.
12 The patients -- with multiple paragraphs that go into each and
13 every potential complication. I mean, it's a pretty
14 exhaustive list.

15 The complications that Mrs. Whitfield sustained are all
16 in that list. They're all contained in there. Those pages
17 are specifically initialed by the -- by the patient. And then
18 of course it's executed with her signature.

19 So Mrs. Whitfield was properly informed about the
20 potential complications that could occur with the surgery, and
21 specifically the complications that did occur with respect to
22 her wound healing.

23 Q. Okay. Going back to the issue about liposuction on the
24 chin. Did you find evidence -- you mentioned that you found
25 some evidence that you believe indicates that she wanted to

1 have this procedure done. What was that evidence?

2 A. Well, there were several bits of evidence. As I said,
3 there's not a specific document that says neck liposuction
4 that Mrs. Whitfield executed. And of course there's testimony
5 on both sides which differs. And I'll leave that for the jury
6 to decide.

7 But there were some documents that suggested that as
8 early as a year before, Mrs. Whitfield was concerned about her
9 neck. She had treatments done at a medical spa where she
10 wanted to have her neck tightened. And that was a year before
11 she had surgery with Dr. Schimpf.

12 Certainly Mrs. Whitfield is the garden variety candidate
13 for neck procedures. I see patients like Mrs. Whitfield all
14 the time, in that age demographic, with her facial
15 configuration. That is a very common thing that we see in
16 plastic surgery. This is not a -- some unusual operation that
17 was requested. So she certainly fits the category of a
18 patient who would plausibly want to have something done on her
19 neck.

20 We have access to information contained in Mrs.
21 Whitfield's diary that indicates that she's having multiple
22 procedures done, that she acknowledges that. And that diary
23 entry is in May, a month before her surgery. And in that
24 diary entry it says -- it itemizes the procedures and it
25 includes -- it includes neck in that list. There's also a

1 diary entry on the date of her surgery, June 6th, where she
2 recognizes that her chin had surgery as well.

3 And then of course there are some in the medical records
4 as well if you want me to address those.

5 Q. Okay. Yeah. Sure.

6 A. We saw, I believe it was yesterday, there is -- there is
7 a protocol when a patient comes to the operating room of how
8 we proceed in terms of preparing a patient for surgery. One
9 of the things that happens is the anesthesiologist comes and
10 does their own independent history of the patient before
11 surgery, before anesthetic. And they go and they ask the
12 patient the same standards questions that doctors ask, you
13 know, what medicines do you take and what problems do you have
14 and so forth, and what are you having done today.

15 And there is a form. It's a pre-anesthesia form. Pre
16 meaning before anesthesia. And itemized in that list of
17 procedures that Mrs. Whitfield would have told the
18 anesthesiologist on the morning of surgery is liposuction of
19 the chin. I'm not sure if it refers to chin or neck, but
20 those terms, for the purposes, have been used interchangeably.
21 But it acknowledges that she was aware that something was
22 being done. And that is before surgery, done by an
23 independent professional, the anesthesiologist who's
24 administering the anesthesia before the patient is having
25 anesthesia. That's the way that document is generated.

1 There was also the item of timeout, which is a very
2 standard protocol that we use in hospitals and surgery centers
3 around the country. We do it in our own hospital.

4 It's an effort to try to make sure that what is done in
5 the operating room is accurate. And it was instituted several
6 years ago, and it's called a timeout.

7 And basically what happens is the relevant professionals,
8 the anesthesiologist, the surgeon, the nurse, the scrub tech,
9 all meet just at the beginning of the surgery and we go
10 through a list. And the nurse reads out the name of the
11 patient, their date of birth, any allergies, what procedures
12 are being done, and so forth, and what sites are being
13 operated on.

14 And that's a checklist of things that's done so that all
15 the people in the room are onboard. And we all must
16 acknowledge it. We all must actually say -- I mean part of
17 the process say, yes, I concur. So that all the professionals
18 on board, before the surgery starts, are aware of all those
19 items. That timeout is consistent, also, with the fact that
20 she was having that procedure done.

21 So certainly if Mrs. Whitfield did not consent to the
22 liposuction of the chin and that was not a surgical site that
23 should have been included, it would -- it would -- you would
24 have to assume that all four of the professionals missed it,
25 which is highly unlikely. So that's another -- another bit of

1 information.

2 I'm not sure if there was ---

3 Q. Yeah, I was going to ask you too, did you also take a
4 look at the informed consent forms that Dr. Kalus had for the
5 procedures that he later did on Ms. Whitfield?

6 A. Yes. This is another area that has bothered me with
7 respect to the back end of the -- of the care of Mrs.
8 Whitfield with -- under Dr. Kalus. Dr. Kalus was quick to
9 criticize Dr. Schimpf for failing to have the chin or neck
10 included in the -- in the documents.

11 Now, there are different documents that doctors will use.
12 Some doctors have procedure-specific documents that are -- in
13 terms of consent that are -- that apply to each operation.
14 So, for example, a breast consent might be a different form
15 than a liposuction consent, and so forth.

16 Dr. Schimpf has that type of consent form that comes from
17 the American Society of Plastic Surgeons. And as I've said,
18 they are very detailed. There are multiple pages. The
19 patients initial and sign it. So there was -- for surgery.
20 There was one for liposuction, just liposuction itself, which
21 outlines pretty much all the risks and benefits of
22 liposuction. He also happened to have a separate one for
23 abdomen and a separate one for legs. He did not have one
24 specifically for chin. But pretty much the risks and benefits
25 that he would have discussed were contained in that generic

1 liposuction form.

2 Now, in contrast, Dr. Kalus doesn't use -- did not use
3 those forms. Dr. Kalus used the forms that are the generic
4 forms that are used at the surgical center or hospital. It's
5 a -- it's basically a very generic consent form that can be
6 used by a gastroenterologist before a colonoscopy, it can be
7 used by a heart surgeon, it can be used to have your
8 gallbladder taken out. They just write in what the procedure
9 is with very generic language.

10 Q. I'm going to hand you what's been previously marked and
11 admitted as Defendant's Exhibit 54 and ask you is that the
12 form that you're referring to.

13 A. Yes, it is.

14 THE WITNESS: Is the jury able to see?

15 MR. SMYTH: I'm going to put it up right now. Okay. I
16 think we've got it on the screen now.

17 Q. Sorry, Doctor. Go ahead. You were explaining.

18 A. So this is the form I was referring to. And this is a
19 very generic consent form that is obtained on the day of
20 surgery at the facility. And this generic -- this form could
21 be used to have an appendectomy, a gallbladder surgery, a
22 colonoscopy, a tonsillectomy. It's a very generic consent
23 form. And what happens is they just fill in the name of the
24 doctor and the name of the procedure at the top.

25 It is in no way even as detailed and as thorough as the

1 consent forms that Dr. Schimpf uses, which are specific to
2 each of the operations that he did, which happens to be the
3 way I also conduct my practice. I feel that's a lot more
4 thorough and complete a form than this.

5 But what happens in this particular operation, this was
6 the October 26th operation that Dr. Kalus did, his third
7 procedure, where he consents the patient for a whole bunch of
8 things including several liposuction areas. He includes
9 liposuction of the thighs. However, at the time of surgery he
10 didn't do liposuction of the thighs. He did liposuction of
11 the knees. It's a totally different area. And yet Dr. Kalus
12 does not have liposuction of the knees on this form.

13 Now, I understand that there are circumstances where
14 patients will sometimes ask for things to be done at the last
15 minute. And with liposuction -- excuse me -- with
16 liposuction, that's not an uncommon scenario. The patient,
17 you know, while we're marking them, they say, Doc, do you
18 think you can get a little bit out of here, too, and a little
19 bit out of there. And some of those areas are defined
20 different areas.

21 So the norm is to go back and adjust the consent form and
22 say, you know, add the flanks or add the inner thighs and so
23 forth, and then just have the patient initial it.

24 But the conversation can happen. The conversation can
25 occur. I don't think that's a big deal. I didn't think it

1 was a big deal when Dr. Schimpf did that for Mrs. Whitfield
2 and did the free neck liposuction. Frankly, I don't think
3 it's a big deal that Dr. Kalus left out the knees.

4 What I do think is a big deal is the fact that Dr. Kalus
5 used Dr. Schimpf's failure to include neck as a justification
6 to claim that he was below the standard of care when, in fact,
7 Dr. Kalus failed to meet his own standard of care.

8 I think that level of hypocrisy is a problem for me. And
9 I think that that is -- that is not appropriate. And Dr.
10 Kalus' excuse at the time, when he was under -- in his
11 testimony, was, well, the patient said if there's any other
12 areas go ahead and do them or something along those lines.

13 MR. HALVERSEN: Your Honor, I'm going to object to
14 pitting.

15 THE COURT: I'm going to overrule it.

16 Q. You can continue.

17 A. Okay. That the patient had said to him at the last
18 minute, well, if you see any other areas go ahead and do it.
19 Well, that's not the way it works in plastic surgery. Plastic
20 surgery is elective. Plastic surgery is planned. This was
21 not an emergency. All of a sudden she didn't have fat in her
22 knees that she didn't have the day before. So it's not the
23 same as suggesting that this came up during surgery. This
24 would have had to have been planned.

25 And if he -- and if she did say that to him, then he

1 should have gone back and documented that in the records.
2 That's a failure of his documentation. That's sloppy record-
3 keeping if in fact that conversation did occur.

4 So I have a problem with doctor -- the criticism that --
5 of being below the standard of care, when in fact the doctor
6 who is making the accusation is himself below the standard of
7 care.

8 Q. Thank you, Dr. Perez.

9 Before we leave the chin issue, did you also see the
10 testimony or an indication that Ms. Whitfield was wearing a
11 head wrap or what's also called a neck support or jaw bra
12 after this procedure?

13 A. Yes, I did.

14 Q. What's the significance of that?

15 A. Well, when we do liposuction -- in general, anywhere we
16 do liposuction there's typically swelling, and so we want to
17 contain the swelling as much as possible. And there are
18 specific garments for each part of the body. You know, in the
19 belly we use girdles. And sometimes in the arms we have
20 special custom-made garments that we use for when we do
21 liposuction specific to the body areas.

22 In the neck, for liposuction or even for facelifts, for
23 example, we use them commonly. There's the hand bandage. I
24 tell patients you're going to look like you had a tooth pulled
25 because this thing goes round and round. And the purpose is

1 really to contain the swelling in the neck and kind of keep it
2 up like that [indicates] so that the neck doesn't puddle and
3 doesn't swell. And that's the garment that Mrs. Whitfield was
4 wearing.

5 Q. I'll show you what's been previously marked and admitted
6 as Defendant's Exhibit 15. Is that the kind of garment that
7 you're talking about?

8 A. Yes, it is.

9 And it is specific to -- it would not be an appropriate
10 garment to wear for a breast patient. It would not be
11 appropriate for a patient who's having liposuction of her
12 legs. It would not be appropriate for a patient who's having
13 eyelid surgery. This garment is specifically for someone who
14 is having done something on their neck.

15 Q. Thank you, Doctor.

16 What I'd like to do now is turn our attention to the
17 surgery that was done on Ms. Whitfield's breast.

18 MR. SMYTH: And maybe it would be a little bit easier if
19 you want to come down out of the stand with the Court's
20 permission ---

21 THE COURT: Absolutely.

22 MR. SMYTH: --- to illustrate exactly how this procedure
23 is done and what your understanding of it is.

24 [Whereupon, the witness exits the witness stand and
25 stands in front of the jury]

1 [Off the record momentarily]

2 A. So, you know, I sometimes joke that in plastic surgery we
3 do three operations. We make big things smaller, we make
4 small things bigger, and we pick up what falls down. That's
5 kind of a summary of plastic surgery. In some cases, we do
6 combinations of those things, and this happened to be one of
7 those cases.

8 Mrs. Whitfield had had a breast augmentation done by a
9 previous surgeon years before. And she went to see Dr.
10 Schimpf, and the outcome of that consultation was that she
11 would have her large implants, that she felt were large
12 implants, reduced and to have a lift, which is not uncommon
13 because as we -- as women age, between pregnancies and breast
14 feeding and the natural aging process, the breasts tend to
15 drift down.

16 And so very often as plastic surgeons we're asked to
17 enhance the patient's breast line. And sometimes it involves
18 simply augmenting the breast. Sometimes it involves
19 augmenting the breast and lifting it. Because if we just
20 augment the breast and the implant is here [indicating] but
21 the breast is droopy, they're disconnected and it doesn't --
22 it doesn't look right.

23 And so sometimes we have to lift the breast to the
24 correct position and also do the augmentation. That's the
25 procedure that was done in this case. It's called an

1 augmentation mastopexy. Augmentation is the enlargement, and
2 mastopexy is a fancy word that we use for breast lift.

3 And so if I may just draw. A typical breast that's
4 droopy has a nipple and areola. The nipple is the pencil
5 eraser sized center. And the areola of course is the darker
6 part of the complex.

7 And very often that position is too low. And one of the
8 standard measurements we do is we measure from the notch down
9 to the nipple. An ideal measurement should be somewhere
10 around eighteen to twenty-two, twenty-three centimeters, which
11 is about seven inches.

12 So one of the standard measurements we do is we
13 measure -- take a tape measure and go down to here and measure
14 that distance. In a patient who has lower than normal
15 position of the nipple, we have to raise it. And that's where
16 the lift comes in. And so we have to put it into the ideal
17 position.

18 In order to do that, we have to cut completely around the
19 areola so that we can move it up to this new position. When
20 we do that, we also have extra skin from the sides. And so we
21 have to take in the skin in this direction [indicating] and in
22 this direction [indicating]. And that creates a vertical
23 seam.

24 Temporarily, when that happens, the breast takes on -- in
25 the operating room, takes on a bit of a boxy appearance.

1 Because if you can imagine if you pick it up, this kind of
2 flops down and there's extra skin on both the inside and the
3 outside.

4 And so what we do then is we take a wedge of skin from
5 the inside and a wedge of skin from the outside. And that's
6 what recreates the new position of the nipple. It's what
7 gives us the vertical and the horizontal component to the
8 scar. And that's how we end up with the typical, classic,
9 garden variety anchor breast scar. Which it has a name. It's
10 called the Wise pattern, named after the physician who first
11 described it.

12 But it basically involves a scar around the areola, a
13 vertical scar, and then the horizontal or smile scar on the
14 lower portion.

15 Q. Is that the way Dr. Schimpf did Ms. Whitfield's surgery?

16 A. Yes, ---

17 Q. And that ---

18 A. This is the procedure that was done on Mrs. Whitfield,
19 with -- with the exception -- now, this is the lift part.
20 With the exception, sometimes we just do that. If the patient
21 does not need to be bigger, does not want to have fullness, we
22 can just do that.

23 But in Mrs. Whitfield's case she wanted fullness but she
24 wanted less than she had before. So the implants that she had
25 taken out, the larger implants, were made smaller.

1 And so when we do this, in the back of that breast,
2 behind the breast tissue, we insert a small implant. And
3 that's what Mrs. Whitfield had.

4 So she had the insertion of that small implant behind the
5 breast, and then the whole anchor-lift procedure. That's
6 exactly the procedure that Mrs. Whitfield had.

7 Q. And did Dr. Schimpf perform that according to the
8 standard of care?

9 A. He did. And his operative report really outlines pretty
10 much the way that language is typically written.

11 Q. Okay. Now, we know that she subsequently developed a
12 complication after the surgery. Do you want to walk through
13 what happened there and what your opinions are in terms of
14 what happened with her breast?

15 A. Sure. Did you want me to show ---

16 Q. Yes, just -- yeah.

17 A. Okay. So one of the things that I just want to point out
18 here is that -- is that the -- because we have crossing
19 traffic of circulation and we have skin that's coming from
20 different directions, this junction of the vertical and the
21 horizontal end, we call it the T. Okay, it's actually an
22 upside-down T. But we call it the T juncture.

23 And the reason that this is important is because this is
24 the weakest point. It's the most vulnerable point because you
25 have an intersection of circulation and you have an

1 intersection of the tissue. And so what I tell patients is if
2 we're going to have a complication related to the wound, it
3 most likely will be in this area because -- from the pressure.
4 Because that's just the way -- it's the weakest point. It's
5 the most vulnerable point.

6 In addition to that you have the implant that normally
7 when a woman is standing that implant is falling down. So you
8 have gravity pushing that implant down, sitting right on top
9 of that juncture.

10 So you've got vulnerable skin and you've got the weight
11 of the implant. So this is, hands down, the most common area.
12 If there's going to be a wound breakdown, this is the reason.
13 This is where it is, and that's the reason why.

14 Now, I have here a low-budget prop. I apologize. But I
15 think for our purposes it illustrates the point that I'm
16 trying to make.

17 So this is what the breast would look like after the
18 lift. And these are the scars that I'm referring to. So it's
19 a scar around the areola, the vertical scar, and then the
20 horizontal scar. And this is what would be the residual
21 breast tissue that remains that is lifted.

22 Now, in a case like this where there's a relatively small
23 amount of breast tissue, the patient would then op to have the
24 implant from behind it.

25 And this [displaying] is what these implants are. And

1 these are actually the same size implants that were placed in
2 Mrs. Whitfield. Mrs. Whitfield started with implants that
3 were 300 and 325 cc's originally. She wanted to downsize.
4 And her downsized implants were 250 and 275 cc's. So this
5 is -- I'll pass them around and you're welcome to see what an
6 implant looks like. And it has the number on there. That's a
7 275, and this is a 250.

8 And so what we have is we have the weight of that
9 implant, even though they're relatively light; because they're
10 spongy. It's a spongy silicone. But they still -- they still
11 is the weight. And that -- and gravity, of course, will make
12 that weight settle down to the lowest point. And, again, the
13 lowest point is this T.

14 The reason that's significant is because that was where
15 Mrs. Whitfield -- was not where Mrs. Whitfield's wound problem
16 occurred. Mrs. Whitfield's wound problem occurred up here
17 [pointing].

18 So if the theory that has been proposed -- again, you
19 know, when the patient is upright, gravity causes the majority
20 of that weight to be at the bottom. So if it's sitting like
21 that [motioning], it's sitting right on top of that T wound.

22 And the reason, as I said, that it's important is because
23 that's not where Mrs. Whitfield's wound dehiscenced. She did
24 have a tiny little wound separation there that's on the
25 photographs, but that's not the main source of the problem.

1 The main source of the problem was up here [pointing].

2 So if the theory is that there was too much tension on
3 the wound, we would expect it to happen down here [pointing].
4 And that's not consistent with what happened.

5 Q. Okay.

6 [Whereupon, the witness re-takes the witness stand]

7 Q. You just finished testifying that Ms. Whitfield's
8 situation was not consistent with too much tension. Can you
9 explain what the factors are, that you're aware of, that
10 support that opinion?

11 A. Sure. The -- so when we do this operation, obviously
12 we're intersecting a bunch of seams. It's pretty basic to the
13 training of a plastic surgeon to understand how much tension
14 to put on a wound. I mean, that's what we do. We do that
15 every day. We do that in every operation. When I do a
16 facelift, I have to know how much tension I'm placing on that
17 face so that -- so that the wound doesn't pull away.

18 The nature of plastic surgery is a little different from
19 other surgical specialties. For example, a general surgeon
20 who takes out an appendix will make an incision, take out the
21 appendix, and close the incision. There's no tension on that
22 incision because there's no tissue taken away.

23 In plastic surgery, we typically remove a lot of tissue.
24 We do that on purpose, because we want -- patients want to be
25 tighter and they want to be slimmer and they want to look

1 better.

2 And so the nature of plastic surgery and plastic surgery
3 procedures is such that we are, by definition, removing tissue
4 and therefore creating tension.

5 So tension is basic to plastic surgery. Every plastic
6 surgeon, certainly every board certified plastic surgeon, has
7 a good understanding of the amount of tension that should be
8 placed at the time of surgery. And if there's a circumstance
9 where we, at the completion of the procedure, feel that it's a
10 little bit too tight, there are things that we can do to
11 modify it right there in the operating room. It's not like
12 it's a total mystery. This is what we do on a regular basis.

13 Now, having said that, because of the nature of this
14 procedure, there are -- there are a number of variables that
15 can potentially cause tension after we leave the operating
16 room. And some of those variables we have control over, some
17 the patient has control over, and some neither the doctor nor
18 the patient have control over. And those variables enter into
19 the mix in terms of what happens in the ultimate outcome and
20 the long-term course. And I think those are part of what we
21 have talked about here as well.

22 Q. Yeah, and I may need you to come back down again. I'm
23 sorry. I just got you seated.

24 [Whereupon, the witness exits the witness stand to stand
25 in front of the jury]

1 Q. But perhaps this set of photographs from Dr. Kalus' chart
2 would help you illustrate your understanding of the
3 progression of the wound.

4 [Off the record momentarily]

5 A. So these are photos that I believe you've seen before.
6 And they're dated. This is June 25th, July 9th, 11th, 11th,
7 13th and 14th. So June -- the surgery was on June 6th.

8 So this is a photograph that was about two-and-a-half
9 weeks after -- after the surgery. What -- it's obviously a
10 very small cropped picture and blown up. But what I gather
11 from this is the surgical tapes that we often use in surgery,
12 the steri-tapes that are put on at the time of surgery, are
13 still intact. And this area around the areola is still
14 intact.

15 So, again, if this wound was too tight at the day -- on
16 the day of surgery I would -- I would expect it to be open the
17 next day. Certainly within forty-eight hours.

18 This [pointing] is now two-and-a-half weeks later and
19 it's still intact. So that tells me that that was not because
20 there was too much tension placed at the time of surgery.

21 The other thing is that -- the other point that I wanted
22 to make is that there's been talk about whether there was an
23 infection or not. If there's the presence of infection, those
24 tapes don't stay on. They just float off because of the puss
25 that's coming out or the liquid that's coming out will take

1 them off. So this tells us that this is -- this is not
2 uncommon for what you would expect two-and-a-half weeks out
3 from this type of surgery.

4 Here [pointing] it looks like the tapes were taken off.
5 This is now July 9th, which is a couple of weeks past that.
6 And it looks like this is around the time when Mrs. Whitfield
7 is starting to have her complication, which is now four-and-a-
8 half -- I guess four-and-a-half, five weeks after the
9 operation. That's not consistent with what happened five
10 weeks earlier on the day of surgery.

11 The -- so the wound has opened up. And then this is
12 now -- this is July 11th, which is I believe the day that Dr.
13 Schimpf saw the patient.

14 So Mrs. -- Mrs. Whitfield went to see Dr. Kalus on July
15 10th, and then the patient -- and then Mrs. Whitfield returned
16 to Dr. Schimpf on July 11th. So this is the photograph from
17 July 11th. Now, there's, you know, some dripping blood and it
18 looks dirty. But this is where you can tell that the wound is
19 now separated. I

20 So what this tells me is that her problem was pretty much
21 defined about the early part of July, which is about four
22 weeks or almost five weeks -- or I guess about four weeks
23 after her surgery, which is consistent with her report and Dr.
24 Kalus' intake form where she's asked how long has this problem
25 been going on and she writes a week.

1 And she saw him on the 10th. So that would put -- over
2 the July 4th weekend would be around the time that she's
3 having her problem.

4 Again, that is inconsistent with something that would
5 have happened a month earlier. It's a totally different point
6 in time. And it suggests that the other variables that I was
7 talking about -- talk about really probably played a greater
8 role.

9 So this is now July 13th. And this is -- this is now the
10 Sunday where Mrs. Whitfield went into the shower, noticed some
11 blood, felt that the wound had opened up, and panicked and
12 called Dr. Kalus and said I want you to take care of me, I no
13 longer want Dr. Schimpf to take care of me. That was on
14 Sunday the 13th.

15 By the way, this is where -- on the 11th would have been
16 the day where Dr. Schimpf put a couple of holding sutures into
17 the wound, which is perfectly appropriate. And I'll discuss
18 that, if you want.

19 And then this [pointing] is -- the final picture is on
20 the day of surgery where Dr. Kalus took Mrs. Whitfield back to
21 the operating room to explore the wound when he took out the
22 implant and closed the wound.

23 Now, if I -- well ---

24 Q. Let me ask you a couple of questions so -- to help put
25 the timeline together.

1 So these first pictures that are dated June 25th, that's
2 about five days after Ms. Whitfield went into the hospital for
3 heart attack type symptoms; correct?

4 A. I don't remember the date, but I know she -- during this
5 period she went because she had panic and chest pain.

6 Q. Right. And was that at all related to the breast?

7 A. No. They evaluated her in the emergency room, and they
8 cleared her heart. And they said just back to your -- follow
9 up with your surgeon. But this would not have been cause for
10 her to have heart attack type symptoms.

11 Q. Have you reviewed the medical bills that are being
12 claimed as damages in this case?

13 A. Yes, I have.

14 Q. Are those bills from that hospitalization, that you said
15 is not related, are they included?

16 A. I believe so.

17 Q. Okay.

18 A. There are many.

19 Q. All right. And then moving forward -- you mentioned that
20 you didn't think this was tension related. Are you familiar
21 with a concept called tensile strength?

22 A. Yes, sir.

23 Q. Explain that to the jury.

24 A. Okay. And if I may have a fresh piece of paper that I
25 can draw on?

1 Q. Sure.

2 A. So, again, basic to plastic surgery is when are wounds --
3 when are wounds strong. And when we cut skin, we have to
4 have -- wait a period of time before that skin is strong
5 enough to hold up on its own. And those -- those have been
6 studied for many, many years. And the strength of that wound
7 is called the tensile strength.

8 And there's a reason why if you go to the doctor and the
9 doctor says -- and you have surgery, and the doctor says I
10 don't want you exercising for a month, well, there's a logical
11 reason why. Even though every patient bugs me about going
12 back to exercise, I'm very insistent on it. And the reason is
13 that there is a -- there is a very logical, well-demonstrated
14 pattern of strength that goes into the wound.

15 So if a wound is made on this day, the skin is cut. You
16 have week one, week two, week three, week four, week five.
17 Starting on week one, this is when the wound is totally -- has
18 no strength at all. You can just open -- the stitches are
19 holding it together, because if the stitches weren't there it
20 would open up. So it has zero strength.

21 What happens over the first three weeks is that there is
22 a progression like that [drawing]. And it takes about three
23 weeks before it starts to plateau to about seventy-five to
24 eighty percent of the strength.

25 It never -- it never -- actually, I have it reversed.

1 These are the weeks. One, two, three, four, five. And this
2 is the strength. I apologize. So this is the percentage
3 of strength. So the percentage of strength is at about
4 seventy-five to eighty percent at week three.

5 It approaches about eighty to eighty-five percent and
6 then plateaus. So actually a wound is never as strong,
7 forever, as is it -- as intact skin is. So a scar is always a
8 little bit weaker. A scar is about eighty-five percent of the
9 strength of an intact.

10 But what's important here is that you reach, very
11 quickly -- within about three weeks, you reach about eighty
12 percent strength. And the reason that's important is because
13 if I have a patient who has a little wound separation here
14 [pointing], it's more problematic because the wound is weaker.

15 If I have a patient who has a wound separation at week
16 three, I have a little bit more of a cushion. I'm a little
17 bit more -- I'm less worried because I know that we've got
18 about seventy-five percent strength so we've just got to hold
19 on a little bit longer and we're almost there.

20 And so the difference between week one and week three is
21 very important. And the reason that is relevant to this case
22 is that this all started at about week three to four. So
23 there's a significant amount of inherent strength in this
24 wound. So we could almost get to the finish line.

25 And that's where Dr. Schimpf tried to intervene. And

1 what he did was he saw this and he put a couple of stitches
2 in, just to hold it together to see if we could keep the wound
3 from completely unzipping. Because one of the concerns is
4 that if you lose one part, you know, that would pull the next
5 one and pull -- kind of like a zipper and it just opens up.

6 And so we don't want to close it completely. You don't
7 want to seal it tight because this is not a sterile wound and
8 you could potentially be ceding bacteria into the wound.

9 So even though if a wound opens, patients -- you know,
10 two weeks later patients say, Doctor, I need my stitches -- I
11 need my wound stitched up, that's the wrong thing to do. You
12 don't want to completely seal it up. You don't want to make
13 it water tight. Because you're potentially locking bacteria
14 in.

15 But what you can do and what is very prudent and what I
16 do and I have done and what Dr. Schimpf did in this case, is
17 put a couple of stitches just to kind of hold it together to
18 see -- we've already survived three or four weeks. Let's hold
19 it together and see if we can get to the finish line with
20 these couple of stitches.

21 And just one final point there. The point has been made
22 about whether anesthesia was used or not. These wounds --
23 when we lift flaps, those little nerve endings that touch the
24 skin have been detached. These wounds are typically numb.

25 I -- it's not uncommon for me to pinch the end of that

1 skin and the patient say I don't feel anything at all. So
2 that's typical. So it's not -- it's not unheard of to put
3 stitches in without using anesthesia.

4 In addition to that, I think Dr. Schimpf made the point
5 that he only wanted to put in a couple of stitches. Well, why
6 give the patient with multiple shots of anesthetic, which is a
7 needle, and the local, which burns, just to put that one
8 stitch in? You might as well just put the one stitch in.

9 So it's not barbaric. It doesn't -- as barbaric as
10 they've made it sound to be. It is actually a very common
11 practice. I have done it myself many times.

12 And I tell patients, listen, it's going to be a little
13 pinch; but it's going to be one pinch as opposed to the
14 needle, the anesthesia needle, and then the sewing needle. So
15 that is not an uncommon practice. And Dr. Schimpf did that in
16 an attempt to try to pull things together so that the whole
17 wound would not come apart

18 And from this picture, it looks like he was successful.
19 From this picture, as much as this picture to a lay person
20 makes you cringe a little bit - I understand that - but, you
21 know, the lay person is not used to seeing complex wounds.
22 That's what we do in plastic surgery, we treat complex wounds,
23 our own and other specialties.

24 If an orthopedic surgeon, if a general surgeon, if a
25 heart surgeon, has a nasty complicated wound problem, we're

1 the ones they come to.

2 So we're used to dealing with this thing. This is not
3 anything exotic. Anybody who says, I've never seen this
4 before, tells me that he has very little experience. Because
5 this is not an uncommon way -- type of wounds for us to
6 interact with, our own and others.

7 But what this tells me, there's a lot to be learned from
8 this photograph right here, for me as a clinician. Excuse me
9 [cough].

10 And this is the photograph in the operating room. You
11 can tell that the drapes are on. So this is a photograph in
12 the operating room on July 14th when Mrs. Whitfield fired Dr.
13 Schimpf and turned her care over to Dr. Kalus.

14 Dr. Kalus took the patient to the operating room to
15 what's called debride. Debride just means cleaning up the
16 edges and explore the wound. During the course of that
17 surgery he poked his finger and went to the back end of that
18 bra that I showed you and exposed the implant. And at that
19 point, he made the determination that the implant needed to
20 come out.

21 Now, if I look at this wound, what this tells me is,
22 number one, there's no significant evidence of infection. The
23 edges have a little bit of normal redness, but all wounds that
24 are healing have a little redness. And infection would be
25 redness streaking up the breast like a bad sunburn. She

1 doesn't have that. She doesn't have any element of what looks
2 like puss coming out of there. The culture did not show that
3 later, either.

4 `This fat actually looks pretty good. This looks like
5 yellow, healthy breast fat. The breast is mostly made of fat.
6 This fat looks pretty good.

7 And there are two other very important things that are in
8 this picture that are very encouraging to me as a -- as a
9 clinician. Number one is these little red areas. These red
10 areas are what's called granulation tissue. Granulation
11 tissue is the healing tissue. It's the cavalry that's coming
12 to heal this wound.

13 The body rushes blood and cells to pull that wound
14 together. And when we start seeing this -- these red areas,
15 we're seeing granulation. That means there's healing going
16 on. There's good healing going on.

17 Ironically, the day before was when Mrs. Whitfield was in
18 the shower and said she poured blood out. Well, she didn't
19 pour blood out. The hematocrit shows -- the blood count shows
20 that she didn't lose any significant volume of blood.

21 But that's not surprising. Patients panic like that
22 and -- when they see blood. I mean, a lot of patients aren't
23 used to seeing blood. I understand that. I get those calls
24 all the time, you know, I'm bleeding, I'm bleeding, and
25 sometimes it's just a little bit of blood. So I don't fault

1 Mrs. Whitfield for that.

2 But the irony in that is that that blood is because
3 there's healthy granulation tissue in that wound. So I would
4 have said, Mrs. Whitfield, that's actually good blood; that's
5 the cavalry; that's the good stuff that's coming to mend this
6 wound so don't panic ---

7 MR. HALVERSEN: Your Honor, I'd like to object and take
8 something up with you.

9 THE COURT: All righty.

10 [Whereupon, an off-the-record bench conference is held]

11 Q. All right. Doctor, one more thing before you sit down.

12 It's been -- the term has been used plastic surgery
13 urgency, or something to that effect, in this trial. Do you
14 believe this is a surgically urgent wound, based on your
15 review of the materials?

16 A. No. The -- as I said, this looks like it's a good,
17 healed wound. I would be satisfied at this junction, four
18 weeks out from surgery, that this -- I'd be optimistic that
19 this would heal.

20 And what -- my personal management of this wound would
21 have been to continue with local wound care to see if we could
22 get more of that granulation.

23 And by the way, there's a skin bridge in there, too,
24 which is also encouraging. More of that to heal so that -- so
25 that the wound itself would eventually heal closed.

1 And I believe that's likely what would have happened
2 without the need to have the surgery that Dr. Kalus did. I
3 don't fault Dr. Kalus. But I believe that that would have
4 been a more prudent choice.

5 Q. And is that what you call conservative management, as
6 opposed to rushing the patient to surgery?

7 A. Yes.

8 Q. And do you believe that's in the patient's best interest,
9 given the presentation here?

10 A. I do, because -- because whenever we have to take an
11 implant out in a patient in this circumstance, that's an
12 important decision. It weighs very heavily. Because when you
13 take an implant out, you're committed to leaving that implant
14 out for a period of time, typically about three months. And
15 that is very, very unsettling for patients. And especially in
16 this context, in a patient with some mental health issues, I
17 think it would be a very unsettling period.

18 So I would -- I would be very cautious about taking this
19 implant out. I prefer the conservative approach.

20 Q. All right. And one more thing before you return to your
21 seat. Just a couple more pictures. I want to kind of fast
22 forward a little bit to the surgery that Ms. Whitfield had
23 with Dr. Kalus after this. And maybe you can kind of walk the
24 jury through these photos as to what happened.

25 A. Okay. So what Dr. Kalus did was he took out the right

1 implant. He made that determination that it needed to come
2 out. And, again, it's a judgment. I don't fault him for
3 that. That was his judgment at the time of surgery. I would
4 have not done it, but that was his call. And you -- and he
5 closed the wound.

6 And so this is the patient's right breast, the one where
7 he took the implant out. And you can tell that the wound has
8 healed very satisfactorily.

9 It's sinking down [easel malfunctioning].

10 MR. SMYTH: It's what happened when I set up a tent too.

11 A. So it looks like the wound has healed very
12 satisfactorily. Fortunately for Mrs. Whitfield, she appears
13 to be a good healer. Her scars are, you know, very
14 satisfactory. They're pink, because they're fresh; but
15 they're actually healing very well.

16 And, you know, this was a successful outcome. This was a
17 successful outcome. I disagree with his -- with his course.
18 But, you know, good, honest doctors can disagree. But the
19 fact is that he did a decent job here to get this wound closed
20 and to take this implant out.

21 And, of course, the left side, I think he may have done a
22 small touchup here. But really insignificant. And the left
23 side has healed, as well, very satisfactorily.

24 Q. Okay. And then he made the decision later to remove the
25 left implant. Can you show us the results of that?

1 A. Sure. Well, so Mrs. Whitfield remained like this for a
2 period of several months. And then the decision was made to
3 go into a second stage for Dr. Kalus.

4 In my opinion, at this stage I would have done an
5 augmentation on the right, replaced that implant that was
6 taken out, that 275 implant, cc implant that you saw, and
7 finish. That's the easiest solution. And we wouldn't be here
8 today, I believe, if that had been done.

9 Instead, for reasons that are -- that are somewhat
10 unclear, Dr. Kalus embarked on a -- on a -- on procedures on
11 both sides, but mainly on her left side, that involved taking
12 out more breast tissue from both sides, taking out the implant
13 on the left side, and then doing a full reduction of breast on
14 the left side, which made absolutely no sense to me
15 whatsoever.

16 The left side was not broke. It didn't need to be fixed.
17 It needed to be left alone. And so he underwent these
18 procedures.

19 Dr. Kalus claims that it was Mrs. Whitfield's decision,
20 that it was her choice to have that left implant taken out.

21 I believe it was based on false or -- well, false
22 information that she was given by Dr. Kalus. But Dr. Kalus
23 said it was her decision.

24 When I had the opportunity to examine Mrs. Whitfield she
25 said it was a collaborative decision. So it was one or the

1 other who made this call.

2 But either way, I think it was the wrong thing to do.
3 Because the consequence, predictably, if you take this implant
4 out and you do a huge reduction on the left side, you're going
5 to end up messing up the left side. And that's exactly what
6 happened.

7 And you can see here that the right breast is a little
8 bit smaller because some breast tissue was taken out of the
9 right breast, in my opinion without any necessity. It was
10 not -- did not need to be done.

11 But here, this clearly is a mess. This clearly on the
12 left side is a mess. Dr. Kalus took the left implant out and
13 then -- which was 250 cc's.

14 Q. So that would be this implant [displaying]? I'm sorry.

15 A. This is 275.

16 Q. I'm sorry, I gave you the wrong one.

17 A. So he took out the implant. And she had a 275 -- may I
18 have the 275 as well?

19 Q. Yes.

20 [Whereupon, complied with request]

21 A. So Mrs. Whitfield had a 275 on the right which was taken
22 out. Dr. Kalus takes out the other implant, which is 250;
23 roughly about the same.

24 If Ms. Whitfield just wanted to be without implants,
25 which I don't think was a good choice, but for whatever reason

1 she said I just don't want implants, then just take it out and
2 leave it at that.

3 But in addition to that -- this is a prop of what 400
4 and -- what 500 grams, I guess of fat, looks like. He went in
5 and took a whole bunch of breast tissue out that he had no
6 business taking out. And he left her with a totally deflated
7 breast on the left side. I have no idea why he would do that.
8 It was predictably a very, very poor choice to make. And he
9 made her worse off than she was after he fixed this part
10 [pointing]. And beyond that then, of course, there's another
11 stage, as well.

12 Q. Okay. Thank you.

13 [Whereupon, the witness re-takes the witness stand]

14 Q. Do you believe the decision to remove that left implant
15 explains, at least in part, why Ms. Whitfield continues to
16 have issues with the symmetry?

17 A. Oh, yeah. The symmetry that -- I mean Mrs. Whitfield had
18 a pretty straight-forward asymmetry after Dr. Kalus' first
19 surgery, the one where I showed you where he just took out the
20 right implant. Putting another implant in there would have
21 given her a very reasonable symmetry.

22 You know, in plastic surgery we don't strive for exact
23 symmetry. I tell patients, you're not -- your body's not
24 going to be a mirror image. Even supermodels don't have eyes
25 and hands and breasts that are precisely the mirror image. We

1 try to achieve reasonable symmetry.

2 If Dr. Kalus had put that implant in on the right side
3 and called it a day, Mrs. Whitfield would have reasonable
4 symmetry and it would have been finished. Instead, he created
5 greater asymmetry by going into the left breast where he had
6 no business going.

7 Q. Okay. And have you reviewed the additional surgery that
8 Dr. Kalus performed on Ms. Whitfield?

9 A. Yes, I did.

10 Q. All right. What -- tell the jury what your understanding
11 of what Dr. Kalus did after removing that left implant.

12 A. Well, so Dr. Kalus' first surgery was, of course,
13 removing the right breast implant. The second surgery that
14 Dr. Kalus performed was this one that we just discussed where
15 he removed some breast tissue from the right but then also
16 removed the implant and a great deal of breast tissue, as you
17 saw in that prop from the left.

18 A period of several months went by, from March to
19 October. And in October Dr. Kalus embarked on a third set of
20 procedures. And among those procedures, Dr. Kalus
21 acknowledged that he was not -- that that was a poor result,
22 the one you just saw.

23 And so now he's in a situation where he's trying to fix
24 the problem he created by putting fat back into the breast.
25 And there is a technique called fat-grafting, which is

1 somewhat controversial in plastic surgery, where we take fat
2 from one part of the body and put it into another.

3 Even though it sounds intuitively logical and every woman
4 has -- I've ever seen for breast augmentation has always asked
5 me, Doctor, can't you just take it from here and put it here.
6 It's not that simple.

7 We do fat-grafting in different parts of the body for
8 small defects. People who have like indented scars, you can
9 kind of pump them up with the fat and it will fill it.

10 The problem with fat-grafting is that it is notoriously
11 unreliable to remain in the tissue. Because we're taking fat
12 from one part of the body. It's processed. But there's no
13 circulation attached to it. So there's no guarantee that any
14 of it will survive, number one. Number two is that it will
15 survive unpredictably. So if I put fat in two areas, I don't
16 know if half of it's going to be away in this one and three-
17 quarters is going to be away in that one. And so it survives
18 unpredictably.

19 And in the breast there is a very specific problem. And
20 that is that when we put fat from another part of the body
21 into the breast, the part that doesn't survive undergoes a
22 process called necrosis, meaning that it dies. When fat
23 necrosis occurs, it sometimes can resemble cancer on a
24 mammogram.

25 And so if I take fat from one part of the body and put it

1 into the breast and a year later the patient has a mammogram
2 and you see these little what's called salt-and-pepper
3 calcifications that look like cancer, we -- well, is that --
4 is it really cancer or is it from the fat that I put in there.

5 And so for that reason, fat-grafting to the breast is a
6 very controversial area. Even doctors who do it, do it in
7 relatively small volumes.

8 MR. HALVERSEN: Your Honor, may we approach?

9 THE COURT: Sure.

10 [Whereupon, an off-the-record bench conference is held]

11 Q. Doctor, you were explaining the treatment that Mrs.
12 Whitfield received subsequently from Dr. Kalus. Do you
13 believe that the treatment that he offered her was appropriate
14 or reasonable?

15 A. You're referring to the third surgery that ---

16 Q. Correct.

17 A. --- we were just talking about?

18 Q. Yes, sir.

19 A. No, not at all. I think every one of those procedures
20 was not necessary or indicated. And some of them were
21 actually contraindicated; and, in fact, frankly, there is
22 fraud in a component of that surgery as well.

23 Q. And what do you mean by that?

24 A. The fraud?

25 Q. Yes, sir.

1 A. Well, there are two areas specifically. Number one is
2 that the last surgery -- I'll just outline it so the jury
3 understands. He does liposuction. More liposuction, which
4 was unrelated to Mrs. Whitfield's problem with the breast in
5 the first place. It's a totally independent thing.

6 But he also -- and he does the fat-grafting that I
7 mentioned. He also does what's called an umbilicoplasty, a
8 belly-button operation. Has nothing to do with surgery that
9 Dr. Schimpf did in her breast, but he's doing a new operation.

10 The thing about it is that, first of all, there's poor
11 documentation as to what her symptoms and findings were to
12 even justify that procedure. And -- and he does what is
13 called an umbilicoplasty, which is basically making the belly
14 button look better, tuning an outie into an innie and making
15 it look nice. And for whatever reason, maybe Mrs. Whitfield
16 wanted that done and so he did it.

17 However, in the operative report he claims that he put
18 one stitch in for that operation. And he also claims that
19 there was a hernia that he fixed with that operation. Now, a
20 hernia can be a medically-necessary operation ---

21 MR. HALVERSEN: Your Honor, I have objections.

22 [Whereupon, an off-the-record bench conference is held]

23 THE COURT: All right. Ladies and gentlemen of the jury,
24 we're going to go ahead and take about a five-minute break.
25 Well, let's do this. We've been going for an hour and a half,

1 because we started at 9:00, obviously. And so let's go ahead
2 and take our midmorning break for about ten minutes and then
3 I'll get you right back in. Okay?

4 [Whereupon, the jury exits the courtroom 8/30/19,
5 10:23 a.m.]

6 THE COURT: All righty. And what was your objection?

7 MR. HALVERSEN: Your Honor, my objection is to the
8 relevance of this whole line of questioning about -- and it's
9 highly improper to be accusing other witnesses of being a
10 fraud. It's a part of pitting.

11 But notwithstanding that, you know, the relevance is --
12 we're here for and he's expressed his opinions on the
13 procedure to the neck, his opinions about the breasts, and how
14 Dr. Schimpf met the standard of care. Now he's going down a
15 road about beating up Dr. Kalus because he -- I don't even
16 know what -- about a hernia operation. So I just I think it's
17 not relevant.

18 THE COURT: All righty.

19 MR. SLOTCHIVER: Strike the language as to fraud, Your
20 Honor, if you would. I don't believe it's appropriate in any
21 manner whatsoever.

22 It's not pitting. He actually accused another doctor of
23 committing fraud to the Court. I'm assuming there's
24 regulations to the doctors, like lawyers, that you have to
25 report these incidents. I assume he hasn't done that, because

1 there's no fraud.

2 THE COURT: I ---

3 MR. SMYTH: Your Honor, these are charges that the
4 plaintiff has admitted into evidence and is asking this jury
5 to compensate them for in this case.

6 We have -- we should have the ability to show the jury
7 that these are unrelated and unreasonable charges, both of
8 which have to be proved for them to be acceptable damages.

9 I didn't put this into the evidence. Had they not
10 included these bills in their damages, we may not be talking
11 about this. But now they're asking the jury for a bunch of
12 surgeries that have absolutely nothing to do with her breasts
13 and they're asking to be paid for that.

14 MR. HALVERSEN: If there's an operation for the hernia
15 that's in the bill, we're not going to ask it for -- from the
16 jury.

17 MR. SMYTH: It's already been admitted.

18 MR. SLOTCHIVER: They had every opportunity to question
19 Dr. Kalus about the procedures. They had every opportunity to
20 question Dr. ---

21 THE COURT: Hold on. Hold on. What are y'all -- what
22 are y'all arguing? I don't -- I don't need both.

23 Yes, sir?

24 MR. HALVERSEN: If there's something in there about -- we
25 won't request it as damages from the jury. We'll ask to -- if

1 there's a bill in there for a hernia or something, not to pay
2 attention to it. I mean, we're not seeking damages from a
3 hernia repair.

4 THE COURT: All right. All right. Then that solves the
5 problem. So I will then I guess sustain the objection as to
6 the relevancy of the hernia, because obviously y'all are going
7 to give a curative -- are not going to address it in your
8 closings and not asking for it as to damages. So we'll move
9 on past that.

10 MR. SMYTH: Sorry, Your Honor. One housekeeping matter.
11 And I don't mean to interrupt the Court. But this document is
12 in evidence with their summary. They've told this jury
13 they're asking -- Mrs. Whitfield on the stand said I'm asking
14 for \$188,000 in damages.

15 I don't know how we address that because their summary
16 includes all of this. It hasn't broken out which procedures
17 are covered and which aren't. We have a number of other
18 contentions of things that are not recoverable in this case on
19 that bill. So I'm not sure how we fix that problem since it's
20 already been testified to and in evidence.

21 THE COURT: Well, I mean I assume you fix it in your
22 closing and just say that anything that's submitted in that
23 bill as to unrelated surgeries that have been testified here
24 during this week or -- if you get to that damages part are to
25 not to be considered. I don't have a problem charging them

1 that.

2 MR. SMYTH: Okay.

3 THE COURT: I mean, I can -- we can make it a small
4 charge and just say there are bills in the -- or there are
5 procedures in the bills that are unrelated to ---

6 MR. SMYTH: Can I establish with the witness that those
7 charges are unrelated?

8 THE COURT: Sure. You can ask him that one single
9 question.

10 MR. HALVERSEN: Yeah. And I ---

11 THE COURT: I mean, that resolves your issues as well.

12 MR. HALVERSEN: Well, I'm a little bit hesitant about
13 going as far as making it a jury charge that there are
14 unrelated things. That feeds into their whole theory of the
15 case that she sought all this medical treatment that was
16 unnecessary.

17 THE COURT: Okay.

18 MR. HALVERSEN: I mean, if there is one hernia repair or
19 something, I'm sure we can -- something we can address with
20 the jury. You can talk to them on closing that they put in
21 something about a hernia repair. We can tell the jury there
22 might have been one bill in there for a hernia repair. I
23 mean ---

24 MR. SMYTH: It's not just that, Your Honor. There are
25 multiple procedures in there that are not covered. The bills

1 include excisions of basal cell cancers and all kinds of
2 things that have nothing to do with this case. And they never
3 took it out. They included it in their exhibit.

4 THE COURT: Mr. Perez, if you want to step down and take
5 a quick break, that's completely fine. Because we are going
6 to take up something that will be unrelated to anything. We
7 are going to take up some jury charges. So if you want to go
8 use the restroom, get some water, feel free to take a break.

9 THE WITNESS: Thank you, Your Honor.

10 THE COURT: Yes, sir.

11 MR. HALVERSEN: How about this, Your Honor. If -- a jury
12 charge, if the jury finds a medical bill that isn't -- that is
13 not related to -- causatively related to the care and
14 treatment that the plaintiff claims, that may be discounted or
15 not compensable. Something like that.

16 THE COURT: Sure. Y'all -- like I said, I'll be happy to
17 charge them something as to that. It doesn't matter.

18 All right. Let's do this. We'll talk about that in
19 conjunction with what we're going to talk about now, because
20 this is something that Julie can be working on so we can keep
21 the jury -- I mean keep the case going.

22 CHARGE CONFERENCE

23 THE COURT: So did y'all receive -- my jury charges are
24 obviously different than y'all's, because I have all the
25 preliminary stuff that has to be in there. So mine is like

1 twenty-seven pages already.

2 I have looked at your first set last Sunday, Mr. Smyth,
3 and then I have reviewed y'all's this morning. Did y'all get
4 together and agree on the ones that you could agree on?

5 MR. HALVERSEN: Yeah, Your Honor, we've agreed to your
6 charges in their entirety.

7 THE COURT: Okay.

8 MR. HALVERSEN: And so ---

9 THE COURT: I took -- I took one thing out. I took out
10 personal injury.

11 MR. HALVERSEN: Right.

12 THE COURT: Somehow that got put in there.

13 MR. HALVERSEN: That's one we drew a question mark on.
14 And then otherwise, Mr. Halversen and I have been able to work
15 together on our set of charges. I don't know who wants to go
16 first, but ---

17 THE COURT: Well, let's do this.

18 MR. HALVERSEN: We have ---

19 THE COURT: Let me do this, the way we'll do it.

20 So personal injury, as you know, is out. I took that one
21 out. I also took -- or I'm letting y'all know I do this.
22 Y'all can object to it for the record. I've been doing it. I
23 never don't do it. It's a little disconnect, as I've told
24 most lawyers from the old school, the new school. I send the
25 charges back so they have them. They can -- they can refer to

1 them. They can read them.

2 I have been doing this -- I mean, this is probably my
3 fifteenth or twentieth trial that I've had, and I have not had
4 anybody come back and ask me a question on the law yet. Now,
5 they always ask can they have more sandwiches. They'll ask
6 how much insurance was there. I mean, they ask all the
7 questions you would expect. But no one has ever asked me
8 anything on the law. So I send it back. So just to let you
9 know about that.

10 So let's do this. We're going to start with -- because
11 we have to do it chronologically, because she has to be able
12 to put them in there. So let's go to y'all's request to
13 charge.

14 MR. HORTON: Yes, Your Honor.

15 THE COURT: Yeah. The defendant's request to charge.
16 Y'all originally had one through -- y'all's are numbered. So
17 let's go based on that. You have 1 through 32.

18 MR. HORTON: And, Your Honor, I sent a second set last
19 night that's going to reduce it to three.

20 THE COURT: So those are your three?

21 MR. HORTON: Yes, sir.

22 THE COURT: Okay. Then that makes more sense. Then
23 we'll get out of that. I was assuming you were adding three
24 onto what you'd already proposed.

25 MR. HORTON: No, these are -- that's modified from what

1 we'd originally proposed to roll.

2 THE COURT: So ---

3 MR. HORTON: To do together. Mr. Halversen and I have
4 discussed this charge, Your Honor; and we have a disagreement
5 about only one sentence, which is the -- if that is fair,
6 Brent? You -- yeah.

7 MR. HALVERSEN: I mean, I ---

8 THE COURT: Which one are we on? Number 1, number 2?

9 MR. HORTON: Number 1.

10 THE COURT: All right. Let's go.

11 MR. HALVERSEN: I personally don't like the commentary,
12 which is narrative of the -- complication not evidence of
13 negligence.

14 MR. HORTON: Oh.

15 MR. HALVERSEN: You know, if it said complication in and
16 of itself, I mean that's just narrative. But I think ---

17 MR. HORTON: That's fine.

18 MR. HALVERSEN: It's fine when it says the mere fact that
19 the plaintiff experienced complications is not evidence in and
20 of itself of negligence on the part of the defendant. I'm
21 fine with that.

22 I don't -- I do not like the next sentence which says
23 negligence may not be inferred from the incurrence of a known
24 complication. The next -- and I'll talk about that in a
25 second. The next sentence says you may not speculate that

1 misfortune was the result of negligence in the absence as to
2 how physician deviated from the standard of care. I'm okay
3 with that sentence.

4 What I don't like, Your Honor, is that second sentence I
5 referred to which says negligence may not be inferred from the
6 incurrence of a known complication.

7 For -- so as a lawyer, when I read that, I pause for a
8 minute and I'm like, okay, what does that mean. It says
9 negligence may not be inferred. That means when you have a
10 known complication. Okay, that doesn't mean negligence
11 happened. But I think as a lay person if a lay person reads
12 that, they say negligence may not be inferred from the
13 occurrence of a known complication. Hey, that, to me says you
14 can't have negligence if it's a known complication. Game
15 over. Defendants win. That's why I don't like that sentence
16 at all.

17 The rest of it I think gets to what they're trying to say
18 is if you've got a complication it doesn't mean it's
19 negligence. So that's my point there.

20 THE COURT: Okay.

21 MR. HORTON: Your Honor, I'd ask that we charge Fletcher
22 vs. MUSC. That's a black letter statement of law in South
23 Carolina. Negligence may not be inferred. That's --
24 that's -- exactly. That's the hurdle they have to get over.

25 MR. HALVERSEN: I'm just saying, Your Honor, we get the

1 same point across without confusing the jury. And I think the
2 jury can easily get -- it imparts the exact same information
3 they're going after, which is just because you got a
4 consultation doesn't mean it's negligence. I just believe
5 that that sentence is misleading, and I think it could mislead
6 the jury.

7 THE COURT: All right. What about Number 2?

8 MR. SLOTCHIVER: We've agreed to 2 and 3, Your Honor.

9 THE COURT: All right. And so have y'all agreed to any
10 other charges?

11 MR. HALVERSEN: The next part depends on ---

12 MR. SLOTCHIVER: These are our charges ---

13 MR. HALVERSEN: Yeah.

14 THE COURT: Okay.

15 MR. HALVERSEN: And we have -- it's what I sent this
16 morning was -- is the total aggravation charge. And Mr.
17 Horton and I agreed to limit it to -- because some of the --
18 some of the charges seem a little bit redundant. And we
19 agreed to --

20 [Plaintiff counselors confer]

21 MR. HALVERSEN: So I am going to put a box around what
22 we've agreed to.

23 THE COURT: Okay.

24 MR. HALVERSEN: And to omit I'll just put key.

25 THE COURT: Thank you.

1 MR. HALVERSEN: Omit everything else.

2 THE COURT: All right. And so we -- so we're going to
3 charge them just on the boxed information. I'm going to read
4 all these into the record. So we'll talk about them later.
5 But all right. So we've agreed on that.

6 And what about the plaintiff's charge of adverse
7 inference; did y'all agree on that one?

8 MR. HALVERSEN: We did not.

9 MR. SMYTH: No, Your Honor.

10 THE COURT: All right. And did y'all agree on reading
11 the statute?

12 MR. HALVERSEN: No, Your Honor.

13 THE COURT: All right. So let's talk about the first
14 one, then. The statute ---

15 MR. HALVERSEN: The violation of the statute; you want to
16 talk about that first?

17 THE COURT: Yeah. Did that exhibit -- is that a part of
18 an exhibit?

19 MR. HALVERSEN: One is in the record. One, Your Honor,
20 disallowed from coming into evidence because of their argument
21 about it being regulatory in nature.

22 So the one that's in evidence is the one I put in the
23 jury charge, I sent to the Court this morning, which is the
24 DHEC regulation about the obligation to keep and maintain
25 records and doing the signed informed consent.

1 THE COURT: Okay.

2 MR. HALVERSEN: So the one I sent -- I admitted the other
3 statute that was on the previous charge. The new charge I
4 sent this morning just has that one statute.

5 THE COURT: Yeah. We didn't -- I didn't allow in Section
6 40-47-110; but we did talk about this code section, 61-91,
7 Section 700, at length.

8 MR. HALVERSEN: Yes, Your Honor.

9 THE COURT: So what is your -- what is your objection?

10 MR. HORTON: Our objection is this is the standard for
11 licensing ambulatory surgery facilities. It applies to
12 licensees. The licensee is Pat O'Neill, who is not a
13 defendant to this case, Your Honor. Dr. Schimpf operated in
14 his O.R. He's the licensee. That applies to Pat O'Neill. It
15 does not apply ---

16 THE COURT: This is the same argument you made before,
17 correct, when I allowed them to get into this?

18 MR. HORTON: Yes, Your Honor. And you ---

19 THE COURT: Well, let's talk -- let's don't talk about
20 that part of it.

21 MR. HORTON: Yes, sir.

22 THE COURT: The semantic of Mr. O'Brian verses Mr.
23 Schimpf. I mean, he's testified that -- or Dr. Schimpf has
24 testified now that he has his own regulatory place and that
25 they were sharing it and that they were sharing ---

1 MR. HORTON: Yes, Your Honor.

2 THE COURT: --- staff. And so I think he's -- even
3 though someone has pulled the license, I think he still falls
4 under that code section. So what is the -- I mean, what is
5 the harm in charging that if we've already gotten into it?

6 MR. HORTON: I believe there's a licensing exception to
7 negligence per se.

8 THE COURT: Okay.

9 MR. HORTON: That is the entire basis of our argument
10 here. Negligence per se only applies when you prove that the
11 code section is applicable. That is our -- that's the crux of
12 our argument, Your Honor.

13 THE COURT: All right. And how is it not applicable in
14 this case?

15 MR. HORTON: It's not applicable ---

16 THE COURT: Because you're saying that it was Dr. O'Brian
17 and not Dr. Schimpf?

18 MR. HORTON: That's part of it. And, two, this statute,
19 this whole regulatory scheme, is not designed to protect an
20 individual in plaintiff's position.

21 It's about how you hold a license to run a stand-alone
22 surgery facility, which is why the licensing exceptions exist.
23 It's not thou shalt not run a stop sign. It's, you know, you
24 have to do these 150 things to hold a license.

25 And that's why those licensing exceptions. We argue this

1 in every nursing home case that comes up. You know, Your
2 Honor, that's the basis for it. You heard it the other day
3 from those other gentlemen who were arguing the cases, Whitlaw
4 vs. Kroger. It sets out the whole scheme here very clearly.

5 And we believe that under the Rayfield case, which is the
6 initial negligence per se case, it's the lead case on the
7 matter, you know, they can't prove that this is a statute that
8 applies to the protection of persons similarly situated to
9 Jeane Whitfield. This is -- this regulatory scheme exists to
10 determine who can run a stand-alone surgery facility.

11 THE COURT: Okay.

12 MR. HALVERSEN: Your Honor, may I?

13 THE COURT: Sure.

14 MR. HALVERSEN: Your Honor, if their argument was
15 correct, then we -- there would never be a duty that we could
16 introduce that a facility is supposed to maintain an organized
17 record for the patient's benefit.

18 I mean, he just said that that's not for the benefit of
19 the patient. It's right in the damn -- sorry. Sorry. Excuse
20 my language. It sits in the -- the facility shall initiate
21 and maintain an organized record for each patient. It's for
22 the patient's protection.

23 In terms of this argument that it was Dr. O'Neill's
24 facility at the time and not Dr. ---

25 THE COURT: He's just making that for the record. That's

1 fine.

2 MR. HALVERSEN: Okay.

3 THE COURT: Let's -- all right. And so what -- but I
4 would disagree with that, Mr. Smyth, because he's agreeing --
5 he's agreeing that they shared everything.

6 Just because "A" goes and pulls the license and "B" is
7 working under that same standard, I don't think just because
8 of the fact he's -- you know, he's the one that's pulled the
9 license changes the duty for Dr. Schimpf.

10 MR. HALVERSEN: In fact, Your Honor, to hold their
11 argument to its logical extension, if he wasn't the licensee
12 at the time, then these licensing statutes which there are
13 relying on technically wouldn't even apply.

14 But setting that aside, they've also claimed that Dr.
15 O'Neill was never the patient of -- I'm sorry, Ms. Schimpf
16 [sic] was never Dr. O'Neill's patient. It's always been Dr.
17 Schimpf. They were sharing the office space. They were
18 sharing the medical equipment. They were sharing the O.R. So
19 for them to say, up, hey, that's over there now ---

20 MR. HORTON: The exact same as Dr. Kalus operating in
21 Charleston Surgery Center. He doesn't hold the license. I
22 mean that's another entity entirely.

23 THE COURT: But my point is I agree with you, ---

24 MR. HORTON: Yes, Your Honor. Sorry.

25 THE COURT: --- he still is under the duty to do all of

1 these things. I don't care if he's doing surgery in his back
2 yard. I mean, it says that -- if it's -- I mean as long as
3 his back yard apparently has an ambulatory center.

4 But the duty still exists to Dr. Schimpf. And so I think
5 that -- we've talked about it in the trial. We've discussed
6 it ad nauseam about these records. So I don't see that
7 there's ---

8 MR. HORTON: May I make one point, Your Honor?

9 THE COURT: Absolutely.

10 MR. HORTON: That's the distinction between negligence
11 and negligence per se.

12 THE COURT: I agree with that.

13 MR. HORTON: You know, he's got the duty to maintain
14 records under the standard of care. We've talked about that
15 ad nauseam. Negligence per se is a different animal. It's an
16 animal constructed out of the series of Supreme Court
17 decisions on it. And you know what my argument is on that.
18 So I would just like to note that for the record. That's
19 Rayfield and Whitlaw, Your Honor.

20 THE COURT: Well, didn't we discuss it previously -- but
21 I mean I think Mr. Smyth was making the argument at the time
22 and I said, well, they can talk about it as a duty but the
23 damages is going to be their largest hurdle. And that's what
24 I think we discussed. And you agreed with me that that's the
25 issue, is that did the fact that he did not maintain and keep

1 these records, which I find he had a duty to do whether he was
2 doing the surgery under Dr. O'Neill's license or his own,
3 because the second prong of that ---

4 MR. HORTON: Which is the other reason we would think
5 that they don't get a charge on negligence per se is the fact
6 there's three and four of Whitlaw. You know, violation of a
7 statute does not -- that's a quote from Whitlaw. Next, you
8 have to prove that it's the but-for cause and the proximate
9 cause, so two more hurdles, ---

10 THE COURT: All right.

11 MR. HALVERSEN: May I address those terms?

12 MR. HORTON: --- before you can charge negligence per se.
13 To get a charge on negligence per se you have to get over the
14 causation hurdle.

15 THE COURT: All righty.

16 MR. HALVERSEN: I agree with him.

17 Now, let's take a look at the statute, Your Honor, DHEC
18 regulation statute. And it says, Subparagraph B, specific
19 entry/documentation shall include, at a minimum - and then
20 look at Sub 11 - signed, informed consent.

21 What have we been talking about for this last week?

22 THE COURT: Well, he's just saying is, is that under
23 negligence that they have a duty to provide all of those, not
24 negligence per se. And that's his argument.

25 MR. HALVERSEN: So we ---

1 THE COURT: But he's saying that you've got to get --
2 here's -- how do you get -- what -- have y'all gotten over
3 the -- what argument do you have that y'all have gotten over
4 the hurdle of causation of any damages that these records are
5 not -- are non-existent?

6 MR. HALVERSEN: Based on -- based on the testimony that
7 Dr. Schimpf admitted there was no specific, signed, informed
8 consent for the liposuction to the neck. Based on our expert,
9 Dr. Rosenberg's testimony that that was the deviation in the
10 standard of care that caused her harm, caused damages to her
11 neck. The psychological damages she's testified to, to having
12 cut on her neck. The damages that Dr. Marcino has testified
13 for psychological damages for having been cut on her neck.

14 So it all ties together, Your Honor, right there, not
15 having the informed consent. Why is there an informed consent
16 signed? Testimony has shown, so that everybody knows what's
17 being done and somebody knows that that's the patient I'm
18 cutting on and that's the procedure I'm doing.

19 THE COURT: All right.

20 MR. HORTON: I'm sorry, Your Honor; I'm thick-headed. I
21 still can't get past the applicability of the statute to our
22 client. And then the reason being is we're imposing a duty on
23 an individual that the statute does not impose. The statute
24 is designed to address the facility. He is not the facility.
25 He never has been. He shared the facility. But that doesn't

1 alleviate the facility owner of the duty.

2 So there's a difference there in placing a legal duty on
3 him that did not exist - and he's testified did not exist -
4 and then charging them for violating a statute that he is not
5 responsible for complying with.

6 THE COURT: All right.

7 MR. HALVERSEN: So I think that's a big hurdle. But I
8 also think their -- the other arguments are very strong as
9 well as to why that should not be charged and the proximate
10 cause and the damages.

11 THE COURT: All right. I will note your thick-headedness
12 for the record, and I will -- I will note that I disagree with
13 you wholeheartedly. So we are all -- we are all on the same
14 page.

15 All right. I am going to take that under advisement in
16 the break we're going to have here in about five minutes,
17 but -- we need to go up there and do them.

18 What about adverse inference? That's the last one.

19 MR. HALVERSEN: Your Honor, the case cited at the bottom
20 of a page, Stokes verse Spartanburg Medical Center, apply with
21 my adverse inference: Without medical records, pursuant to
22 South Carolina law, plaintiff is entitled to an adverse
23 inference through a specific jury instruction, whether the
24 record is lost or destroyed.

25 There's certainly evidence that they can ponder about,

1 whether or not these tapes were erased, whatever, not made;
2 but there's certainly a lot of evidence, affirmative evidence,
3 that the records were missing per their own testimony. I
4 think they want to differentiate that ---

5 [Plaintiff's counselors confer]

6 MR. HALVERSEN: Yeah, photos are a part of the records.
7 I forgot to mention that. But I forgot to -- they want to say
8 that in the Stokes case it's somehow factually different
9 because it was some kind of like monitoring strips that
10 weren't and that's somehow factually distinguishable.

11 Well, I mean, on that logic, every case is going to be
12 factually distinguishable. We have missing records. We're
13 entitled to an adverse inference. It's pretty -- pretty
14 straightforward.

15 THE COURT: All righty.

16 And what is your ---

17 MR. HORTON: Your Honor, he is misquoting Stokes. Stokes
18 says that it's reasonable to charge that when a party fails to
19 preserve material evidence for trial, then they get the
20 charge. So that assumes that the evidence that failed to be
21 preserved, which is clear in Stokes, those are the facts ---

22 THE COURT: Like a spoliation ---

23 MR. HORTON: --- that it existed, "A".

24 THE COURT: --- charge.

25 MR. HORTON: Yes, Your Honor.

1 And that it was then destroyed.

2 So Pat O'Neill, the gentleman we're talking about here
3 who runs the surgery center, gave an affidavit which is in
4 evidence that says - and he reviewed the audit log which
5 controls the MR - that no records were destroyed.

6 The case, Stokes, that he's asking you to charge, comes
7 out of the scenario where evidence existed and didn't make it
8 into the plaintiff's hands. That's a different circumstance.
9 It's not -- it's distinct from what we're talking about here.

10 That's my argument. If you'd like to see ---

11 MR. HALVERSEN: Your Honor, ---

12 MR. HORTON: --- O'Neill's auto-log.

13 MR. HALVERSEN: --- if there is some kind of spoliation
14 distinction he's making, there was clear testimony from Vicky
15 Tolbert. If you remember, she's on the stand and I asked her
16 was there -- were there dictations on these tapes at one point
17 in time. And she said, yeah, the transcription said it was my
18 understanding that there was transcription that was original
19 there that is not there.

20 So we do have a situation where -- according to the
21 testimony, where there was evidence of medical records that
22 pertained to our client, per their testimony, that isn't here
23 anymore.

24 MR. HORTON: Your Honor, that testimony shows that the
25 tapes had wound one way and the other, and not that something

1 had existed and been destroyed.

2 MR. HALVERSEN: Photos, too, were once in existence. We
3 don't have any explanation as to why. Dr. O'Neill testified I
4 can't say that -- there was no evidence they were deleted.
5 There's no evidence that they weren't deleted. It's kind of
6 like a negative. But they were in existence at one time. We
7 all agree on that. And they're not here.

8 THE COURT: All right.

9 MR. HORTON: And this is another issue as to the church
10 and state divided here between O'Neill and Schimpf. Dawn, the
11 woman who's passed from cancer, is an O'Neill employee
12 employed by O'Neill Surgery Center, who takes the pictures and
13 whose responsibility it is to upload them. If that duty is on
14 anyone's head, it's on Pat O'Neill's head and not Schimpf's.

15 THE COURT: All right. Anything else for the record
16 before we take a break?

17 MR. SLOTCHIVER: We have the other one. We have one more
18 motion, Your Honor.

19 MR. HALVERSEN: Oh, yeah, we have -- I'm sorry, we had
20 one more, the adverse -- one more adverse inference.

21 THE COURT: Okay.

22 MR. HALVERSEN: And this is as to punitive damages. As
23 you may recall, many moons ago at the beginning of the week
24 when we talked to you about the motion to strike and how we
25 got these financials, at the last-minute scrambled, got our

1 CPA to review it, he couldn't make any sense of it. He's
2 testified that the records were inaccurate and unreliable.
3 I also deposed their CPA on it. The CPA also agreed they
4 were -- that came in. And the CPA -- their CPA said they were
5 inaccurate and unreliable.

6 But what information we also had from that -- that Mr.
7 Ray Roberts, our CPA's testimony, was that the -- that the
8 balance sheet and the financial documents for just
9 Sweetgrass -- and this is just going to apply to Sweetgrass,
10 not -- well, actually, might apply to both. But I'll get into
11 that.

12 For Sweetgrass, the balance sheet, he testified that
13 based on the April 30th, 2019 document, that that was
14 unreliable. Net worth is a factor for the jury to consider
15 under the case law as one of the prongs of in considering
16 punitive damages. So we were given inaccurate and incomplete
17 information as to -- as to the net worth of the defendants, as
18 to -- as to Sweetgrass.

19 As to Dr. Schimpf personally, the information we got on
20 his personal tax return, we have testimony that is not refuted
21 that he was under-reporting his income for two- -- the year
22 2017. That's evidence that the financials also for him
23 personally, that we've been given, is inaccurate and
24 unreliable.

25 If Your Honor is less inclined to go with that as to Dr.

1 Schimpf, I do believe strongly that the information we got
2 from Sweetgrass entitles us to an adverse inference because
3 there was direct testimony from our CPA against -- again, that
4 was not refuted, that the balance sheet information which
5 contains the net worth which he testified to of \$400,000 - we
6 believe is low - but it's inaccurate for the reasons he stated
7 under oath.

8 THE COURT: All righty.

9 MR. HORTON: Yes, Your Honor.

10 So, "A", the initial CPA's deposition they're referring
11 to, they didn't bring him. It's not in evidence. It's not in
12 the record. It has no bearing upon what we have to decide
13 here.

14 "B", they've been able to establish Schimpf's net worth
15 as well as the practice's net worth. There's no entitlement
16 to an adverse inference. There's nothing missing. There's no
17 documentation that the jury needs to make the decision that's
18 not in evidence; therefore, they don't get an inference which
19 is based upon the spoliation case law.

20 THE COURT: All right. All right. We're going to take a
21 break and I'll come back and let you know what I decide.

22 MR. HORTON: Thank you, Your Honor.

23 [Whereupon, a recess is taken 8/30/19, 10:51 a.m. to
24 11:02 a.m.]

25 THE COURT: All right. Go ahead and bring in the jury.

1 [Whereupon, the jury enters the courtroom 8/30/19, 11:03
2 a.m.]

3 THE BAILIFF: The jury is seated, Your Honor.

4 THE COURT: All righty. Thank you very much.

5 Mr. Smyth?

6 MR. SMYTH: Thank you, Your Honor.

7 THE COURT: Yes, sir.

8 Dr. Perez, we're getting close to the end here.

9 **RESUME DIRECT EXAMINATION BY MR. SMYTH OF DR. JORGE PEREZ:**

10 Q. Dr. Perez, we're getting close to the end here. I wanted
11 to ask you a few questions though on the topic of damages in
12 this case.

13 I believe you've got the plaintiff's exhibit in front of
14 you which outlines the damages that have been submitted by the
15 plaintiffs; and I wanted to ask you a few questions about
16 those, if you would, please.

17 In your review of those bills and charges did you find
18 evidence that there were charges submitted that had nothing to
19 do with this case?

20 A. Yes, sir.

21 Q. And would that include charges for removal of cancer?

22 A. Yes, sir.

23 Q. Or skin lesions, I guess?

24 A. They -- they were reported as cancers, but they were not.
25 They were just freckles.

1 Q. Would it also include charges for a hernia repair?

2 A. Yes, sir.

3 Q. Would it also include charges for the cardiac event?

4 A. Yes, sir.

5 Q. And do you believe any of the charges related to the
6 surgeries that Dr. Kalus performed in that subsequent
7 postoperative period are the responsibility of Dr. Schimpf for
8 any reason?

9 A. No, sir. I don't believe that any of the charges related
10 to Mrs. Whitfield's case, when Dr. Kalus assumed the care, are
11 at all related to Dr. Schimpf.

12 Q. All right. Are there also charges included, in what the
13 plaintiffs have submitted, for future surgeries?

14 A. Yes, sir.

15 Q. And have you reviewed the proposals that they submitted
16 in conjunction with those future surgeries?

17 A. Yes, sir.

18 Q. Do you believe those are necessary or appropriate in this
19 case?

20 A. Well, I believe that Mrs. Whitfield will need surgery
21 going forward. I disagree with the options that were
22 discussed by the other two experts on the case. However, I do
23 not believe that those are a consequence of Dr. Schimpf's
24 surgery. I believe they're wholly -- the responsibility
25 wholly lies with Dr. Kalus and the path that he took Mrs.

1 Whitfield on after he assumed her care.

2 Q. All right. And let's talk about the options that have
3 been discussed. Dr. Rosenberg had some proposals. Were you
4 in the courtroom when he testified about what those were?

5 A. I was, sir.

6 Q. And what did he testify that he thought needed to be
7 done?

8 A. Well, Dr. Rosenberg -- I also read Dr. Rosenberg's
9 deposition from several months ago, and I was here when he was
10 testifying.

11 Dr. Rosenberg's position basically is that Mrs. Whitfield
12 does not have sufficient breast tissue to simply put an
13 implant in, as I have proposed -- I proposed, after Dr. Kalus'
14 first surgery where he removed the right implant, my solution
15 would have been a simple breast augmentation and be done with
16 it.

17 Q. I want to show you a picture that maybe you can use. Is
18 this a photograph that you took during your examination of Ms.
19 Whitfield?

20 A. Yes, sir.

21 Q. All right. And would this be helpful in illustrating why
22 you don't believe Dr. Rosenberg's surgery was appropriate?

23 A. Sure. Can you put it on the easel?

24 Q. Sure.

25 A. May I come down or ---

1 Q. Let's just do it from here.

2 A. Okay. So this is -- this is the photo that I took of
3 Mrs. Whitfield on July 21st, last month, when I came to
4 examine her. And it basically shows her condition now.

5 Again, my original proposal, when her left breast was
6 intact, would have been to simply augment the right, put an
7 implant in, get reasonable symmetry, and be done.

8 Obviously, she underwent a cascade of procedures that
9 have left her with a greater asymmetry and this problem that
10 we have now today.

11 Going forward, she needs to have implants basically on
12 both sides. Dr. Kalus' recommendation was to do fat-grafting
13 again, which I totally disagree with, and then do implants.
14 Well, the purpose of fat-grafting is to avoid implants, so it
15 seems silly and redundant to do them both.

16 The -- in this case I think if Mrs. Whitfield, in order
17 to restore her esthetically, I would put an implant in on both
18 sides, just put a larger implant in on the left and a smaller
19 one in on the right to try to compensate, to give her as close
20 to asymmetry as possible.

21 I would just make one caveat, and that is that there are
22 mental health issues here that have intervened that I think
23 take precedent before this even gets undertaken. But from an
24 esthetic point of view, that's what I would recommend for her.
25 That would be my recommendation.

1 Dr. Kalus, as I said, his proposal was to first inject
2 more fat, which is again, unpredictable, and then follow it
3 with the implants. I'm not sure why both of those are
4 necessary. The implants I think are adequate.

5 Dr. Rosenberg, the expert from New York, said that -- he
6 actually proposed even stranger solutions to this. One
7 solution that he had proposed was a soft-tissue -- what's
8 called a soft-tissue expander. A soft-tissue expander is used
9 in cases where patients have had cancer and they've had a
10 mastectomy where the entire breast is removed and, along with
11 it, a lot of skin so that it is very, very tight, there is
12 absolutely no room to accommodate any significant size
13 implant.

14 And in that setting what we do -- and that's a breast
15 reconstruction, which is for -- again, for cancer. What we do
16 is we put in a balloon, basically, that starts out empty, and
17 then we fill it with water gradually over a period of time to
18 allow the skin to stretch, very much the way a belly stretches
19 during pregnancy. And during that period of several months,
20 that skin stretches. And then we come back at a second stage
21 and do the augmentation. That was one proposal that Dr.
22 Rosenberg made. I think that is absolutely unnecessary.

23 Dr. Rosenberg did not examine the patient. I had the
24 ability to examine Mrs. Whitfield. I had the ability to touch
25 Mrs. Whitfield's skin and do measurements. And there's

1 absolutely -- I am one-hundred percent certain that Mrs.
2 Whitfield can accommodate implants as she is today without the
3 need for an expansion first.

4 I routinely put in implants in young patients with very
5 tight skin, who've never had children, who have tiny A-cup
6 breasts; and I can -- I can put implants in those patients.
7 There is absolutely no question that Mrs. Whitfield can have
8 implants in without the need for a pre-expansion. So that
9 idea I think is illogical.

10 He also had proposed - and I'm not sure if he did it here
11 or if he did it in his deposition - very esoteric, complicated
12 breast reconstructions where tissue was taken from different
13 parts of the body, either from the back, what's called the
14 latissimus dorsi flap, or from the belly, which is called the
15 tramp flap, or even a crazier idea, which is free-tissue
16 transfer, which is basically taking the butt, detaching it,
17 and hooking it back up under the microscope. I

18 Those are operations that are done exclusively, with the
19 very rare exception, in cases of breast cancer and mastectomy,
20 and often radiation where you can't even get an implant in.
21 They have -- they are very complicated surgeries. They carry
22 much more additional scarring. They have all kinds of
23 complications that potentially can occur. And it would
24 absolutely be wrong to do that, to even suggest to do that, in
25 the setting of a cosmetic patient.

1 So I think all of those proposals are just not to be
2 taken seriously. I think that in Mrs. Whitfield's case I
3 think it's pretty straightforward. I think it's obvious that
4 one implant back then after Kalus' first surgery would have
5 been adequate; and now two implants would be appropriate, and
6 call it a day.

7 Q. Do you believe the primary reason Ms. Whitfield needs
8 addition surgeries is because of the surgery Dr. Kalus did on
9 her in March?

10 A. Yes, absolutely. Everything that has followed for Mrs.
11 Whitfield's care has been a consequence of the poor decisions
12 made by Dr. Kalus in concert with Mrs. Whitfield.

13 Dr. Kalus in his testimony said that it was Mrs.
14 Whitfield's decision, she was the one who wanted the implants
15 out; and he blamed her for those bad decisions.

16 I think that he bears that responsibility whether -- it
17 may be a combination of the two, but I think that that
18 responsibility lies with them. That has nothing to do with
19 the care and treatment that she received for the five weeks
20 that she was with Dr. Schimpf.

21 Q. And I've just handed you, Doctor, Exhibit 46, which has
22 been previously agreed upon and admitted into evidence. Do
23 you recognize that document?

24 A. Yes, sir.

25 Q. What is it, please?

1 A. This is a pathology report from the surgery on March
2 11th, 2015, on Mrs. Whitfield; and it's the result of breast
3 tissue that was examined.

4 Q. Is that the surgery where he removed the tissue and the
5 implant?

6 A. Yes, sir.

7 Q. And what was Dr. Kalus' justification for doing that
8 surgery? Do you remember?

9 A. Yes. Well, there were two components to that surgery.
10 He removed tissue from both breasts, with the justification
11 that she had fat necrosis that needed to be removed.

12 Now, fat necrosis, which he believes that he diagnosed
13 clinically, by saying he felt a lump and she had pain. Mrs.
14 Whitfield's surgery had only been eight or nine months before.
15 That very plausibly could have just been simple scar tissue.
16 It takes scars up to two years to mature and soften. And so
17 the fact that you feel a little lump in a post-surgical
18 patient like this is not unusual. The fact that there's a
19 little pain associated with it is not unusual. It is not
20 necessary to go back in and take out more tissue. So -- but
21 he used fat necrosis as the justification to do that.

22 The -- in addition to that, that other big area that you
23 have the prop for, of almost 500 grams of tissue, that's a
24 huge amount of breast tissue that he took out of Mrs.
25 Whitfield on the left side.

1 He claims that he did it to achieve symmetry. Obviously,
2 that backfired completely, because he created a much created
3 asymmetry. But the justification, in part, was because there
4 was fat necrosis in that tissue that needed to come out.
5 There was none. There was none.

6 Q. And how do you know that?

7 A. Because that's contained here in the pathology report.
8 It's contained in the pathology -- so he sent the tissue on
9 both sides to the pathologist. The pathologist looks at it
10 under the microscope and gives us a definitive answer of
11 what's in there. And -- and on the right, there is -- it's
12 described in the microscopic description as some fat necrosis,
13 which is relatively insignificant. On the left side, there's
14 no -- no fat necrosis reported at all.

15 Q. And that's the side that he removed this amount of
16 tissue?

17 A. Yes, sir. And I'm sorry. One final thing. And in the
18 final -- and that's in the microscopic. In the final report,
19 it doesn't even mention fat necrosis.

20 So the fact that it's mentioned earlier as some, really
21 means that it's insignificant because it's not even contained
22 in the pathologist's final report.

23 Q. And wrapping up, Doctor. Based on your review of all the
24 evidence in this case, do you hold an opinion as to whether
25 Dr. Schimpf did anything that was negligent or below the

1 standard of care in the treatment of Ms. Whitfield?

2 A. No, sir. I believe that this was a complicated surgery
3 in a complicated patient with serious mental health issues
4 that I think impacted some of the decision-making.

5 I think that the procedure that Dr. Schimpf performed was
6 appropriate. I think that there's no indication that it was
7 done improperly.

8 There are many reasons why patients develop post-op
9 swelling and tension that can impact and create this kind of
10 result that we didn't really go into. But there are many,
11 many reasons that have nothing to do with what went on at the
12 time of surgery.

13 I believe that when the complication occurred, however,
14 Dr. Schimpf took care of the patient. His management post-op
15 was appropriate. The things he did, even those stitches that
16 he put in, were absolutely appropriate. I've done them myself
17 in my -- in my own practice.

18 And I think that were it not for the fact that Mrs.
19 Whitfield, you know, had her anxiety issues related to the
20 care and perhaps some interpersonal interactions between the
21 two, she chose to leave his care. But I believe that if she
22 had stayed with him, he would have managed that wound
23 appropriately.

24 I think managing it conservatively with dressing changes
25 could very well have resolved the problem within the coming

Examination of Dr. Jorge Perez - Cross by Mr. Halversen

1 two to three weeks and she would not have needed any further
2 surgery.

3 And in the worst case scenario, what Dr. Kalus did in
4 removing it, could have been easily corrected with a simple
5 augmentation down the line.

6 Q. Thank you, Doctor. Do you hold the opinions that you've
7 expressed here today in this courtroom to a reasonable degree
8 of medical certainty as a board certified plastic surgeon?

9 A. Yes, I do.

10 MR. SMYTH: Thank you, Doctor. Those are all the
11 questions I have. Please answer any questions the opposing
12 counsel may have.

13 THE WITNESS: Sure.

14 **CROSS-EXAMINATION BY MR. HALVERSEN OF DR. JORGE PEREZ:**

15 Q. Good afternoon. Doctor, what is -- where is your
16 practice located?

17 A. Fort Lauderdale, Florida.

18 Q. Is it North Fort Lauderdale, is that the mailing address?

19 A. Well, there is no North Fort Lauderdale. It's just Fort
20 Lauderdale.

21 Q. Oh, okay. And what is the name of your practice?

22 A. Well, the legal entity is my own name.

23 Q. And could you please state that for the record?

24 A. Jorge Alexander Perez, M.D.P.A.

25 Q. What's the name on the side of your -- of your building

1 is what I was trying to ask you.

2 A. Well, we have a website that has a sign. It's Perez
3 Plastic Surgery.

4 Q. Doctor, isn't it true you've been sued for medical
5 malpractice before?

6 A. Yes, sir.

7 Q. And was that case resolved?

8 A. It was dismissed without payment.

9 Q. It was dismissed?

10 A. Yes, sir.

11 Q. Wasn't -- wasn't -- there was no settlement in that case?

12 A. None. In fact, I actually sued the patient and
13 prevailed; and she settled with me out of court. Because I --
14 it was a -- it was a very wealthy woman who was very upset and
15 very angry, filed a lawsuit, but turned out to have lied many
16 times under oath. And so when we prevailed at trial, when the
17 case was dismissed, I then sued her and she settled with me
18 out of court. That's the only lawsuit I've ever had in thirty
19 years.

20 Q. So you disagree that there was a settlement?

21 A. There was no settlement.

22 Q. Why is there a stipulation of dismissal filed with the
23 Broward County Clerk of Court dated November 9th, 2001?

24 A. Well, I'm not sure. I'm not a lawyer, so I don't know
25 what that term means. But ---